

Psychiatry and the Law: A History of Our Duty to Protect

[Mara Suzanne Goldstein*](#)

* To whom correspondence should be addressed: Faculty of Medicine, McGill University, 3655 Drummond St., Montreal, QC, Canada H3G 1Y6

On the issue of "dangerousness," the psychiatrist enters where angels fear to tread. At once a physician within a doctor-patient relationship and an agent of social control, the psychiatrist is expected to remedy the ills of the disturbed individual as well as the world in which that individual exists, with potentially brutal consequences. Reflecting changes in social climate and scientific progress, the power of the psychiatrist is questioned, curtailed, and redefined by the courts as society demands civil liberties and then seeks protections. From the shifting trends in civil commitment, deinstitutionalization, medicalization, legislation, and liability, a common thread emerges: that dichotomous thinking--though comforting in its classification of phenomena as mind or body, sick or evil--has failed to provide solutions to the problem of the "dangerous patient."

In the mid-nineteenth century, the state confined the "insane" to public institutions. At first, medical testimony played a very limited role in commitment proceedings because, as Alan Dershowitz explains, people knew who they considered to be "intolerably obnoxious" (1). Soon after the establishment of asylums, however, Dr. Isaac Ray, the first physician to suggest that the mentally ill should be treated in hospitals rather than punished in jails, wrote a treatise on the medical model of insanity. By the end of the nineteenth century, madness was no longer seen by society as a social phenomenon but rather as a disease to be treated by doctors with little or no interference by the courts.

It was not until the civil liberties movement of the early 1970's that the power of the psychiatrist was first questioned and ultimately revoked (2). The prevailing role of the psychiatrist in many instances "not only as arresting officer, but as prosecutor, judge, and jailer as well" (3) was contested. The "need for treatment" criteria introduced by Dr. Ray were therefore replaced with a new framework: the "dangerousness" criteria (4-6). A person could not be detained merely because a doctor thought she needed treatment, but only if she was deemed dangerous to herself or others.

Although the dangerousness criteria were meant to represent a rejection of Dr. Ray's model, psychiatric medicine in the 1970's was very similar to the paternalistic institution described by Dr. Ray more than a century before. Patients were subjected to what the doctor thought was best for them. This *parens patriae* model of ethics meshed well with the medical model although effective treatment for the mentally ill was minimal. The undesirables, the "intolerably obnoxious," were locked away by virtue of the medical semantics of the *Diagnostic Statistical Manual*. Strange behavior was medicalized, and pathologies included deviations from social mores, such as homosexuality and promiscuity.

In their 1974 treatise, activists Ennis and Litwack showed the dangerousness criteria to be a part of this larger oppressive trend. Leaders of the first social movement to change the power of the psychiatric profession, they claimed that a person could more accurately predict dangerousness with the flip of a coin than with a psychiatric consult (7). Although judges and juries believe psychiatrists to be experts and defer to their judgment and recommendations, there may be nothing in the training, experience, or techniques of psychiatrists that makes them more able to predict dangerousness. In fact, Ennis and Litwack found that a psychiatrist is likely to overpredict dangerousness. During an era of renewed interest in civil liberties, such a possibility was unacceptable.

Ennis and Litwack argued, therefore, that psychiatry had no scientific basis on which to institutionalize people, that because psychiatrists were not only inept but also biased in their assessments of deviant behavior, they should not be permitted to testify as experts in civil commitment proceedings. Their paper increased the momentum of the pendulum swinging strongly in the direction of extreme civil libertarianism, deinstitutionalization, and decreased power of physicians. This diminished power of the psychiatrist was not due to the failure of the medical model but rather to the failure of psychiatry to live up to the medical model. For advocates of radical social change, the symbolic gesture of closing an institution carried the weight of rejecting the abuses that took place within. The locks on the doors of the asylums were to symbolize the mindset of a society no longer willing to live in the ambiguity of *parens patriae*.

In 1986, *Newsweek* published a story about the state of psychiatry more than a decade after the reforms had taken place (8). Daniel Thornton, a 34-year-old man with schizophrenia and a history of violence, had murdered a 76-year-old woman when his psychiatric therapy was interrupted. His psychiatrist had retired and his counsellor could not see him because of illness. After the murder, Thornton told police that it was the only way he knew to get the psychiatric care he needed. Jeff Brown, Thornton's public defender stated,

We have an all-or-nothing proposition in this system. A person is either in an institution or not in one. And if he's out, we operate on a wing and a prayer that he's not going to do harm to himself or another person (8).

Sending shock waves through the community, such cases proved what studies had shown: that, in the face of publicized horror stories involving mental patients, institutionalization rates rise and the threshold for commitment falls, even without statutory changes (4).

Within a decade of the libertarian reforms, it thus became evident that such civil liberty came with a price tag too high for many to bear. A nation had turned its back on the state only to find itself less than a decade later requesting protection by the very same physicians that had been deemed incompetent. Hence the second social movement in whose wake we are currently functioning takes the concept of "could be detained" (i.e., medical indication for commitment) and replaces it with "must be detained" (i.e., commitment for society's protection). In this model, the medical profession is once again handed the duty of preventative detention, for which it had been previously blamed. Mandated to perform a balancing act between the interests of the patient and those of society, psychiatry found itself lost in the middle, often alone to make crucial decisions.

In 1974, Tatiana Tarasoff was murdered by her boyfriend after he was released by a psychologist to whom he had revealed his violent intentions. The ruling in the subsequent lawsuit against the therapist created, for the first time, a duty for mental health professionals, both psychiatrists and psychologists, to protect society from dangerous patients when they learn that an individual is in danger. Currently, it is common for psychiatrists in North America to warn potential victims, acting as if *Tarasoff* was a valid law even though the *Tarasoff* decision is limited to the State of California (9).

Although the police had arrested and questioned Poddar before the murder of Tatiana Tarasoff, they had released him on the belief that he was rational and not dangerous. The role of the police was ignored in the

civil proceedings, largely due to the fact that, as a society, we do not give the power to police to detain anyone for crimes not yet committed. Since the days of Judge William Blackstone, society expects police to act on the view that it is better that ten guilty persons escape than that one innocent person suffer. The institution of *Miranda* rights in 1966 extended greater protection to suspected criminals, leaving the power of preventative detention to medicine and psychiatry, with high expectations (9,10).

Despite Ennis and Litwack's convincing arguments to the contrary, the court's decision in the *Tarasoff* case made it clear that psychiatrists are expected to predict dangerousness and to do something about it. Alan Stone, in his 1976 paper titled "Suing Psychotherapists to Safeguard Society," explains,

The *Tarasoff* decisions are the product of a court unwilling to admit the consequences for public safety of the recent general trend, in which it has played a substantial role, toward increasing recognition of the rights of the mentally ill and the resulting change in civil commitment procedures. . . These sweeping changes mean that society must tolerate greater disturbance in the community and greater risks of harm to the public (3).

Stone appropriately describes the *Tarasoff* case and the second social movement in psychiatry in terms of a backlash against the first movement and its libertarian reforms.

After the institution of changes in the criteria necessary for civil commitment, otherwise non-detainable patients with mental illness were labeled dangerous, resulting in the mass medicalization of violent behavior. (11) Under the banner of "madness versus badness," the semantics of psychiatry have opened the door of mental illness to those members of society who are the potential murderers, rapists, wife beaters, and child molesters. The anti-social personality disorder is the classic example of the most dangerous members of society being warehoused or claiming refuge in the halls of medicine (6). Thus, Dr. Ray's concept of social quarantine, deemed unacceptable in the early seventies, was revived in the wake of *Tarasoff*, as society suggested that it did indeed want doctors to protect the public from potentially violent people.

In an extensive paper on the issue of the duty of mental health professionals to third parties, Peter Carstensen writes, "At its core, *Tarasoff* involves allegedly negligent failure to treat a disease which had been diagnosed. . ." (12). The disease, in this case, is the patient's dangerousness. Since the days of Dr. Ray and the beginnings of the medical model, there has been a principle of reciprocity which allows detention of individuals in exchange for appropriate treatment (1,15,16). However, as noted by Brouillette and Paris, the patients who are most dangerous are also most likely to be refractory to treatment (14). According to Dr. Renee Fougere of the department of Forensic Psychiatry at McGill University, very few of these patients receive any medication on a regular basis (13). Thus, in light of this reality of psychiatric practice, the role of preventative detention leaves physicians to perform a warehousing function which, according to Brouillette and Paris, is "at best ineffective, and at worst counter-productive" (14).

Thus, the *Tarasoff* ruling and the duty to protect represent the societal belief that the physician is best equipped to make informed choices balancing risks and benefits. Of course, *Tarasoff* was also meant to provide the perfect legal package with respect to social control: a balance between civil liberty and social welfare, with psychiatrists bearing the burden of responsibility. Putting white coats on the agents chosen to protect the masses is palatable to a society that still believes quite firmly in the medical model but is extremely worrisome to psychiatrists, who must familiarize themselves with case law (15) in light of the disturbing possibility that

[t]he more culpable party (the patient) may not be the one most likely to respond to legal stimuli, and so a goal of deterrence points at imposing more liability on the therapist who is more likely to respond and adapt (12).

Stone recognized that, in an attempt to avoid the outcome of the pendular swing towards absolute civil liberty, the courts had exposed therapists to greater liability (3).

One of the major problems with the legal model of psychiatric decision-making is that psychiatrists have lost autonomy in their own profession, and society has yet to conclude what is acceptable or reasonable. In an attempt to find meaning and assign blame in the face of senseless and brutal crimes, the public looks to the psychiatrist who was unable to prevent them. This retro-active rulemaking is, at best, unfair to psychiatrists and, at worst, a dangerous threat to the profession. The psychiatrist is left with only the most general standards of behavior to avoid the risk of liability.

Thus, our current concept of "must detain" hinges on our unrealistic expectations of medicine, our medicalization of violence, and our need to find some satisfactory form of jurisdiction over human behavior. Most basic is our desire as human beings to avoid feeling morally or legally responsible for harm inflicted on others. The solution of "must detain" does not, however, add any new dimensions to the problem of the dangerous patient, and, with many more individuals incarcerated as a preventative measure, may actually represent a throwback to the pre-civil rights era. Just as the public accused physicians of seeking power and monopoly in the 1970's, today criticism may be leveled against psychiatrists for seeking immunity from liability. Either way, we end up back where we started.

The expectations of psychiatry within the medical model have their roots in the idea that a physician must be able to do something. Doctors are taught that it is better to accept illness and be wrong, than to reject illness and be wrong (3). Rarely do we question the validity of such actions. Only now, in the aftermath of multi-resistant infections, have we begun to wonder whether doctors ought to act blindly to appease the public. Before demanding that physicians forcibly admit people whenever danger is suspected, it would be reasonable to determine the effects of such actions. Although the issue of civil liberties is important, many other questions must be answered. What is the effect of placing dangerous people in the same institutions as those who are not dangerous? In a system of dwindling resources, what should our priorities be? If new institutions are to be erected (or reopened), who will pay? Who decides how long people deemed dangerous remain dangerous?

Clearly, to question the pendular dynamic of psychiatry and social responsibility is to question a dichotomy that plagues medicine, science, and Western thought in the 20th century. As a society we struggle to find the right answer, a single reality, which, in the realm of psychiatry and dangerousness, translates into concepts of blame and liability. The problem of the "dangerous patient" has become, however, an amorphous question not answerable with simple, dichotomous models. The shifts and swings seen in psychiatric decision-making and the patchwork solution of duties and liabilities reflect a society unwilling to look at the issues with a wide perspective. Instead of rejecting flawed or incomplete doctrines, our goal should be to invest in and build on the solutions of the past, with every added layer incorporating those who have fallen through the cracks in the system.

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Mara Goldstein received her CEGEP diploma from Marianopolis College (Montreal, Quebec, Canada) in 1992. She is currently a third-year medical student at McGill University (Montreal, Quebec, Canada). Her paper on psychiatry and the law was researched during her four-week elective in Biomedical Ethics at the McGill Centre for Medicine, Ethics and Law. Following residency, she plans to pursue a degree in ethical philosophy with the goal of practicing as a clinical medical ethicist.

