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Current Issues in the Psychiatrist-Patient Relationship: Outpatient Civil Commitment, Psychiatric Abandonment and the Duty to Continue Treatment of Potentially Dangerous Patients - Balancing Duties to Patients and the Public

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Current Issues in the Psychiatrist-Patient Relationship: Outpatient Civil Commitment, Psychiatric Abandonment and the Duty to Continue Treatment of Potentially Dangerous Patients—Balancing Duties to Patients and the Public*

Panelists:

**Professor Linda C. Fentiman
Gaileen Kaufman, Esq.
Professor Vanessa Merton
Ernest F. Teitell, Esq.
Howard Zonana, M.D.**

PROFESSOR FENTIMAN:¹ Our panelists will focus their discussion around the following two hypothetical situations:

HYPOTHETICAL #1:

Bill Williams, a law student, was referred to university student health services after he disrupted a class, claiming to have telepathic powers. He was seen by the head of psychiatric services, Dr. Ron Larson, who determined that Bill had been suffering mental distress for several years. Two years earlier he had

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1. Linda C. Fentiman is Professor of Law and Director of the Health Law and Policy Program at Pace University School of Law. Professor Fentiman has both practice and teaching experience in criminal law and health law, concentrating on bioethics, access to health care for people with HIV/AIDS and other disabilities, and mental disability law. She has written and lectured about the insanity defense, competency to stand trial, the Americans with Disabilities Act, and medical decision-making for seriously ill children and adults. She is the former Chair of the Health Law Committee of the Association of the Bar of the City of New York. Professor Fentiman has also served as Chair of the Association of American Law Schools Section on Mental Disability and the Law. Professor Fentiman earned her B.S. from Cornell University, her J.D. from S.U.N.Y. Buffalo Law School, and her L.L.M. from Harvard University Law School.

been involuntarily committed to a psychiatric hospital after an incident in which he screamed at other students and continually hit himself until he cried. At that time, he told hospital doctors that he was being tormented by a "thing" with grotesque images. Williams was hospitalized for a short time and released after a judge found that he was not dangerous to himself or others, despite the observation of treating physicians that he was fascinated by guns, and owned several.

Dr. Larson diagnosed Bill as psychotic, with grandiose delusions, and treated him with antipsychotic medication. Bill improved, and was able to remain in law school. At the end of the semester, Dr. Larson advised Bill that he was retiring and that Bill should make an appointment with his successor. Dr. Larson prescribed a 30-day supply of antipsychotic medication. Bill went home to his parents, stopped taking his medication, and began a long psychological decline, which included using trees for target practice.

When Bill returned to school, he did not follow up with Dr. Larson's successor, nor did that physician contact Bill to inquire if he needed care. Bill stockpiled ammunition, prepared a backpack with materials for hostage-taking, and continued his target practice. When called to investigate Bill's target practice activities, the police arrested Bill, but released him without charging him with a crime when he explained that he was just preparing for hunting season. Neither Dr. Larson nor the University Health Services was ever notified of Bill's arrest. One January day, Bill walked down a busy street randomly firing his shotgun, killing two strangers. Bill was tried for murder, found not guilty by reason of insanity, and committed to a state mental hospital.

Can Bill bring a lawsuit against Dr. Larson? University Health Services? The police? On what basis? Can the families of the victims sue any of these potential defendants?

HYPOTHETICAL #2:

A. John Howell, M.D. was doing his residency in child psychiatry at a hospital connected with a medical school. As part of his residency, Dr. Howell was required to undergo psychoanalysis with Dr. Paul Fitz, a psychiatrist on the faculty of the medical school. Over the course of six months and after ninety

sessions of psychoanalysis, Dr. Howell revealed to Dr. Fitz that he was a pedophile, and that he wanted to go into child psychiatry in order to meet children.

Dr. Fitz asked Dr. Howell whether he had ever molested a child or intended to do so. Dr. Howell told him no. Dr. Fitz also asked Dr. Howell whether he had ever fantasized about a particular child. Dr. Howell told him no, but that he did have general fantasies of sex with children. Dr. Fitz felt comfortable that Dr. Howell's pedophilia was a mind-set and not a pattern of action, although he had observed that Dr. Howell was an intelligent man who was interested in getting what he wanted and not letting obstacles stand in his way. In addition, Dr. Howell spent considerable time defending sex between adults and children, pointing to its widespread practice in ancient Greece. After consulting five other psychiatrists about whether he had an obligation to report Dr. Howell's pedophilia, Dr. Fitz concluded that he did not. He determined that the best way of protecting children was to continue his therapeutic relationship with Dr. Howell and try to dissuade him from acting on his urges.

If you were consulted by Dr. Fitz, what advice would you give him about his legal obligations?

B. Dr. Fitz did not report Dr. Howell to the state licensing board or to medical school officials. Four months after completing his residency, Dr. Howell molested a ten-year-old boy whom he was treating. The family of this ten-year-old thinks that Dr. Fitz should have done something to prevent Dr. Howell from treating children, and are now considering whether to bring a lawsuit against Dr. Fitz and the medical school.

If you were a lawyer consulted by the boy's parents, what advice would you give about whether they have grounds for a lawsuit against Dr. Fitz and/or the medical school?

Both hypotheticals are based upon real-life cases,² where the tensions between the competing obligations of psychotherapists to patients and the community became tragically clear.

2. Hypothetical One is based on shootings in Chapel Hill. See William Glaberson, *Killer Blames His Therapist, and Jury Agrees*, N.Y. TIMES, Oct. 10, 1998, at A1. See also *Jurors Didn't Expect Doctor to Provide Williamson Perfect Care, But Did Find Lapses*, THE NEWS AND OBSERVER, Nov. 18, 1998, at A18. Hypothetical Two is based on *Almonte v. New York Med. College*, 851 F. Supp. 34 (D. Conn.

We are going to begin with hypothetical number one. I will begin by asking Mr. Teitell: Can Bill bring suit against Dr. Larson and/or the University Health Services?

MR. TEITELL:³ Well, I think there are two issues. First, there probably is a case if there are facts indicating that Dr. Larson did no more than suggest or tell Bill that he needs to make an appointment with the successor clinician and did not do more. This is particularly true with somebody who has a mental illness and who in the past has been hospitalized with the kind of illness that Bill has. Then the psychiatrist who has been treating him on a regular basis, monitoring his medication and knowing how important it is, has a duty to do more—to make sure that this person is in treatment.

From a legal standpoint, as well as a practical one, there is a difference between someone who has a mental illness and a person with a physical illness. If you say to someone who has a physical illness that you are retiring and he needs to see Dr. X or you recommend that he see Dr. X, that is probably enough. However, with a mental illness, part of the treatment may be to take steps to make sure that the person is in treatment, especially with a patient like Bill. Therefore, you would probably need to have more facts in order to bring a case.

The second question is whether I want this case. That is a question I have to ask and answer every day with new cases. This case is not appealing from a plaintiff's standpoint, because representing someone who has killed two people, in my mind, is going to be a difficult sell to a jury. I view jury trials as morality plays where the jury can make their own public policy. We cannot buck that public policy, but I think jurors will. In hypothetical number two, I have a completely different view. Jurors make up their own public policy, and I think it is difficult in

1994). The cases are referred to throughout the dialogue, and citations to the cases are provided in the footnotes.

3. Ernie Teitell is a partner in the law firm of Silver, Golub & Teitell in Stamford, Connecticut. He is a practicing attorney with twenty-two years experience. In addition, he has served as an adjunct professor at Quinnipiac College School of Law since 1987, where he teaches trial practice. Mr. Teitell has been a faculty member of the National Institute of Trial Advocacy Programs since 1994, as well as a frequent lecturer for the Connecticut Bar Association and the Connecticut Trial Lawyers.

Bill's case to ask the jury to award substantial money to someone who has killed two people.

Is there a case against University Health Services? This hypothetical does not give us a lot of information as to what the relationship was between Dr. Larson and University Health Services. Certainly, if Dr. Larson were an employee of University Health Services, then you would have a case.

PROFESSOR FENTIMAN: He was the director of psychiatry.

MR. TEITELL: Okay. If he was the director of psychiatry and indeed was an agent of the University, I think we would have a case against the University. A lot of times, though, in hospitals, for instance, doctors are independent contractors, and there is not a clear agency relationship. Therefore, I think that is the issue.

PROFESSOR FENTIMAN: Dr. Zonana?

DR. ZONANA:⁴ These are tough issues. I do not know if I necessarily agree with my colleague. The question, it seems to me in part, is: What do clinicians have to do to avoid being accused of abandoning a patient? Moreover, how far do clinicians have to go to make sure that the next step in line is set up and established? Do you actually have to find another clinician for somebody? Is it adequate to give patients three names and refer them? Do you have to wait and see that the person establishes another relationship?

Generally, our professional organizations say that you do not absolutely have to insure that another relationship has been established. Obviously, in certain circumstances, that is impossible. If somebody dies, somebody suddenly leaves, or something like that, some other referral has to be made. It is not always possible. However, you can hear, certainly from a plaintiff's lawyer's point of view, how it looks just to give a referral and not do anything more.

This came up in several cases. There was the *Naidu*⁵ case in Delaware where a clinician released a patient, knowing his

4. Dr. Zonana is Professor of Psychiatry and Director of the Law and Psychiatry Division of the Connecticut Mental Health Center at Yale University School of Medicine, and Medical Director of the American Academy of Psychiatry and Law.

5. *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988).

“longstanding and continuing dangerous propensities.”⁶ He simply gave the patient a thirty day prescription, without reviewing the patient’s history of spitting out medication,⁷ and scheduled a follow-up appointment which the patient did not keep.⁸ Without any further contact with Dr. Naidu, the patient went to New York to enroll in college courses and six months later caused a fatal car accident which took the life of a member of the DuPont family.⁹ The clinician was sued and the jury awarded the plaintiff’s widow \$1.4 million in damages.¹⁰ The court held that the clinician had a broad-based obligation to protect the public from potentially violent patients who present an unreasonable danger.¹¹

There was another case in Pennsylvania where a physician saw a student who did not want to continue taking medication. The clinician gradually withdrew the medication, and the student seemed okay. When the student indicated that he wanted to go back to school in Colorado, the physician told the student to go to University Health Services and actually gave him the name of somebody. The student went to Colorado but did not contact anyone for treatment. He completed school, graduating in six months. Then the student came back home, got a rifle, and killed someone about whom he was delusional. Again, the question was whether that was an adequate referral by the physician. How much does the doctor have to do?

Can you sue? Sure. Somebody will (and, in fact, did) take a case like that. These incidents put increasing pressure on clinicians to try to figure out what is enough. When something bad happens, it never looks like enough.

MS. KAUFMAN:¹² I think that is exactly the point. Hind-sight is 20/20, but psychiatrists, psychologists, and therapists are not guarantors relative to their patient’s conduct. They can

6. *Id.* at 1073.

7. *See id.* at 1069.

8. *See id.*

9. *See id.*

10. *See Naidu*, 539 A.2d at 1066.

11. *See id.* at 1073.

12. Gaileen Kaufman is an attorney associated with the law firm of Bai, Pollock & Coyne, P.C., in Bridgeport, Connecticut. Her practice is focused primarily on issues of professional negligence and, specifically, medical malpractice. She is a member of the Connecticut Bar Association and the American Inns of Court.

only make judgements based upon the information available to them. In this hypothetical, we have a student who is stabilized, who is on prescribed medication, who is capable of understanding the nature of the instructions being given to him. To require a psychiatrist who is retiring to be forever bound to this student would place an unreasonable burden on the profession, making it virtually impossible to render effective therapy.

One can never predict to a 100% degree of certainty the future. Psychiatrists, psychologists, and therapists do not have crystal balls. They cannot tell with any degree of certainty when a patient will or will not act so as to justify a constant monitoring of a patient. The only way you can truly ensure that a patient is complying with medication would be commitment. There is really no middle ground in a case like this. This is a patient who was being seen and managed appropriately on an outpatient basis. There is always a chance that a patient will stop taking the medication, but there certainly is no basis for this student to be committed. Moreover, you have a determination in the hypothetical by a court that he is not dangerous.

I do not believe that there is a claim here. Moreover, I think to the extent that one would bring a claim on behalf of this student it really lends credence to an idea that someone can commit socially unacceptable behavior and profit from it. In addition, I think that this feeds into Mr. Teitell's second point, whether he would want to take a case like this. There are problems with the case; it is not clear-cut. Each case has to be dealt with on a case-by-case basis and, in this instance, I think that the measures taken by Dr. Larson were certainly adequate.

MR. TEITELL: Going back and forth here, I do think it is fact-specific. Again, I am talking from the viewpoint of trying this case to a jury, and I think in terms of the facts. Nevertheless, let us suppose, keeping within the claim of the hypothetical, that you depose Dr. Larson, and Dr. Larson admits that he knew about the prior level of stress. He admits that Bill had acted with similar behaviors, mannerisms, and that is why he was committed. He admits that Bill's mental health tends to fluctuate and that the important thing is getting him into treatment and then maintaining that treatment. He states in his deposition that he developed a good therapeutic relationship with Bill, saw him periodically, once a week or whatever, moni-

tored his medication, and that is what kept him well and prevented him from declining. That, coupled with other testimony—from an expert—that mental illness is different from physical illness, that mental illness robs you of control, the ability to understand that you need treatment, can lead to a finding of liability. The reason why we commit people who are suicidal and do not just ask them not to commit suicide is because they have lost the ability to understand that they need treatment. Therefore, we need to protect them while treating them. You cannot rely on the patient the way you can a patient with a physical illness, where you can just make a referral.

The task of the claimant's lawyer in a case like this would be to educate the jury about the difference between mental illness and physical illness. With mental illness sometimes you are robbed of the ability to control and to understand that you need treatment. In that context, then, you can understand that it may not be sufficient just to give a referral or just to instruct the patient to make an appointment with a successor. The therapeutic bond between the doctor and his patient should have prevented his patient from declining treatment, and required him to do more than just give a name—it required him to take more steps. The doctor does not have to be a guarantor, but the doctor may have to take additional steps to see if new treatment has been established, that the treatment is similar to what was going on before, that someone is monitoring his medication, someone is seeing him, and there is a therapeutic relationship. So, again, I think these cases are fact specific, but I can see how a jury might react to that and find the doctor liable, although it's still not a case I would want to take.

PROFESSOR FENTIMAN: I want to ask a question of Dr. Zonana and the other panelists. To what extent might this case provide lessons for institutional health care providers, either in university health service where it is common for students to come and go, or even a hospital-based outpatient mental health center? What is the institutional obligation in addition to that of the particular health care provider to make sure that there is appropriate follow-up and that people do not fall between the cracks?

Moreover, as a corollary to that, building on what Mr. Teitell said, can we presume the incompetence of a patient to make appropriate follow-up arrangements for himself?

DR. ZONANA: Well, the plaintiffs' lawyers certainly presume it, so we have to be sensitive to that. We're operating under the guise of incompetence. The patients are generally allowed to say no to medication, except under certain circumstances, for example, emergencies, and we must step back. Yet, if the patient refuses to follow through on a referral, he can claim incompetence. There are a lot of double standards in these circumstances.

The problem with institutional responsibility is a little more complicated. Certainly university health services are sometimes caught between treating their students as adults and other times acting *in loco parentis* in taking some responsibility for the welfare of the students. In addition, I have seen universities err when they expel a student and do not call the parents or do something similar and leave the situation unresolved. There is a fine line between holding young adults accountable and having the institution take on different degrees of responsibility for carrying out some supervisory function.

One dramatic case of a misuse of civil commitment was in a university setting where a student was threatening to leave the school and the University called in a psychiatrist.¹³ The University held on to this person without any clear indication of a mental disorder.¹⁴ The University was worried about what the student was going to do—go off with an older man or something like that.¹⁵

MS. KAUFMAN: I think the problem presupposes that individuals with mental illness are perpetually incapable of ever making their own decisions. I do not think we can do that, and I do not think we can, with any degree of confidence, say that someone diagnosed with a mental illness cannot be appropriately stabilized and managed on an outpatient basis. I simply think that here you have someone monitoring the patient's medication level, and that person has become stabilized; and then we are dealing with a highly functioning individual here.

13. See *Maniaci v. Marquette Univ.*, 184 N.W.2d 168 (Wis. 1971).

14. See *id.* at 170.

15. See *id.*

We are not dealing with someone who is incapable of running his own affairs. Bill is a law student—for whatever that is worth. He is managing to complete a rigorous course of study. He is maintaining enrollment in the program. I do not think just by virtue of the fact that he has been diagnosed with a mental illness that he is incapable of understanding the instruction to obtain follow-up care. I have a problem with that, and I think it is inappropriate to classify people diagnosed with a mental illness in that manner.

PROFESSOR MERTON:¹⁶ I find it curious that none of the panelists mentioned what seems to me a critical fact, that this guy had a lot of guns and apparently Dr. Larson knew that. Weapons fascinated him. In addition, based on the literature and even, I think, on the presentation at the last session, a fascination with weapons and access to weapons are two critical and distinct factors. Does that not create a heightening of the obligation?

MR. TEITELL: I think you are right, and I think that is what makes it appealing to a jury. In other words, the doctor knew that this person had guns, and the jury is going to ask why he did not do more. The jury might react to this with a heightened level of sensitivity. I think the gun issue has more play because in terms of this being a morality play, the jurors are going to ask why the doctor did not tell someone, why didn't he do more? Moreover, I think that would be the issue if there were a lawsuit against the police. I think it would be a difficult case, but again, it is the gun issue.

16. Vanessa Merton is Associate Dean for Clinical Education and Professor of Law at Pace University School of Law, where she teaches health law and directs the clinical and externship programs. She is also the Executive Director of John Jay Legal Services, the law school's free legal clinic, and co-founder of the Access to Health Care, Health in the Workplace, and Prosecution of Domestic Violence Clinics.

Professor Merton has lectured and published extensively on issues of biomedical and legal ethics and on health issues of importance to women, most recently domestic violence, the exclusion of women subjects from medical research, and the phenomenon of female genital mutilation. Professor Merton was the founding chair of the Institutional Review Board of the Community Research Initiative of New York, one of the first centers for community-based biomedical research on AIDS, and the first Associate for Law at the Hastings Center Institute for Society, Ethics, and the Life Sciences. The honor of which she is most proud of is being chosen as Outstanding Professor by the 1995 graduating class of Pace University School of Law.

PROFESSOR MERTON: I also want to focus this discussion on the lawsuit that might be filed on behalf of the families of the people who were killed.

MS. KAUFMAN: Well, then, we get into an issue of predictability, the duty to control, the duty to warn, and whether there is an identifiable victim. Relative to Dr. Larson, at the time he was treating this student, there were no indicators that he had any intent to act out any type of violent fantasy or impulse. None of the signs or symptoms pointed in that direction. This was the ultimate random act of violence, and many state laws vary. New York law differs from Connecticut law¹⁷ — you have to look to the individual state laws for an analysis on how stringent the requirements are to hold that a doctor has the duty to warn or can breach confidentiality.

In this hypothetical, a victim is not identified. An intent to harm is never articulated to Dr. Larson. Therefore, I do not know how he could warn anyone. I do not know what mechanism he could use to warn; if he did so, he would be breaching confidentiality, which in many states is a violation of a statute. Therefore, I do not know that there would be any type of a claim brought by the families of the victims. It depends on state law.

DR. ZONANA: Guns are another therapist's nightmare. It is probably now a reasonable standard about which you must inquire. What we can do about guns is another issue. We often have a lot of patients who tell us they have a license, they have guns, and they are going to keep them no matter what you do. In addition, the National Rifle Association has been very effective in making it difficult to remove guns. Nevertheless, it is a thorny problem. We have a slew of examples where we try to work with both patients and families to no avail. Short of threatening to stop the treatment, there are very limited means by which you can remove guns.

PROFESSOR MERTON: What about notifying the licensing board?

DR. ZONANA: About what?

PROFESSOR MERTON: That you have someone with a gun license who is suffering from incapacity and is dangerous.

17. Compare N.Y. MENTAL HYG. LAW § 33.13(c)(6) (McKinney 1996) with CONN. GEN. STAT. § 52.146f(2) (1999).

DR. ZONANA: If someone goes running out the door and says he is going to shoot someone, no one has a problem with notifying the licensing board or the police. Most of the time, though, when someone has a gun, you are dealing with vague factors and high risks. Fifty percent of the people, even those in the highest risk group, are not going to do anything. Is that enough to breach confidentiality and call the licensing authority or Motor Vehicle Bureau? Most of the time, that is not going to be sufficient. At least that is my view according to my experience.¹⁸

PROFESSOR FENTIMAN: We have a couple of questions from the audience.

18. In 1999 Connecticut passed a statute permitting the removal of guns in certain circumstances: Public Act No. 99-212, An Act Concerning Firearm Safety.

Sec. 18. (New) (a) Upon complaint on oath by any state's attorney or assistant state's attorney or by any two police officers, to any judge of the Superior Court, that such state's attorney or police officers have probable cause to believe that (1) a person poses a risk of imminent personal injury to himself or herself or to other individuals, (2) such person possesses one or more firearms, and (3) such firearm or firearms are within or upon any place, thing or person, such judge may issue a warrant commanding a proper officer to enter into or upon such place or thing, search the same or the person and take into such officer's custody any and all firearms. Such state's attorney or police officers shall not make such complaint unless such state's attorney or police officers have conducted an independent investigation and have determined that such probable cause exists and that there is no reasonable alternative available to prevent such person from causing imminent personal injury to himself or herself or to others with such firearm.

(b) A warrant may issue only on affidavit sworn to by the complainant or complainants before the judge and establishing the grounds for issuing the warrant, which affidavit shall be part of the seizure file. In determining whether grounds for the application exist or whether there is probable cause to believe they exist, the judge shall consider: (1) recent threats or acts of violence by such person directed toward other persons; (2) recent threats or acts of violence by such person directed toward himself or herself; and (3) recent acts of cruelty to animals as provided in subsection (b) of section 53-247 of the general statutes by such person. In evaluating whether such recent threats or acts of violence constitute probable cause to believe that such person poses a risk of imminent personal injury to himself or herself or to others, the judge may consider other factors including, but not limited to (A) the reckless use, display or brandishing of a firearm by such person, (B) a history of the use, attempted use or threatened use of physical force by such person against other persons, (C) prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities, and (D) the illegal use of controlled substances or abuse of alcohol by such person.

AUDIENCE MEMBER: The judge released this man, although a psychiatrist recommended inpatient hospitalization. I am not willing to take the personal responsibility to treat this patient if he is not in what I feel is the appropriate treatment setting. Can a panelist address taking this position and saying that he will not treat him or her as an outpatient?

DR. ZONANA: That is a wonderful position to be able to take. And maybe if you have an office on Park Avenue, you can do that. But increasingly if you are working in a public mental health center, that is no longer an acceptable response. Most of you, probably, if you work in any kind of institution, have 50 to 100 patients who literally are saying they are not going to do most of what you tell them, and they will not even come in for appointments. Treatment teams are being sent out to bring medication to their door, and maybe they will take it one day and maybe they will not. It is not an ideal form of therapy. You are making attempts to reach out and develop an alliance, but you do not have the authority to force the patient to comply. You are doing substandard treatment by any measure, and yet the standard of care requires these attempts, even if the patient refuses. You make outreach efforts. People are no longer in institutions for long periods of time, so you go under bridges, you go to apartments, and you do a variety of things, to be as effective as possible. Obviously, that is different from taking on a patient where there is an agreement and an ongoing relationship.

AUDIENCE MEMBER: You talk about a reasonable standard to inquire about guns. Would it also be reasonable in this case to obtain a release from the patient to talk to his parents, because the crime started when he went home for the summer? They could have monitored the medication; they could try to follow up.

DR. ZONANA: I would say that certainly depends on the clinical context. If you have some indication that you think this is someone who is likely to blow, who may deteriorate in some way, a violent way, then, sure. On the other hand, if you think this type of violence is not an issue and if the patient has strong feelings about talking to the family then you might make another decision. I think this decision depends on how disorganized or how sick the patient is.

MR. TEITELL: I would just like to look at this from a lawyer's perspective if we had to try this case. I would like to be able to give the jurors alternatives because if you say the doctors had only one option, then it is a much tougher case. However, if you say the doctor had choices and he chose not to talk to the family, or he chose not to see what was going on at home, or he chose not to do any of the things that he could have done — instead, the doctor only chose to give the patient the name of a successor, then I think that might help the plaintiff's case, and I like that issue.

MS. KAUFMAN: I just think it would depend on the nature of the problem which the student presents. There may be instances where the doctor would not want to even bring that up in the context of therapy, given the sensitivity of the issues that the patient may or may not be dealing with. Just because a student reports to a university health center seeking counseling, just because he is a student, does not by virtue of that fact, in and of itself, always merit that some contact must be made with the family. In point of fact, it may be just the opposite. We are dealing with a functioning adult here. We are not dealing with a child—or an infant—under the age of eighteen.

PROFESSOR FENTIMAN: One last question, and then we are going to go to the next hypothetical.

AUDIENCE MEMBER: Unfortunately, I have a couple of questions. The first is, would the psychiatrist who took over Dr. Larson's practice have any responsibility for following up with Bill? The second is, would there be any difference in your mind if Bill, instead of killing someone else, had killed himself? Third, more specifically to Mr. Teitell, you say the doctor should have done more. Do you have any concept of what that more should be and when enough is enough?

MR. TEITELL: I do not know. It is difficult to say if Dr. Larson had any duty and whether the successor would have built a patient relationship. I am not sure I would say the successor had a duty.

I would like the case better if Bill kills himself, because then he becomes more the victim than when he kills two people, which is always going to be on the jurors' minds. Then you can start talking about how Bill needs protection from himself. Now, there are still some difficulties, but from my perspective,

and from a jury's perspective, it is a better case, a more sympathetic case.

MS. KAUFMAN: I just think the analysis of the whole duty issue is consistent with an earlier comment Mr. Teitell made in response to that question. You are asking about someone who never established any type of patient relationship with this individual. The successor has no way to be aware that Bill has declined treatment since the end of the semester. Moreover, given the information that was available to Dr. Larson, there was no basis for him to take further action in order to inform the successor. So I really do not think there is a viable claim.

PROFESSOR FENTIMAN: I just want to say that this hypothetical raises important questions for mental health providers and institutions. How are they going to insure continuity of care as a way of minimizing their liability for letting someone fall through the cracks? There are significant issues of patient abandonment, and, in fact, that's what the jury in North Carolina found when they awarded Bill \$500,000.¹⁹ It may also be significant that in North Carolina, guns and hunting season may be more common than they are here, and perhaps Bill's affection for guns was normal behavior, and thus less for the police to be concerned about.

In any case, we're going to switch now to hypothetical number two which involves a case closer to home. Dr. Zonana is going to provide a summary of the issues in this case.²⁰

DR. ZONANA: This was a very interesting and difficult case. I was involved in it along with one of our other panelists. Let me give you a little bit of background.

I was asked to review this case for the defendant. Some very interesting legal and psychiatric questions arose that a reader does not get from a very quick review of the newspapers.

This was, first, in federal court; this was not in state court, and that was because two states were involved.²¹ At the time the suit was brought, the victim's family was grieving and angry. Again, these are the basic things that lawyers say cause

19. See William Glaberson, *Killer Blames His Therapist, and Jury Agrees*, N.Y. TIMES, Oct. 10, 1998, at A1.

20. The case being referred to is *Almonte v. New York Med. College*, 851 F. Supp. 34 (D. Conn. 1994).

21. See *Almonte*, 851 F. Supp. at 34.

malpractice suits. What you have to do is prove that there was a duty and that there was a breach of that duty that was the proximate cause of harm.

In general, there are statutes of limitations as to when you can bring malpractice actions. For most states, like Connecticut, there is a two-or three-year window in which to commence the action.²² This case was brought several years after that. So the question is, how did it come about?

Connecticut passed a law, as did a number of other states, based on the repressed memory theory.²³ Repressed memory theory was designed to allow people who recall an event years after the event occurred, for example, that they had been abused as children, to later sue the perpetrators. So one could bring a suit seventeen years from the age of majority,²⁴ which is eighteen years old in Connecticut. This gives the victim an enormous window. This statute was then turned on its head when it said the physician could be seen as a potentially responsible person under this statute.²⁵ This extended statute of limitations was brought under the malpractice statute's umbrella, and that was one of the main issues that allowed the case to go forward.

As we talk about this keep in mind the kinds of things you think should override confidentiality in this case. If you believe a disclosure should have been made, what could this department have done if it knew? What other alternatives might the doctor have tried? How do pedophilic fantasies differ from other sexual fantasies? Moreover, what constitutes a good treatment plan?

Again, so we are all on the same page, a diagnosis of pedophilia requires at least six months of recurrent, intense, sexually arousing fantasies, urges, or behaviors involving sexual activity with a prepubescent child or children. This was a real case. All of this material appears in the trial record or was repeated in the newspapers. It is part of the public record, so I am not disclosing anything that is confidential. Dr. Howell was a resident who was in a psychiatric residency program at the

22. See CONN. GEN. STAT. § 52-584 (1999); CONN. GEN. STAT. § 52-577 (1999).

23. See CONN. GEN. STAT. § 52-577d (1999).

24. See *id.*

25. See *Almonte*, 851 F. Supp. at 37.

time.²⁶ One of the unusual issues in this case was that New York Medical College has an elective during the residency program in which someone can choose to do psychoanalytic training.²⁷ New York Medical College and Columbia, perhaps, are the only two places that allow that. Most other analytic training programs accept candidates only after completion of a basic residency program. The analyst involved, Dr. Fitz, was on the clinical faculty of New York Medical College.²⁸

Several other interesting questions arose during this case. Dr. Howell (the resident) began his residency and entered training analysis with another analyst, stopped that, and began a second analysis with Dr. Fitz.²⁹ Some months after the second analysis started, he assaulted the child victim at Danbury Hospital in Connecticut on a rotation.³⁰ This incident raises some questions about moonlighting, which is always a problem for departments and residents. Was this part of actual training or was it moonlighting?

The claim made against Dr. Fitz was that he had a duty to warn potential victims.³¹ Although Dr. Fitz knew that Dr. Howell posed a danger, he did not do anything to warn the children.³² The court held that the victim was within a foreseeable class of victims but the issue of foreseeability would be left to the jury.³³ Due to Dr. Fitz's status as a faculty member at New York Medical College, he had a responsibility to evaluate Dr. Howell's fitness to continue as a resident and as a candidate in the analytic institute.³⁴ In addition, because Dr. Fitz was an agent of New York Medical College, his negligence is also attributable to the medical school.³⁵

26. *Garamella v. New York Med. College*, 23 F. Supp.2d 153, 158 (D. Conn. 1998) [hereinafter *Garamella I*]. *Garamella I* refers to a ruling on New York Medical College's motion for summary judgment.

27. *See id.*

28. *See id.*

29. *See Almonte*, 851 F. Supp. at 36.

30. *See id.*

31. *See Garamella v. New York Med. College*, 23 F. Supp.2d 167, 173-75 (D. Conn. 1998) [hereinafter *Garamella II*]. *Garamella II* refers to a ruling on Dr. Ingram's ("Dr. Fitz's") motion for summary judgment.

32. *See id.* at 171.

33. *See id.* at 174.

34. *See id.* at 169.

35. *See id.* at 164-65.

One of the questions, of course, is how could Dr. Fitz be made to divulge information about Dr. Howell when Dr. Howell was not involved in the lawsuit? The quick answer is that this case occurred before the *Jaffee*³⁶ decision, and the Second Circuit had said that cases would be judged on an individual basis as to whether there was a privilege or whether, in the interest of justice, confidentiality could be waived. Most people never really understood the difference between state and federal courts. Federal courts were more open and waived privileges more readily than the state statutes allowed.

When you start a residency program and implement it, the administrators do not work out detailed guidelines about what the reporting criteria are, who is supposed to do what, and related issues. So when you looked at the case records in terms of what the obligations were, Dr. Howell was only evaluated as a candidate in the analytic institute. The evaluation centered on whether he was appropriately in analysis, whether he was prepared to take on and analyze his own patients, and whether he was prepared as an analyst. These are the criteria from the analytic institute.

The *Tarasoff*³⁷ issues are very complicated. Connecticut statutes permit disclosures without patient consent when a patient represents a substantial threat of harm to himself or others.³⁸ Most states have statutes that allow you to make disclosures without a specific *Tarasoff* duty when you think there is an imminent risk of danger.³⁹ Most of us work under a *Tarasoff* conception, although a few states now have said it does not exist for outpatients because the states feel there is no ability to control outpatients.⁴⁰

The real question, since Connecticut had a "*Tarasoff*" type case, was whether victims fall within a foreseeable class, and what is a reasonable class beyond which you could claim the victim was non-identifiable. Here, the question is: Are all the

36. See *Jaffee v. Redmond*, 518 U.S. 1 (1996).

37. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).

38. See CONN. GEN. STAT. § 52-146f(2) (1999).

39. Connecticut law has a model statute that has been copied by other states.

40. See *Boynton v. Burglass*, 590 So.2d 446 (Fla. Dist. Ct. App. 1991); see also *Nasser v. Parker*, 455 S.E.2d 502 (Va. 1995). Some courts have avoided passing directly upon *Tarasoff*, reserving discretion to follow, reject, qualifiedly adopt, or discard it. See *Leonard v. Latrobe Area Hosp.*, 625 A.2d 1228 (Pa. 1993).

children a sufficient class, or is that too non-specific? Therefore, that was one of the essential issues discussed. There were a number of pretrial motions, and the magistrate ruled that the hospital patients were within a foreseeable class to whom you might hold a duty. The issue of foreseeability was disputed and it was left for the trier of fact to decide.

As you have heard before, if you are forced to warn others of every fantasy revealed by patients in the context of therapy, what is that going to do to treatment? The plaintiff countered that public policy dictates that psychiatrists report actual or suspected child abuse. So you go into the issue of what the child abuse reporting statutes are, and this again is where the Connecticut statute is like New York, in that it requires disclosure if there is reasonable cause to believe that a child has been abused or neglected.⁴¹

Therefore, here it is really a question of which situation would you prefer, being sued for the breach of confidentiality or being sued for failure to warn. The court held that the psychiatrist has a duty to speak where harm to an identifiable class of victims is a foreseeable consequence, and that the jury could find the victim to be in a foreseeable class, since the disputed issue of foreseeability was reserved for the trier of fact.⁴² The defendant argued there was no one to warn and nothing about which to warn.⁴³

The details are what count in a case like this. Let me just give you what the disclosure was and the reader can judge what to do with it. Dr. Howell entered analysis in about November, and analysts do not usually call prior therapists to find out what the preceding therapists know. Analysts consider it a standard of care that they do not want to be contaminated by other analysts' views of the patient. So no call was made to preceding clinicians. That is one issue. Six months or so into the analysis, Dr. Howell discloses the following information to Dr. Fitz about his South American trip:⁴⁴

That in fact he had in mind in going to South America . . . that he would be interested in children . . . but perhaps he would

41. See CONN. GEN. STAT. § 17a-101a (1999).

42. See *Garamella II*, 23 F. Supp.2d at 174-75.

43. See *id.* at 175.

44. See *id.* at 170.

find a little girl. And he wanted me to know that he loved children, he loved to take care of them, but he also had very strong sexual feelings towards them. . . . And he went on and he described how it wasn't so very important whether they were little boys or little girls, but that it was very important to him and that he saw it as his right and the right of pedophiles everywhere to engage in this behavior.⁴⁵

Dr Fitz had a very strong emotional reaction to Dr. Howell's position and likened it to the emotions you would feel if you were held up at gun point.⁴⁶

So, upon hearing that kind of disclosure, what would you do? In retrospect, it is always easier. If you are the clinician at that point, what do you do?

AUDIENCE MEMBER: Further exploration.

DR. ZONANA: What do you explore?

AUDIENCE MEMBER: I would go further into the issues that he raised. Did he have intentions, et cetera. I would explore further.

DR. ZONANA: Yes.

AUDIENCE MEMBER: I am a lawyer, not a clinician. I think what I might do under these circumstances is tell him to take all this information, make the resident a John Doe, go into court seeking declaratory relief, and ask the court to tell me what to do in order to protect myself down the road. Then listen to the opinion of the court.

DR. ZONANA: Most of the time, at least in my experience, the courts are not very interested in telling you what to do. They like to have you do something, and then tell you.

AUDIENCE MEMBER: As a clinician, would you not have wanted more definition? Would you not have wanted Dr. Howell to tell more about his prior episodes, attempts, and possibly even successful contacts with children? Would you not want to build up some kind of a background of material so that ultimately if you did have to act in the legal arena, then you would have adequate material from which to base your actions?

DR. ZONANA: Sure. History is critical.

45. *Id.*

46. *See id.*

AUDIENCE MEMBER: Well, maybe this is not a very sophisticated response. Putting myself in the role of a lawyer being consulted by the treating analyst who's asking me what I think he should do in terms of his legal responsibility, I would have to look at this as a person who is in a child psychiatry residency. Now, maybe he would make a great surgeon, or a great other type of doctor, but the notion that this person is ever going to be an ideal child psychiatrist just strikes me as peculiar. I would advise my therapist-client that at a minimum there is a responsibility to intervene at this point. The *Tarasoff* duty is not only the duty to warn; it is the duty to take reasonable steps to prevent foreseeable harm. In addition, certainly a reasonable step would be to get this doctor out of child psychiatry.

DR. ZONANA: Okay. He is not in the child psychiatry program at this point. He is in the basic residency. He is planning to go into a child psychiatry residency program.

AUDIENCE MEMBER: As we know, hindsight is a cinch, but wouldn't the therapist be concerned and cognizant of the fact that these issues may arise later in therapy?

DR. ZONANA: Absolutely. There was no question that those concerns were all there.

AUDIENCE MEMBER: I think part of the problem is whom do you notify?

DR. ZONANA: Okay. If he called you as his attorney and said do I have a duty to make a disclosure to the Department of Children and Families, would you say yes or no?

PROFESSOR FENTIMAN: Why don't we ask our panelists?

MS. KAUFMAN: In this case, you have someone who has revealed a fantasy that has taken some period to reveal. This is not something that came out in the first therapy session. It took a period of time for this revelation to occur. You have the issue of whom to warn. There has never been any articulated threat; there has never been any intention expressed to act on the fantasy; there has never been any potential victim identified. Whom do you warn?

If you warn members of the faculty, there is a good chance he may very well leave therapy. Now you have effectively set adrift in society someone with a medical license and no mecha-

nism by which to monitor him or to ensure that these impulses remain in check. The best course of action is to keep him in therapy where you can keep an eye on him and you can monitor the status of those impulses.

DR. ZONANA: Evaluation is important. Another clinical fact that you might want to know is that a year before, he had been married. Further, when asked if he had acted on any impulses with children, he said no. So what do we tell clinicians to do in those circumstances? Call up somebody. Right? Consult. So the doctor called and consulted. He called someone from the Psychoanalytic Institute ("Institute"), and asked for advice on what he should do and how he should handle it. The advice from the Institute and from the consultants was - what would you guess?

AUDIENCE MEMBER: Continue the analysis.

DR. ZONANA: No, interestingly that was not the advice of either one. At least the doctor said that if this was the issue, then analysis was not the treatment of choice. You do not treat pedophilia with psychoanalysis these days. There were a number of consultations, including consultations with forensic psychiatrists, and Dr. Fitz was told not to continue. The advice from the Institute was that it thought Dr. Howell was an unsuitable candidate to be an analyst. Therefore, he needed to resign as an analytic candidate at the Institute, but not to resign, necessarily, from the residency. What do you think of that decision? Does that make sense?

AUDIENCE MEMBER: The information has already been disclosed to the doctor, so it does not stop at whether or not the patient resigns. What is the next step? In other words, this doctor kept going and kept trying to get answers. For me, if I request a second opinion, and I'm not comfortable with the second opinion, or I still have some concerns about it, then the fact that the second opinion doesn't settle it for me suggests that there really is a problem. Then I will turn to the administration for more of an answer.

DR. ZONANA: When the Institute told Dr. Howell to resign from the Institute, it was not saying that Dr. Fitz would not continue to see him. He planned to continue to see him, but the Institute wanted to give the message that this was a significant issue that had practice implications.

AUDIENCE MEMBER: I think that their concerns were tunnel vision and self-serving, if you will. They were concerned about the impact that such an individual might have on their profession, but what about the fact that this individual was continually having contacts with the general public, and specifically had career designs that brought him into the sphere of working with children as a physician? Their perspective seems rather self-serving.

DR. ZONANA: If that is all it was, then I would agree with you. But without knowing all the details it is hard to know. To me it makes sense that, as a therapist, I would make it one of my goals in therapy to ask him why, with these kinds of fantasies, he is picking child psychiatry as a field, where he's going to have a hard time and perhaps risk his career.

AUDIENCE MEMBER: The peculiarities of psychoanalytic training are that the analyst is both a therapist and a kind of teacher and supervisor. So one recommendation might be, in addition to continuing therapy with the analyst, that there be an aggressive process of counseling by an administrator, maybe the training director. Is there any way that this man can continue to be a psychiatrist?

DR. ZONANA: Well that is certainly the next question. How many of you, based on what you know, would have called the training director? In addition, what would you have told him?

AUDIENCE MEMBER: Well, after some discussion with the patient about the necessity to do this, I would call the training director and simply explain the situation fairly.

DR. ZONANA: This group takes no prisoners; I can see that. How many of you have ever had strong sexual fantasies about patients? Anybody? Do you think you might be leaning towards the fundamental attitude that pedophiles are weak-willed? Do we hold pedophiles to different standards? How do you feel about that?

AUDIENCE MEMBER: Dr. Howell was somewhat satisfied with his view on this. He thought that it was politically correct. He thought that he should have the right to do this. That is different from what you suggest.

DR. ZONANA: And if twenty years ago he had been gay and said the same thing, would you have turned him in? The

same issues came up around then. These are very strong and charged values. Some people have very strong political feelings but do not necessarily act on those feelings or act in a political way to try to change the position of a society or a group. The question is what does action mean here.

AUDIENCE MEMBER: But you're not seriously suggesting that behaviors between consenting adults, albeit homosexual behaviors, are in any way analogous to what will happen here when you have an adult who has desires for children and an overreaching opportunity. Furthermore, as was hinted at in the last comment, here we have an individual who is attempting to justify not just his illegal but his immoral behavior with the fact that he loves children. You have a very serious and deeply seated problem here.

PROFESSOR FENTIMAN: I want to switch this to the legal ground for a moment and ask our plaintiff's lawyer and our defense lawyer what to do with the law that talks about a reasonably foreseeable victim. Is there a reasonably foreseeable victim? Are children as a class sufficient to target an obligation on the part of the treating psychiatrist to warn and to protect? It seems to me there are a number of additional options. In addition to getting the fellow out of the Institute, Dr. Fitz could have reported this case, and maybe should have reported this case, to the Office of Professional Medical Conduct. He could have asked him to leave the residency program, which might, itself, raise issues under the Americans with Disabilities Act. What would you recommend?

MR. TEITELL: Usually, I do not have psychiatrists come to my office seeking advice. I get the other side. But what I like about what the professor just said is that there are many things that Dr. Fitz could have done and which, I think, really make this a strong plaintiff's case. Again, I look at it as Professor Merton did. Think of these four or five facts. This person has told you he is a pedophile. This is a person who has told you he believes he has a right to it, he believes that it is right to do it, and he has had fantasies about it. Moreover, he is a psychiatrist who either is going to be a child psychiatrist or has an interest in child psychiatry, and he is about to finish his training and go into that field. That is a very dangerous situation, which

is why it is such a compelling case from the plaintiff's standpoint.

But I think if a therapist comes into your office, you've got to figure out steps that he has to take in order to warn. I know you are a sophisticated audience of scholars and professors. I think the issue is what is the right thing to do here, knowing that you have someone who has told you all this, and your relationship is not just as a therapist. This is a therapist, a faculty member, someone who has other responsibilities, and you are going to send this person out knowing he is going to have the knowledge, ability, and training to manipulate patients. I think that is where I fall on the issue. I know, again, it is easier in hindsight.

MS. KAUFMAN: I do not think there is any question that as the therapist in this hypothetical, you are dealing with an abhorrent diagnosis. The reaction is visceral. However, regardless of how abhorrent the diagnosis is, the individual still requires treatment. One point I do need to make is that the DSM diagnosis⁴⁷ has changed since the time of the incidents that gave rise to this particular case. At the time, the focus was on an act or a fantasy. The revelation in this hypothetical is still at the level of a fantasy. There has never been an act. There has never been any type of intent to act that has been articulated to the therapist. To make a report to the Office of Professional Medical Conduct predicated upon nothing more than a fantasy changes the therapist into the "thought police." Moreover, looking at the statutes, disclosure is in violation of the statutes.⁴⁸

Now, it may very well be that the statutes need to be changed. Nevertheless, if you look at the statutes, there is some requirement that an individual be either identified or identifiable.⁴⁹ In the hypothetical, there is never an individual who is identified or identifiable. This rule applies when reporting to the Office of Professional Conduct or any licensing board. It

47. See AMERICAN PSYCHIATRIC ASSOCIATION, DSM IV, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 528 (4th ed. 1994). The Diagnostic and Statistical Manual of Mental Disorders is a manual which establishes the necessary criteria to diagnose clinical mental disorders.

48. See N.Y. MENTAL HYG. LAW § 33.13 (McKinney 1996); see also CONN. GEN. STAT. § 52-146f (1999) (providing limited situations where consent is not required for disclosure).

49. See *id.*

also applies to a report to other members of the administration when it is a member of the faculty. That does not mean that the administration is controlling the manner, method, and means by which the therapy is rendered.

Therefore, I think a report in this case not only would be in violation of statute, but could also be potentially dangerous. If this individual perceived it as a betrayal, it might very well set him adrift, and he would have access to children anyway.

DR. ZONANA: Let me just say, at least in a way of conceptually framing it in my mind, that I regard this kind of assessment as similar to a suicide assessment. I think you have to make an assessment about how strong you think the impulses and the likelihood to act are. Some suicidal patients will tell you they are not going to do it, and you do not believe it, and some patients will tell you that they will not, and you do believe it. You feel that there is some kind of alliance. In addition, those are contextual and difficult issues that you have to raise.

I would have to say that there has to be a certain amount of ambivalence, in spite of how strong the patient sounds, in this bare presentation of it. Clinicians need to ask themselves why the patient is bringing this up. Why is he telling the analyst? What is he expecting his analyst to do with this information? Here's a guy who has married, who has gone through medical school, and who must know what the laws are, and what is likely to happen if he violates them. Is there any ambivalence here that reflects something he wants to examine? What is a reasonable framework in which to look at it? Say that you went to the training director, and let us say you did it in the most careful way. You did not just spill out every fantasy, but you say, that you have a patient you have been seeing who is raising some questions about his ability to practice. You think there is a problem here. So what would the training director do?

AUDIENCE MEMBER: That was going to be my question. Suppose I was the training director, and I received the information. In addition, I made the decision to call this person to my office. I am going to say to this person that I have heard this information about him, I want him to take a leave of absence, and I want him to go into a sexual offender's program.

DR. ZONANA: I take it you would love that case, right?

MR. TEITELL: No, I would not like that case.

PROFESSOR FENTIMAN: I am going to ask Professor Bernhard.

PROFESSOR BERNHARD:⁵⁰ I can understand why the therapist who hears what sounds like a dangerous fantasy or plan becomes frightened by the enormity of the responsibility and is unsure about how to deal appropriately with the situation. I am particularly empathetic in that I thought I heard you say that keeping this particular patient in therapy might not be the preferred treatment. What is the responsible approach if I am not even sure that my skills and training will help? Should I simply monitor the patient and keep him in the relationship and hope that nothing terrible happens? At that point I feel dizzy. What do I do?

DR. ZONANA: Okay. There are obviously a number of things, depending on what your comfort level is or what you think you know about the disorder. I think certainly that the technical aspect of moving from psychoanalysis to a psychotherapeutic setting requires some idea of what you are doing and some plan about how you are going to proceed. One can certainly proceed in a certain way in order to get him to a point where, if he feels his impulses are not in good control, you might refer him somewhere for more specific treatment.

AUDIENCE MEMBER: Is there somewhere to go?

DR. ZONANA: Sure. One of the side effects of taking Prozac is a decrease in the sexual drive. A lot of psychiatrists now are much more comfortable with using anti-depressants in the treatment of some of these sexual disorders. So there are a number of things that can be done. You may go to the training director and say he has a problem, and then send him to somebody else for an assessment about whether he can continue or start another sort of residency track. I am not sure how all that plays out. One could construct several scenarios about how that

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could have played out. But, that was clearly a decision that was not made in this case. Dr. Ftiz did not tell the training director.

Now, for the analyst's reaction. I may be older and more jaded now, and most of us hear about a lot worse without evoking this kind of reaction. We are used to hearing fantasies about parents having sexual feelings towards their kids, and all sorts of things that are not unusual. Therefore, I think the analyst's reaction tells me something about what he is going through which plays a role in the ultimate outcome here.

AUDIENCE MEMBER: Yes, I have a question about the initial conversation with the analyst.

PROFESSOR FENTIMAN: The significance in that whole revelation, the initial conversation during which it was revealed that he had the pedophilic thoughts, is the fact that he did not act. In addition, that was explored throughout the therapy to determine what the status of the fantasy was. However, that comes out when he first makes the disclosure, and the important detail was the fact that he had not acted on it.

AUDIENCE MEMBER: So the question here then is to what extent did this clinician feel that the group would address this problem?

PROFESSOR FENTIMAN: Your question brings an interesting analogy to mind. In this scenario, the resident has now disclosed his urges but not his actions, and that situation is analogous to a surgical resident who tells his supervisor that he is HIV positive. The question is whether he can continue in his surgical residency. In addition, does the psychiatric resident pose more or less of a risk than the risk posed by the surgical resident? Moreover, what does the Americans with Disabilities Act of 1990⁵¹ have to say about that? Further, how do we balance in an individual case the need to protect the public and the need for people to be able to continue their careers? I am going to ask Dr. Zonana and then our legal commentators.

DR. ZONANA: I see a distinction here, because you are talking about the competence and the capacity to deal with child psychiatry when you have a diagnosis of a pedophile. In other words, this really goes to his ability to function as a child

51. 42 U.S.C. § 12101 (1990).

psychiatrist if he fantasizes about children, as he expressed. That seems to be the distinction here.

In addition, I think that part of this issue is complicated not only because it is a therapeutic relationship, but because there is a faculty relationship. He is in training to treat children, and so I see a distinction between that and the AIDS issue.

MS. KAUFMAN: There is another distinction between that and the AIDS issue. That distinction is that there is some control over the behavior with the pedophilia diagnosis, whereas with the AIDS issue someone can be infected with the virus without any volitional act on the part of the physician. I do not see disclosure or taking steps as appropriate based upon the mere revelation of a fantasy that is kept in check throughout therapy.

DR. ZONANA: I think Ms. Kaufman's point is an important point, and I think if there was anything that was not well done here, it was the follow-up. Moreover, I think that follow-up plays more of a role. The therapist did not see him at all in August, and then he did not come in very frequently in the fall and, finally, he tapered off. If there was reason to think that one was sitting on a hot issue, it seems to me you would say to a patient, "You have to come in," and not leave it open. In addition, that is where maybe some of the role shifting from being an analyst to being a therapist plays more of a part. However, you see, it is all layered on this, and the follow-through is as important as the revelation. It is the evaluation of whatever the statement is, and then the follow-through which hangs it all together.

PROFESSOR FENTIMAN: Yes, thank you. Maybe we could imagine for a moment that the panel is to be the trier of fact and trier of law. We are making our closing argument to you concerning our client. We said that what has been shown in this trial is that when somebody tells you this in therapy he is either testing the analyst or the therapist. He is looking for approval. He is looking for disapproval. He is asking for help, or he is asking to be stopped because he has mixed feelings. And so what I did in this closing was go with my patient's or client's request to help resolve conflict, to give my disapproval, and to stop the best way that I could, part of which was disclosing.

MS. KAUFMAN: I think there's a big problem with that. The problem is, in large measure, statutory. You simply cannot make disclosures like that, because patients have an entitlement to confidentiality. The whole point of confidentiality is to provide a setting for the patient where revelations of fantasies such as this can be made with absolute candor, without fear that there will be disclosure unless a certain set of circumstances is present.

I also think there are ways to effect disapproval and communicate that disapproval to the patient in the context of therapy short of disclosure. Sometimes a patient comes to your office with a certain mindset. I do not think it is impossible to imagine that over the course of therapy and time, especially if you have good rapport and an established relationship with the patient, that mindset might change. Maybe the patient might recognize the fact that his original mindset is inappropriate. Maybe the patient might come to embrace treatment. However, often at the initial revelation, the patient is not at that point.

DR. ZONANA: This is a tough balancing question. The issue here was narrowly presented. Because the analytic program was part of the residency, the court felt there was a greater obligation to make a report to the training program. Then if you inform the Institute, why do you not inform the residency program? What if you are treating this person privately? Now, the court said there probably would not be an obligation, but they did not really look at that issue. If you have a clinical faculty appointment, does that make a difference? How do you parse this out? This is a difficult issue. People always call to ask if they have to report something. In addition, I think most of these clinicians should focus on the clinical management rather than on whether or not the report is or is not made. The reporting question is usually the easier one at the time, although this obviously opens vistas about which most of us have not really thought through.

MR. TEITELL: I just want to say, before our time ends, that this was a jury case.⁵² It is my view that it really does not matter what the expert said. You said the facts of this case are

52. See *Almonte*, 851 F. Supp. 34.

that this person was a faculty member.⁵³ He was in a residency-training program.⁵⁴ He was trained to go into psychiatry with an interest in child psychiatry.⁵⁵ He went to the therapist and said that he went to South America looking for a little girl, hoping to find her because he is essentially a pedophile.⁵⁶ He believes he has a civil right to do that.⁵⁷ That is all there is to this case. In my mind, with that story, the jury is going to make up its own public policy, every time. It is not going to rely on experts. It is not going to rely on discussion. Now, whether you think that's right or wrong, I think that is the practicality of this kind of case. In addition, if the therapist came to a lawyer beforehand and that lawyer had the foresight to play that out, obviously the advice would be clear. Nevertheless, I think that if this type of case is tried before a jury, the jury is going to see this as a clear morality play. It is going to decide its own public policy, in my view, almost every time and say you just cannot have this happen.

MS. KAUFMAN: Unfortunately, public policy is also reflected in our statutes and the one peculiar quirk to this case is that in order to avoid an action for negligence, essentially the therapist has to rewrite the law. One has to commit an illegal act in order to avoid being sued and I think that's a big problem with this case, and that is why Dr. Fitz was in a difficult situation.

PROFESSOR FENTIMAN: Could I suggest a follow up question? Why do you see the statute as precluding disclosure in this case?

MS. KAUFMAN: If you look at the New York statute,⁵⁸ it refers to an endangered individual and a disclosure to that individual. There was never any endangered individual; no particular victim was ever identified. Again, you are dealing with somebody who repeatedly says that he has fantasies, but no intent to act on those fantasies, and that those fantasies are quiet.

53. *See id.* at 36.

54. *See id.*

55. *See id.*

56. *See Garamella II*, 23 F. Supp. at 170.

57. *See id.*

58. *See* N.Y. MENTAL HYG. LAW § 33.13 (McKinney 1996).

The Connecticut statute⁵⁹ refers to substantial risk of imminent physical injury by the patient to himself or to others. We do not have imminent physical injury. We do not have a threat of that, because there is never any threat of action under this fact pattern.

PROFESSOR FENTIMAN: We can certainly argue about the imminence, but on the merits point out that the expert judgment that had been reached by the treating therapist was that there was a real, manifest risk. Now, if you have reached the opposite judgment that this is pure fantasy that is never going to be acted on, then we do not even reach the point of interpreting the statute. You do not have any basis for disclosure. On the other hand, if you decided that this person is someone who has a sense of entitlement in acting this way, then I am not so sure that you cannot make a judgment that if he is about to start treating children, there are identifiable potential victims. Moreover, the hardest point, I think, is the last point, whether they or their surrogates have to be warned.

DR. ZONANA: I think at that point, yes, but that was not really the factual situation. He was in his last year of adult residency and had not yet entered the child program. Although in an adult residency, there are periods where he would have seen children. So there may have been other things that happened that nobody knows about or were not part of the case. At least as far as the doctor was concerned, he had been through pediatrics in medical school and said he had not done anything. So from the therapist's point of view, there is a basis to worry. The question is whether it reaches the threshold for reporting.

59. See CONN. GEN. STAT. § 52-146f (1999).