Duty to Warn: When Should Confidentiality Be Breached?

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Family physicians may be confronted with the dilemma of when to breach a patient's confidentiality to warn an intended victim of specific threats of harm. The courts have consistently ruled that persons who have a therapeutic relationship with patients have a duty to protect society from specified and foreseeable danger, yet at the same time to act judiciously in guarding against unnecessarily violating a patient's confidentiality. The dilemma imposed by this dual obligation is illustrated by a case report. Guidelines for assessing dangerousness and determining a course of action are offered so physicians can respond to their patient's threats of violence. **J FAM PRACT 1990; 30:179-184.**

Given family medicine's biopsychosocial model of patient care, family physicians frequently engage in counseling relationships with their patients. Such a relationship carries certain legal and ethical responsibilities that may have been overlooked during residency training. One issue that has been of great concern for psychiatrists, psychologists, and other mental health professionals is breaching confidentiality to warn others of a patient's intent to harm an identifiable third party. The courts have consistently held that psychotherapists have a duty to protect others from specific threats of harm.[1] As family physicians place themselves in the role of psychotherapist, it is incumbent upon them to be aware of issues involved in confidentiality, the specific aspects of duty to warn and duty to protect, and the constitutional obligation to avoid unnecessarily restricting individual freedom. In particular, these issues may surface for family physicians when treating problems of domestic violence.

The focus of this paper will be on reviewing the relevant literature with respect to breaching patient confidentiality to protect others from harm. One of the authors' cases will be presented to illustrate the inherent conflict of these obligations. Since the proper course of action is not always clear, guidelines for making decisions about breaching confidentiality when the potential for violence exists will be offered so that physicians can determine their own stances.

CONFIDENTIALITY VS DUTY TO WARN

Communications between patients and their physicians have generally been considered confidential. As stated in the Hippocratic oath, "what I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men . . . I will keep to myself."[2] Medical ethics stress the importance of confidentiality based on the assumption of an individual's right to privacy and on the assumption that the consequences of breaching this right to privacy normally outweigh possible benefits.[3] The courts have ruled, however, that in some circumstances physicians have an obligation to break confidentiality when the welfare of others is in jeopardy. For example, physicians have a duty to protect the public from harmful, contagious, or dangerous patients.[4] This duty to protect occurs when a physician believes that a patient will harm others and that the victim(s) can be identified.

Although physicians have a duty to protect others when dangerousness can be predicted, research has shown that such predictions are unreliable.[5] There is no empirically based model for predicting dangerousness. Mental health professionals are twice as likely to be incorrect as correct in their assessment of whether a patient will commit an act of violence. Studies have shown that professionals most

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often overpredict dangerousness. Furthermore, the accuracy of predicting dangerousness decreases when making long-term as opposed to short-term predictions.[6]

Despite evidence that mental health professionals cannot predict with certainty that a patient will be violent, the courts have ruled that therapists have a duty to protect a person whom their patient threatens to harm.[1,5,6] In 1974 the California Supreme Court issued a landmark decision in *Tarasoff v Board of Regents of the University of California*.[7] A patient in psychotherapy with a psychologist threatened to kill a woman, whom he felt had rejected him, when she returned from summer vacation. In consultation with staff psychiatrists, the psychologist initiated involuntary commitment proceedings that were unsuccessful because the patient did not fulfill the stringent criteria for civil commitment under California law. The psychologist also notified police of the patient's threats. The police briefly detained him, but he was released after they determined that he was not imminently dangerous since the identified victim was not even in the country. When the woman returned approximately 2 months following this incident, however, the patient killed her.

The woman's parents initiated a wrongful death suit against all parties, alleging that their daughter should have been warned of the danger to her. The defendants argued that such a warning would have breached confidentiality, especially in view of research that has indicated that predictions of dangerousness are unreliable.[5] The court stated, however, that although it recognized that effective psychotherapy requires confidentiality, psychotherapists have a duty to protect an identifiable victim from foreseeable harm, even if confidentiality must be breached.[7] In *Tarasoff*, the court determined that the legal duty to protect was based on the special relationship between the therapist and patient, and given this relationship, responsibility for controlling the patient's behavior belonged to the therapist.[1]

The *Tarasoff* decision has since been extended by at least 12 states and several federal jurisdictions to include violent acts against persons in close relationship to an identified victim,[8] against property,[9] and when therapists "should have known" danger existed.[10] Yet, the question remains, how can one be responsible for another's violent behavior when dangerousness is so difficult to predict? Furthermore, how does one sufficiently control another's behavior in an outpatient setting? Finally, how does one separate a patient's wishful fantasy from actual danger that justifies breaching confidentiality and possibly damaging the patient-physician relationship? Given that the courts have extended the duty to protect, the issue becomes: when does duty to warn supersede confidentiality?

CASE ILLUSTRATION

A 43-year-old married college professor came to his physician with a complaint of weight loss. In the past, he had been followed for occasional episodes of bronchitis and irritable bowel. During this visit, he reported that he had been losing weight for several months, had poorly formed stools, and had increased abdominal cramping. He denied fever, night sweats, rectal bleeding, nausea, or vomiting. The patient's physical examination revealed him to be moderately agitated. There was mild epigastric and lower quadrant abdominal tenderness on the left side. Findings on the rest of the examination were normal.

On further questioning, the patient disclosed that he was distraught over problems in his marital relationship. He recently learned that his wife was having an affair, and that she had consulted an attorney about filing for divorce. The patient admitted to symptoms of depression, including insomnia, difficulty concentrating, fatigue, loss of libido, and lowered self-esteem. When specifically questioned about suicidal ideation, he responded "Suicidal, no; homicidal, maybe." He claimed to have fantasies about killing his wife and her lover, the content of which involved both of them begging his forgiveness for their affair while he killed them slowly and painfully. The patient, however, denied having formed a plan to carry out his fantasy or having the means to harm his wife and her lover.

Given the ambiguity of the patient's homicidal intent, the patient was referred to one of the authors for an assessment of dangerousness. The patient reported no violent behavior during childhood or adolescence, although he described himself as "an angry kid." He reported having been physically and emotionally abused by his father, and fantasized about avenging the abuse. Although he denied ever attempting to harm his father, he was uncertain as to why this was so.

The patient denied physically abusing his wife during their marriage. He did admit that in the past when he had become upset with her, he had made harassing telephone calls to her at work, had thrown a lamp at her, and had broken into her car looking for evidence of an extramarital affair. He stated that they frequently argued, and that the neighbors had called the police on at least one occasion. The patient admitted that he had done "a strange thing last week." After learning of his wife's affair, he located a pistol that had been unused for several years and shot the family cat.

During the interview, the patient was agitated and labile. He cried and mumbled repeatedly that he loved his wife. When asked whether he would attempt to harm his wife, he replied, "I don't think so—maybe—I don't

know." There was no evidence of psychotic thought processes.

Because of the patient's despondency over his marital relationship and the ambiguity of his intent to harm his wife, he was hospitalized for observation and further evaluation. He agreed to a voluntary admission, and granted the treatment team permission to contact his wife about his hospitalization and the threats he had made against her. Both individual and conjoint marital counseling sessions were conducted during hospitalization, and it was determined that the patient was neither suicidal nor homicidal. After 3 days of inpatient treatment, his symptoms improved. The patient was discharged and he continued in outpatient psychotherapy for 5 months. The focus of treatment was helping him cope with the dissolution of his marriage.

This case illustrates the potential conflict in the dual obligation of protecting society and patient confidentiality. In this instance, the patient waived his confidentiality, thus facilitating the therapist's course of action. Had he refused the therapist's request to notify his wife of this potentially dangerous situation, the therapist would have been placed in the position of weighing the potential benefits and risks of breaking confidentiality to protect an identified victim on the basis of ambiguous data. In view of *Tarasoff* and its extensions, one might assume that it is best to err in the direction of breaking confidentiality and warn persons that they are potential victims of a patient's threats. Therapists who break confidentiality without adequate clinical justification, however, may be found liable. In *Hopewell v Abidempe*,[11] a psychiatrist was found guilty of breaching confidentiality because he did not adequately assess the likelihood of a patient carrying out an act of threatened violence before notifying the patient's supervisor. Thus, given the ramifications of a poor decision regarding duty to warn, physicians who have a counseling relationship with patients must be able to assess adequately the likelihood that a patient may carry out threats of violence, and must implement a course of action.

GUIDELINES FOR DETERMINING DUTY TO WARN

Although the *Tarasoff* decision has been cited as legal doctrine in only a few states, and no family physician to the authors' knowledge has been subject to malpractice litigation on these grounds, it is therefore prudent for physicians who engage in counseling relationships with their patients, especially when dealing with domestic issues, to assume that *Tarasoff* guidelines would apply to them. Family physicians who have a special relationship with a patient, that is, a counseling relationship, and whose patient commits an act of violence, would likely be held to the standard of care of psychiatrists, psychologists, and other mental health professionals. Failure to warn an intended victim because of an inadequate assessment or no documented assessment of dangerousness when the physician "should have known" that violence is a possibility[10] would likely place him or her in jeopardy of malpractice litigation. Poor clinical judgment regarding duty to warn or an ill-conceived plan of action carries not only the threat of malpractice liability and injury to a third party, but the potential for damaging the patient-physician relationship as well. To minimize this triple risk, guidelines for assessing dangerousness, selecting a course of action, and implementing it will be offered.[12]

ASSESSING DANGEROUSNESS

In assessing dangerousness, history of violent behavior and information on current psychological status should be obtained. Given the absence of an empirically based model for predicting dangerousness, assessing BASIC (behavior, affect, somatic functioning, interpersonal relationships, and cognition)[13] has proven clinically useful. An overview for assessing patient dangerousness and references to the literature appear in Table 1.

Behavior

The best predictor of future behavior is past behavior.[6] Assess the patient's history of violent behavior, including recency, severity, and frequency of violent acts. Have there been arrests or convictions for violent behavior? Were there previous hospitalizations for "dangerous" behavior? Does the patient report having been involved in physical altercations at work, in bars, or at school? Was the patient a victim of child abuse? Did the patient witness spouse abuse? Does the patient currently engage in abusive behavior toward a spouse or child? Does the patient have a history of poor impulse control? Affirmative answers increase the likelihood of violent acting out.

In addition to a past history of violent behavior, it is essential to determine present circumstances. Is the present situation similar to one in which the patient has reacted violently in the past? Has the patient made a specific threat against an identifiable victim? A verbal threat alone is not sufficient cause to warn an intended victim.[20] How does the patient intend to implement his or her threats? Consider lethality, detail, coherency, and organization of plan; highly lethal, well-organized plans to harm another individual increases the likelihood of dangerousness. Does the patient have access to the means to carry out his or her plan? Is the patient in close proximity

TABLE 1. GUIDELINES FOR DETERMINING DUTY TO WARN

Assessing Dangerousness	References
Behavior	
Past Violent Behavior	1,5,6,14,15,16,17
Recency, severity, and frequency of violent behavior	1,15,16,18,19
Arrests/convictions for violent behavior	6,15,16
Hospitalizations for dangerous behavior	3,6,15
Physical altercations at work, bars, or school	
Abusive behavior towards wife or child	18
Poor impulse control	15,19
Present Circumstances	
Present situation similar to one that led the patient to violence in the past	15
Specific threat against an identifiable victim	1,5,14,18,16
Plan to implement the threat: lethality, detail, degree of organization	1,15,16
Access to means of carrying out plan	5,15–17,19
Proximity of patient to intended victim	5,6
Motive	14,16
Expressing fear of harming others	15,19
Affect	
Anger	
Overcontrolled or undercontrolled	15,19
General degree of anger	15,19
Specific anger toward victim	16
Anger combined with sadness	15,16,19
Labile affect	15,19
Somatic Expression	
Disinhibiting use of alcohol or other substance abuse	6,14–16,19
Interpersonal Relationships	
Emotional connectedness to family, friends, and/or co-workers	16
Frequency of contact with these significant others	
Degree of social isolation and lack of social support	
Anger directed toward significant others in past	18
Aggressive or passive approach to resolving conflicts	
Cognitive Expression	
Homicidal ideation or fantasies	19
Awareness of negative consequences for violent actions	
Ability to separate fantasy and impulse from behavior	16
Paranoid ideation, delusions, or hallucinations	15,16,19
Moral or religious beliefs which prevent violence	

to the intended victim? Does the patient engage in alcohol or other substance abuse that may disinhibit behavior? Affirmative answers increase the probability of dangerousness.

Affect

Is the patient angry? Sad? Labile? If angry and sad, assess for homicide and suicide potential. If angry, does the anger seem overcontrolled or undercontrolled? Overcontrolled anger can be more dangerous than anger that is easily expressed. Does the patient seem generally angry, or is the anger exclusively directed toward the victim, or both? Extreme anger directed toward an individual in combination with an "angry personality" increases the likelihood of violent behavior.

Somatic Expression

This area refers to the patient's general physical functioning and health. Although somatic symptoms may provide an index of the patient's stress level that can have deleterious long-term health consequences, they are unlikely to predict imminent dangerousness. Again, however, the disinhibiting effect of alcohol and other substances must be considered.

Interpersonal Relationships

Does the patient seem emotionally connected to family, friends, or co-workers? Does the patient have frequent contact with others? Low social support and social isolation increase the risk of violent acting out. Has the person toward whom the anger is directed been the patient's main source of support in the past? If so, feelings of aloneness and isolation may precipitate acting out. What is the patient's conflict resolution style? A passive approach to resolving conflicts militates against violent acting out.

Cognitive Expression

Obtain a detailed history of homicidal ideation and fantasies. Does the patient anticipate negative consequences for his or her actions? If so, does this anticipation reduce the affective intensity? Can the patient separate the fantasy of wanting to harm another individual from actual behavior? Does the patient report delusions, hallucinations, or paranoid ideation? The presence of any psychotic thought process increases the likelihood of violence. Does the patient have any moral or religious beliefs that may prevent him or her from acting on his or her threats?

SELECTING A COURSE OF ACTION

If the physician determines that the patient may be dangerous, several options are available, including involun-

TABLE 2. POSSIBLE COURSES OF ACTION

Possible Courses of Action	References
Voluntary hospitalization	1,3
Involuntary hospitalization	1,3,5,6,16–19
Warning intended victim, and informing patient of limits to confidentiality	1,3,5,6,14,16, 17,19,21
Notifying the police	1,3,5,6,16–19
Social or environmental manipulations to reduce lethality	5
Conjoint therapy with patient's intended victim	5,16,17,21
Seeking consultation	3,16,14–16,18
Medication changes	3,22
Documenting findings	3,5,14–17
Examining the past medical record	1,3,5,14,15,17

tary or voluntary hospitalization, warning the intended victim, notifying the police, social or environmental manipulations to reduce lethality, and conjoint therapy with the patient and intended victim.[5] An overview of possible courses of action and references to the literature are shown in Table 2.

Under *Tarasoff* guidelines, warning the victim is only one of several alternatives to be considered along with other therapeutic options. Nevertheless, if the physician determines that violent acting out is a possibility, then warning the victim should be included as a component of the treatment plan. Warning an intended victim, however, can jeopardize the patient-physician relationship if the patient feels that his or her trust has been violated. To minimize such difficulties, Roth and Meisel[20] recommend informing the patient of the limits of confidentiality, obtaining the patient's permission to contact the intended victim, and communicating with the victim in the patient's presence.

In addition to maintaining trust and openness in the patient-physician relationship, communicating with the intended victim in front of the patient can shift the focus from the intrapsychic processes of the patient to the problematic interactions of the patient and intended victim.[21] From a family systems perspective, the physician can assess the moves and countermoves that escalate tension and stress in the relationship to the point of threatened or actual violence. This strategy is most useful for stable, albeit dysfunctional relationships, in which there is a repetitive cycle of violence. It is not a viable option when violent behavior is imminent or life threatening or when cognitive processes are significantly or acutely impaired. Furthermore, caution needs to be exercised to ensure that the intervention does not precipitate the very behavior it is designed to mitigate.

IMPLEMENTING THE COURSE OF ACTION

Obviously no treatment plan is effective if it is not correctly executed. When working with potentially violent patients, devise the treatment plan in consultation with colleagues and frequently discuss aspects of the case with them. Because the potential risk is high to all parties, the consultant can help the physician maintain objectivity about the actual likelihood of violent behavior and assist him or her in dealing with whatever feelings the patient elicits that may obfuscate treatment issues.

In summary, the courts have fairly consistently ruled that protecting the public from specified and foreseeable harm supersedes a patient's right to confidentiality. The courts have also ruled that there must be adequate clinical justification for breaching confidentiality to warn an intended victim that he or she may be in danger. Given that there is no empirically based model for predicting dangerousness and that clinicians are unreliable in making such predictions, the dual obligation of protecting society and confidentiality places them in a double bind as they attempt to minimize the risks of injury to a third party, disruption of the physician-patient relationship, and complaints of malpractice. To overcome this dilemma, family physicians should become aware of the legal and ethical issues involved when treating potentially violent patients. In addition, the behavioral science medical education curriculum should include instruction in assessing dangerousness and options for handling potentially violent patients to help physicians determine the appropriate course of action.

References

1. Beck JC: The psychotherapist's duty to protect third parties from harm. Ment Phys Law Rep 1987; 11:141–148
2. Beauchamp TL, Childress JF: Principles of Biomedical Ethics. New York, Oxford University Press, 1979
3. Mills MJ, Sullivan G, Eth S: Protecting third parties: A decade after Tarasoff. Am J Psychol 1987; 144:68–74
4. Knapp S, VandeCreek L: Tarasoff: Five years later. Prof Psychol 1982; 13:511–516
5. Knapp S, VandeCreek L, Herzog C: The duty to protect: Legal principles and therapeutic guidelines. In Keller PA, Ritt LG: Innovations in Clinical Practice. Sarasota, Fla, Professional Resource Exchange, 1986, vol 5
6. American Psychological Association: White Paper on Duty to Protect. Washington, DC, American Psychological Association, 1985
7. *Tarasoff v Regents of the University of California*, 551 P2d 334, 131 Cal Rptr 14 (Cal Sup Ct 1976)
8. *Hedlund v Orange County*, 669 F2d 41, 194 Cal Rptr 805 (1983)
9. *Peck v The Counseling Service of Addison County*, 499 A2d 422 (Vt 1985)
10. *Jablonski v US*, 712 F2d 391 (9th Cir 1983)
11. *Hopewell v Adibempe*, No6d 78-82756 (Pa Ct Comm. Pleas, Allegheny Cty, Civ Div June 1, 1981)

12. Applebaum P: Tarasoff and the clinician: Problems in fulfilling the duty to protect. Am J Psychol 1985; 142:425–429
13. Slaikeu KA: Crisis Intervention: A Handbook for Practice and Research. Newton, Mass, Allyn & Bacon, 1984
14. Beck JC: The therapist's legal duty when the patient may be violent. Psychiatr Clin North Am 1988; 2:665–679
15. Reid WH: Clinical evaluation of the violent patient. Psychiatr Clin North Am 1988; 2:527–537
16. Stromberg C, Haggarty D, Leibenluft R: et al: The Psychologist's Legal Handbook. Washington, DC, Council for the National Register of Health Service Providers in Psychology, 1988
17. VandeCreek L, Knapp S, Herzog C: Malpractice risks in the treatment of dangerous patients. Psychotherapy 1987; 24:145–153
18. Felthous AR: Liability of treaters for injuries to others: Erosion of three immunities. Bull Am Acad Psychiatry Law 1987; 15:115–125
19. Reid W, Balis G: Evaluation of the violent patient. Am Psychol Assoc Ann Rev 1987; 6:491–509
20. Roth L, Meisel A: Dangerousness, confidentiality, and the duty to warn. Am J Psychol 1977; 134:508–511
21. Wexler D: Victimology and mental health law: An agenda. Va Law Rev 1980; 66:681–711
22. Eichelman B: Towards a rational pharmacotherapy for aggressive and violent behavior. Hosp Commun Psychiatry 1988; 39:31–39