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# A CONFESSION OF MURDER: THE PSYCHIATRIST'S DILEMMA

*Philip J. Candilis, M.D. and Paul S. Appelbaum, M.D.\**

## I. INTRODUCTION

The case of the panic-stricken felon who admits to his psychiatrist that another man has been sentenced to death for his crime epitomizes a classic ethical tension in psychiatry. On one hand stand the principles—among them autonomy and fidelity—that promote the confidentiality of patients' communications; on the other are the competing principles—including beneficence and justice—that advance other ends. How are such tensions resolved?

We take the view that ethical principles are not absolute, but binding on a *prima facie* basis. Principles in general are applicable unless opposed by principles of equal or stronger justification. To resolve the ethical dilemma, we need to identify and weigh the ethical principles involved in the context of psychiatric care. We also need to consider an alternative approach to ethical reasoning—utilitarianism—and what effect it might have on the resolution of the conflict.

## II. THE DUTY TO MAINTAIN CONFIDENTIALITY

The roots of confidentiality in psychiatry, as in medicine, run deep. The Hippocratic Oath<sup>1</sup> itself required that what was seen or heard in the life of men should not be "spread abroad," although some commentators claim that this statement may have been more a strategy for gaining economic advantage over competitors than any profound endorsement of patient confidentiality. The 1948 Declaration of Geneva of the World Medical Association held that all information divulged by patients ought to be kept confidential. The British and American Medical Associations subsequently qualified this

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1. CHAUNCEY D. LEAKE, *PERCIVAL'S MEDICAL ETHICS* 213-14 app. I (1927).

standard of absolute confidentiality by recognizing countervailing legal requirements and the potential need to protect individual patients or society. The American Psychiatric Association also recognizes a qualified standard of confidentiality but urges erring in favor of confidentiality in cases of uncertainty. Clearly, the traditions developed in professional codes both underscore the importance of confidentiality and suggest its potential limits.

When professional organizations set higher standards than may otherwise be expected of common social intercourse, such codes and traditions demarcate important ethical boundaries. Professional codes, however, are often driven by specific interests of the profession and are variable enough to require a more comprehensive statement of guiding principles. Furthermore, tradition is not a moral warrant—explicit justification is required for any moral act. Robert Veatch, in developing his triple-contract theory of medical ethics—citizen-citizen, professional-society, and professional-layperson—appropriately cites obligations to the lay public and to external review in limiting the moral weight given to professional codes.<sup>2</sup> Consequently, although professional codes may provide a starting point for general discussions of confidentiality, we need to explore the particular principles that underlie the value of confidentiality in psychiatry.

Confidentiality is rooted in two primary principles: autonomy and fidelity. Patient autonomy is served by the confidentiality of psychotherapeutic relationships. Patients have the freedom to explore intimate secrets, thoughts, wishes, and fantasies in a manner that permits healing, self-knowledge, and attainment of personal goals. These outcomes collectively enhance the patient's "self-rule." Consequently, autonomy is not only a bulwark of principlism<sup>3</sup> in medical ethics, but also an important goal of psychiatric treatment.

Fidelity, or promise keeping, is likewise a cardinal principle of ethics, as well as an important support for confidentiality.<sup>4</sup> A person entering a psychiatrist's office reasonably expects that information divulged will be held in confidence, whether this is promised explicitly or merely implied. This reasonable expectation gives rise to a

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2. ROBERT M. VEATCH, *A THEORY OF MEDICAL ETHICS* 108-38 (1981).

3. Principlism describes an approach to ethical reasoning that first specifies and then, analyzes principles of ethical behavior.

4. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 341-42 (3d ed. 1989).

legitimate moral claim against a profession and a therapeutic process that ground themselves in the trustworthiness of this transaction.

With such strong, principled support for confidentiality, every reasonable effort should be made to find alternatives to breaching confidentiality for the sake of opposing interests. Thus, in the case in question, we take it for granted that the psychiatrist will explore the patient's willingness to turn himself in, or to give the psychiatrist permission to do so. But as Ben Jones has already told his attorney, his mother didn't raise no fool. He is not yet ready to confess to the murder for which Frank Smith has been convicted unless his attorney finds a way to make a deal. We assume for the purposes of this discussion that the easy way out of this dilemma is closed to the psychiatrist. Confidentiality cannot be protected without sacrificing other values. What, then, are the competing duties and their underlying principles with which the psychiatrist must contend?

### III. THE DUTY TO RESCUE

The duty to rescue third parties is grounded in the principle of beneficence. A strong version of beneficence might require a person to actively promote the good of others. Fortunately, for our purposes here, we need only consider the weaker, more philosophically modest version of the principle which asks that people act only to prevent harm to third parties. The harm in question is the death of Frank Smith, innocent of the murder for which he has been convicted.

Although the application of the duty to rescue is quite controversial—as we shall see shortly—even an American polity that has been reluctant in general to impose affirmative duties for the benefit of third parties has recognized that such duties may exist in the medical setting. Moreover, these duties may trump the duty to guard patient confidentiality. Thus, the law requires physicians and other healthcare providers to report gunshot wounds, certain communicable diseases, and suspected abuse of children, elders, and disabled persons. In addition, psychiatrists and other psychotherapists have been held to have duties to protect third parties from their patients' violence. In each of these cases, the benefit to the general good has been determined to outweigh the harm to patients' interests in confidentiality. Why should this rationale not extend to our case?

Perhaps the reason for stopping short of that conclusion here lies in the justifications for resisting broader duties to rescue in American ethics and law. Objections to wide-ranging duties to rescue are often couched in terms of undue burdens on liberty. If persons are obliged

to be beneficent, it is argued, the weight of incremental obligations may overwhelm the liberty to pursue individual goals. Alternatively, some maintain that the uncompensated labor of rescue limits economic freedom and thus militates against endorsing the duty. How potent are such objections in our case? It is difficult to argue that a requirement to save a life would materially burden psychiatrists when the knowledge is available to do so. Such instances are highly unlikely to occur, and the means of discharging the duty are relatively apparent. True, the police may question the psychiatrist, and her testimony may be required at trial. But these obligations are not beyond those ordinarily imposed on citizens who, by chance, become witnesses to a crime. The burdens in this case are *de minimis*.

Other objections to imposing duties to rescue arise from the belief that such obligations cannot be easily bounded. The duty to rescue, it is argued, is inherently limitless. This approach often relies on "slippery slope" or "wedge" arguments, rather than on justifications that discriminate among cases. The slippery slope approach has received criticism for not drawing a particular moral distinction because of the potential need to make difficult distinctions further down the slope. A moment's reflection is enough to recognize how the argument would work here. If we justify a duty to rescue Frank Smith who is about to be put to death, would we hold the same for Patty Johnson who is unjustly serving ten years in prison? What of Jim Franklin who is but two weeks shy of completing a six-month sentence? Or Betty Adams, who is about to pay a twenty-five dollar fine for her neighbor's offense of shoveling snow into a public street.

These are all real questions that, if we accept the moral legitimacy of a duty to rescue, we shall have to address as they arise. They are not, however, reasons to avoid invoking a duty in this case, where the harm is the loss of an innocent life. Slippery slope arguments are philosophically unsound because they move the bounds of argumentation, thus ceding the moral ground. Either saving Frank Smith's life justifies breaching confidentiality or it does not. The conclusion either way is logically independent of the result that might be reached in any of the cases further down the slope.

There are, moreover, aspects of the situation in question that provide natural boundaries for a duty to rescue and prevent us from embracing a wider version of the duty—although we do not mean to suggest that more generally applicable duties to rescue could not be defended. The psychiatrist is one of a small number of people—all of whom face similar ethical conflicts—in possession of the knowledge

that could save Frank Smith's life. Were the information even more widely known, it might be argued that the primary duty to rescue should be assigned to someone without a countervailing duty of confidentiality. Furthermore, as suggested above, the rescue can be accomplished with relatively little effort. These are precisely the conditions identified by Levmore under which our society has been most willing to endorse a duty to rescue: The holder of the duty can be clearly identified and the burden is minimal.<sup>5</sup>

The duty to rescue seems to provide a potent counterweight to the duty to maintain confidentiality. But before we decide whether Dr. Palmer should call the police, we need to consider an additional duty that might make our decision easier.

#### IV. THE DUTY TO PROMOTE JUSTICE

What claim might an ethical duty to promote a just outcome have on Ben Jones's psychiatrist? John Rawls's theory of justice provides the foundation for an analysis of this question.<sup>6</sup> From Rawls's perspective of justice as fairness, the duty to support and comply with just institutions is a fundamental natural duty.<sup>7</sup> As a natural duty, it exists between individuals irrespective of their institutional relationships;<sup>8</sup> thus, if the basic societal structure is as just as can be reasonably expected, all actors have a natural duty to help promote it. Although Rawls derives his theory from a contractarian perspective, he does not presuppose an act of express or tacit consent—here by Ben Jones. In the case where a psychiatrist faces a gross miscarriage of justice and a duty of confidentiality, the duty to promote justice—as the more fundamental of the two—prevails.

Indeed, one might argue that the obligation to promote justice applies with particular force to a physician or similar professional. The attainment of professional and social standing is not entirely a just or rational process. Individuals can gain standing by winning a series of biological and social lotteries. They may be born into favorable circumstances, resist disease and early death, and serendipitously avoid economic want, social deprivation, or plain bad luck. They may come upon good opportunities by chance or inher-

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5. Saul Levmore, *Waiting for Rescue: An Essay on the Evolution and Incentive Structure of the Law of Affirmative Obligations*, 72 VA. L. REV. 879 (1986).

6. JOHN RAWLS, *A THEORY OF JUSTICE* (1971).

7. *Id.* at 115.

8. *Id.* at 334.

ently possess a talent valued by others. Such individuals, some commentators claim, owe a greater duty to society by virtue of the stature gained from social definitions of worth and other natural lotteries. Consequently, psychiatrists may legitimately be asked to pay a higher price—the burden of acting to promote a just outcome—for their status in the community.

Arguing strictly from the perspective of principlism, then, there appear to be two strong principles that suggest sacrifice of confidentiality may be the ethically desirable outcome. Such a conclusion would be even stronger if it comported with an estimate of the practical harms and benefits of Dr. Palmer's action. We turn next to a consideration of these utilitarian concerns.

## V. THE UTILITARIAN PERSPECTIVE

In contrast to principlism, utilitarianism focuses on the gains and losses from a particular course of behavior, either in a specific case or as a general rule. Indeed, the policy debate surrounding confidentiality in psychiatric treatment is most often framed as a utilitarian issue: whether the harms that flow from failing to protect patient confidentiality outweigh whatever benefits may be gained. So as not to consider the consequences of broadscale intrusions on the confidentiality of psychiatric treatment—such as opening the psychiatrist's consulting room to the medical equivalent of courtroom television—it should be emphasized that our concern here is with the specific issue raised by the Frank Smith/Ben Jones case: whether a psychiatrist should reveal confidential information that will save a person's life.

The key objection to any limitation on psychotherapeutic confidentiality is that it will deter patients in general from seeking treatment or from revealing sufficient information to benefit from treatment because they fear the betrayal of their confidences. Although utilitarian arguments are ultimately empirical, research data offers little assistance in determining the existence or magnitude of this effect. To be sure, surveys of patients, potential patients, and psychotherapists have shown repeatedly that confidentiality is highly valued. Many patients report they would not have sought treatment without some assurance that their communications would be protected. Nonpatients claim that they would not even consider psychotherapy without such guarantees.

It is difficult to evaluate the scope of this effect in the absence of actual comparisons of patients' behavior under conditions of complete and less-than-complete confidentiality. Although patients may claim

that they would avoid treatment without absolute assurances of privacy, it is likely that they will ultimately weigh the probability and adverse effects of unwanted disclosure against the probability and beneficial effects of seeking treatment. Whether any particular infringement of confidentiality deters people from seeking treatment, therefore, relates strongly to the nature of the limitation on confidentiality itself.

Assume for purposes of analyzing this case that the Smith/Jones affair ends with Dr. Palmer calling the district attorney's office. Moreover, given the media appeal of the situation, it makes banner headlines. Mr. Smith and Dr. Palmer do the daytime talk show circuit, and a chat-room on America Online is devoted exclusively to discussions of the case. Thus, it becomes widely known that Dr. Palmer "turned in" her patient Ben Jones, breaching the confidentiality of their psychotherapeutic relationship. What are the potential consequences?

It seems very unlikely that large numbers of patients will be deterred from therapy for fear that they too will be turned over to the authorities. If Dr. Palmer does a good job explaining that she and her colleagues would only undertake such an act when another person's life was at stake, the pool of people at risk of being diverted from therapy would be limited to undiscovered murderers, a group not likely to utilize psychotherapy. If Dr. Palmer frames the principle more broadly and indicates that she would be unwilling to see an innocent person spend substantial time in prison, the number of people directly affected grows somewhat, and the slippery slope rears its ugly head again. But it is difficult to imagine that the average psychotherapy patient—concerned about a relationship, dysfunctional behavior at work, or problems with the children—will so identify with Ben Jones's predicament as to be deterred.

Of course, some people may generalize—incorrectly—from the Smith/Jones case that psychotherapists cannot be trusted to keep any confidences at all. Another group will be concerned that their *fantasies* of violence, much more common than might be imagined, will be reported to the police. The size of these groups is difficult to estimate, however, and in both cases their behavior depends on misinterpreting the implications of Dr. Palmer's actions. Such misinterpretation is difficult to guard against under any circumstances.

We might also consider the other side of the coin: A psychiatrist who acts to save an innocent life and prevent a perversion of justice may do more to increase respect for the profession than to derogate



it. Recognizing the difficult dilemma faced by a psychiatrist who is committed to confidentiality in general, the public may admire her rectitude in deciding that Frank Smith's life nonetheless comes first. The overall effect of the episode could be to promote greater use of psychiatrists' services by the very people who were previously uncertain about psychiatrists' values.

Whatever the harms that might ensue should Dr. Palmer recount Ben Jones's confession to the authorities, they do not seem to be of great magnitude. Although it would be easy—and incorrect—to assert that the corresponding benefit of saving a life should be given infinite value, such an exaggeration is unnecessary here. The unquestionably substantial value of preserving Frank Smith's life from an unjust end by the state seems unopposed by significant negative consequences. The utilitarian balance appears to tip in favor of disclosure by Dr. Palmer.

## VI. CONCLUSION

Neither of us in real life looks forward to facing the dilemma posed by a patient's confession to a capital offense for which someone else is to be put to death. But we are comfortable that the ethical analysis outlined here would provide guidance in dealing with the possibility. Both principlist and utilitarian analyses support the validity of breaching Ben Jones's confidentiality to save Frank Smith's life.