BENCHMARK
INVITED SUBMISSION

AHMED V. STEFANIU - IS THE SKY REALLY FALLING?

John J. Morris M.A., LL.B.

Lawyer, Borden Ladner Gervais LLP, Toronto, Canada

Introduction[1]

More than three decades ago in the case of *Tarasoff v. Regents of the University of California*[2] the Supreme Court of California found a psychologist, Dr. Moore, liable for the death of Tatiana Tarasoff. She was murdered by one of his patients. The patient had confided to Dr. Moore an intent to kill Ms. Tarasoff. He requested that the campus police detain the patient. However, they released him a short time later as he seemed rational. No one warned the woman or her family. When, several months later, the patient killed Ms. Tarasoff, her parents sued Dr. Moore and other employees of the university. Dr. Moore argued that by reason of patient confidentiality he had no duty to warn Ms. Tarasoff or her family. The court rejected that defence:

> The confidential character of patient psychotherapist communications must yield to the extent that disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.[3]

The *Tarasoff* decision has been referenced in several Canadian decisions; it has also been the subject of a number of academic articles.[5] Although it now represents an established legal principle, the burden it places upon mental health professionals towards third parties remains somewhat controversial.

An example of that controversy is found in a recent decision of the Ontario Court of Appeal. In *Ahmed v. Stefaniu*[6] , the Court of Appeal upheld a finding of liability against a psychiatrist who had released a patient from a psychiatric facility. Fifty-nine days after his release the patient murdered his sister. This decision, to which the Supreme Court of Canada denied leave to appeal[7] , has created a "buzz" among members of the Canadian psychiatric community. A decision of the Ontario Court of Appeal, the highest court of Ontario, is considered a very weighty legal authority in Ontario and other provinces. Some would argue that the decision has created an unreasonable imperative for defensive psychiatry in this country. As one reviewer put it,

> Psychiatrists will have to err on the side of caution, and keep patients committed or commit patients themselves at the first sign of intended aggression.[8]

This article will examine the legal context for the Court of Appeal's decision and provide, it is hoped, some reassurance for those who may have concluded that it constitutes a major precedent for evaluating the legal responsibility of other psychiatrists in similar circumstances.

The Evidence

Justice Armstrong, who wrote the Court of Appeal's unanimous decision[9] set out the following background:

5 In October 1995, Johannes was admitted to the Scarborough General Hospital as an involuntary patient. He was said to have threatened his landlord and engaged in aggressive behaviour. He was prescribed medication to treat a psychotic disorder. After his release from Scarborough General Hospital, he was readmitted as a voluntary patient with a diagnosis of acute psychosis. After his second hospital stay, he lived with his sister and her two daughters where he functioned reasonably well. He returned to work.

6 In the summer of 1996, the condition of Johannes deteriorated. He exhibited bizarre, aggressive and paranoid behaviour. On September 25, 1996, his sister contacted Johannes' family doctor and expressed concern about her brother. She told the family doctor that Johannes had threatened to hurt her if she did not prove that she was "on his side" within two weeks.

7 The following day, September 26, Johannes was forcibly taken by the police to the emergency department of the Humber Memorial Hospital. On September 27, 1996, the appellant assessed Johannes and concluded that he was lacking insight, with severe paranoia, and that he had a potential for violence. On September 28, 1996, Johannes was admitted to the Humber Memorial Hospital as an involuntary patient pursuant to a Form 3 under the *Mental Health Act*. The attending physician on September 28, 1996, found that Johannes was likely to cause serious bodily harm to another person. He was also declared not mentally fit to consent to treatment.

8 Johannes appealed his involuntary hospital admission to the Consent and Capacity Review Board. A hearing was held on October 8, 1996. In its decision, the Board concluded:

> [T]he Board is of the opinion that at this time, without treatment, there is a likelihood that the patient if he left hospital would continue to deteriorate to the point where there is a likelihood that he will cause serious bodily harm to another person. He would simply lose control due to anger and frustration.

 (ISSN: 1916-2405)

9 In mid-October, the appellant recorded the following in a progress note concerning Johannes: "further deterioration of his mental state with potential for self harm and/or harassing others".

10 On October 24, 1996, Johannes struck another patient. He had to be placed in two-point restraints due to his level of agitation. On October 31, 1996, Johannes threatened the Department Chief and a staff psychiatrist. Following the latter episode, Johannes was involved in a fight with two staff porters. Two security guards were required to subdue him and place him in four-point restraints. While in Humber Memorial Hospital, physical restraints were used on Johannes on 25 different occasions.

11 In mid-November, the hospital security records disclose that Johannes attempted to assault two patients. On December 2, 1996, the appellant did an assessment of Johannes. Her progress note refers to Johannes as remaining delusional and paranoid.

12 The nurses' notes of December 3, 1996, describe Johannes as very angry, loud and intrusive, with threatening body language and a rigid posture. He is further described as "extremely hostile". On the following day, December 4, 1996, Johannes threatened a nurse.

13 In addition to the above, there was also evidence before the court that over the course of his hospital stay, Johannes became less threatening in his manner, facial expression and interactions with the hospital staff. Although not a model patient, there was observed a general trend of improvement in his behaviour.

14 In the early evening of December 4, 1996, the appellant carried out an assessment of Johannes. In her progress notes, she described Johannes as having no signs or symptoms of paranoia or psychosis. She found him very appropriate, co-operative and with a great sense of humour. During this assessment, he told the appellant that he had no intention of harming himself or anybody else, including his sister. He also told the appellant that all of his behaviour at the hospital had been "staged and planned". She understood him to tell her that he had faked his psychosis. She testified that she took this information with a grain of salt. The appellant concluded on December 4 that Johannes probably did not meet the criteria for an involuntary patient at that time. She decided to meet with Johannes the next day for further discussion.

15 The appellant met Johannes on December 5. Her progress note presents a somewhat mixed picture of the patient:

> Patient seen again today. Pleased he is finally released. Good mood, pleasant, co-operative, but inappropriately flirtatious (jokingly insists we go for dinner). Has plans about job, picking up his car, and restarting life. No signs of delusions, paranoid thinking or psychosis. Denies any suicidal or/and homicidal ideas ... (illegible) or plans. Alert and oriented - however remains provocative, macho and in [sic] the same time angry and fragile.

16 The appellant concluded on December 5, 1996, that Johannes no longer met the criteria to be detained in the hospital as an involuntary patient. She changed his status from involuntary to voluntary under the *Mental Health Act*. In doing so, she considered a number of factors including: the patient's general trend of improvement, his stated intention that he did not plan to harm himself or others, his response to medications, the decision of the Consent and Capacity Review Board, his previous admission to Scarborough General Hospital, consultations with other psychiatrists and conversations with his employer.

17 When the appellant changed Johannes' status to voluntary, she suggested that he remain in the hospital on a voluntary basis but he refused to do so. He also declined to follow the appellant's suggestion that he continue with a psychiatrist whom he had been seeing prior to his admission to Humber Memorial Hospital.

18 When Johannes left the hospital he moved back into his sister's apartment.

19 Johannes returned to Humber Memorial Hospital on more than one occasion to visit a female patient. Such visits were disruptive and he was asked to leave the premises. On one occasion, he was escorted off the premises by the police and spent the night in jail.

20 On January 21, 1997, Johannes attended at the North York General Hospital emergency department. He was assessed by Dr. Weinstein, a psychiatrist. Dr. Weinstein noted that Johannes was depressed. He was also noted as being well dressed and articulate. In response to questions from Dr. Weinstein, Johannes said that he was not capable of hurting himself or others. Dr. Weinstein saw no indication of violence or potential for violence from Johannes on January 21, 1997. Dr. Weinstein concluded that Johannes did not meet the criteria for involuntary admission.

21 On January 22, 1997, Johannes attended at the Toronto General Hospital emergency department where he was seen by Dr. Lee, a Toronto General Hospital resident. Dr. Lee reviewed his medical history, including his involuntary admission at Humber Memorial Hospital. Johannes requested an immediate psychiatric consultation. Dr. Lee declined to order a consultation because at that time she did not regard Johannes as a danger to himself or to others. Dr. Lee assessed Johannes to be stable and opted to go with out-patient care. Dr. Lee concluded, in consultation with her supervisor, Dr. Caravaggio, that Johannes did not meet the criteria for involuntary admission under the *Mental Health Act*.

22 On January 24, 1997, Johannes murdered his sister at her apartment. At the time that he murdered his sister, he was in a floridly psychotic, acutely delusional rage in which he believed that his sister was possessed by the devil.

APPELLATE REVIEW AND THE PRINCIPLE OF "JURY DEFERENCE"

An important aspect of this case – which helps explain if not justify the result is that it was a trial by judge and jury. The vast majority of civil cases in Ontario are tried by judge alone. In fact, it was thought at one time that cases involving medical malpractice were too complex to be submitted to a jury.[10] More recently, the courts in Canada have rejected this as a general principle and concluded that juries are sufficiently sophisticated to understand the evidence and to deliver a just verdict even if the case involves complex medical issues.[11] Nonetheless, jury verdicts in medical malpractice cases are still relatively rare.

In appealing the verdict in this case, Dr. Stefaniu was entitled to only a limited review by the Court of Appeal. An appellate court is limited to questions of law, and to a very limited extent, questions of fact. In reviewing factual findings of a jury, the Appeal Court must accept those findings unless it can be demonstrated that no reasonable jury, properly instructed by the trial judge, would have reached those findings.[12] Similarly, the judge's charge to a jury will only lead to a verdict being overturned if it can be demonstrated that the charge was inadequate or wrong, and also, that it would have materially affected the jury's verdict.[13]

In the *Stefaniu* case, Justice Armstrong considered the limitations of an appellate court on several occasions throughout his reasons for judgment. He closely reviewed the evidence of Dr. Hector, the expert witness called by the plaintiff to demonstrate that Dr. Stefaniu breached a reasonable standard of care. Counsel for Dr. Stefaniu had argued that Dr. Hector, in the course of his cross examination, had conceded that Dr. Stefaniu had not been negligent, but rather, had committed an error of judgment. As a matter of law, an error of judgement would not result in a finding of legal liability.[14] However, Justice Armstrong concluded that there is "often a fine line between a mere error in judgment and a failure to meet the professional standard of care".[15] He concluded that "the jury could find that the line was crossed."[16] In other words, he was unwilling to conclude that the jury verdict—that Dr. Stefaniu was negligent—was so unreasonable that it ought to be set aside.

The Court was also asked to review the causal relationship between Dr. Stefaniu's decision to discharge the patient December 5, 1996, and the murder of his sister on January 24, 1997. Dr. Stefaniu's counsel had argued that even if she was wrong in changing the patient's status from involuntary to voluntary, which resulted in him being released from the hospital, it was "unreasonable" to conclude that the murder was the result of Dr. Stefaniu's negligence. Only several days before the murder, the patient had attended at two different hospital where it was determined, following medical assessments, one by a psychiatrist, that he did not meet the criteria for involuntary admission. Her counsel argued that even if the patient's status had not been changed appropriately on December 5, Dr. Stefaniu, or another psychiatrist, would have changed it, appropriately, days or weeks after December 5, 1996, and before he killed his sister on January 24, 1997. However, Justice Armstrong did not agree. In his view, it was

> Open to the jury to find on the basis of the evidence that but for the change in Johannes' status to a voluntary patient on December 5, the murder of his sister would not have occurred. The jury was entitled to reject the submission of counsel for the appellant, based on the evidence of the emergency room physicians, that Johannes' status would have changed in any event prior to the date of the murder on January 25, 1997.[17]

This is another way of saying that the Court of Appeal, which was not present at the trial and did not hear the evidence directly, is paying deference to the "trier of fact"[18] This is much different than a judicial finding that Dr. Stefaniu breached the relevant standard of care and was negligent. It is not the Court of Appeal asserting: "This jury was right: Dr. Stefaniu was negligent." Rather, the Court of Appeal is saying: "You've asked us to overturn the verdict of the jury. However, we weren't at the trial. We didn't hear the witnesses testify. We're not saying the jury is right, but unless you can show us that it was clearly wrong, we must, as a matter of law, defer to the verdict the jury reached."

Implicit in the Court of Appeal's decision is a message that in another case, even with similar facts, a different judge or a different jury might reach a different conclusion. Accordingly, as a precedent for other similar cases, *Stefaniu* is of limited value. The Court of Appeal decision merely confirms the binding precedent[19] that an appellate court is restricted in its review of a trial decision and cannot overturn the decision unless there is an error of law or unless the finding of the trier of fact is so unreasonable that no properly instructed jury would have reached such a verdict. As experienced appellate counsel know, this is a very heavy onus to discharge and so it is not surprising that the Court of Appeal was unwilling to set aside the trial decision when one considers the limited jurisdiction for it doing so.

Accordingly, the *Stefaniu* decision does not stand for the proposition that the Court of Appeal concluded that Dr. Stefaniu was negligent. It did no such thing. It only concluded that it was not prepared, given its limited jurisdiction, to say the jury was clearly wrong and set aside its verdict.

THE ABSENCE OF REASONS

Even if the Court of Appeal decision does not represent a binding authority in future cases, won't judges and juries look at the outcome at trial of the *Stefaniu* case in the future and consider it persuasive?

If the reasoning of the Court of Appeal in a particular case contains an analysis of a legal issue and reaches a reasoned conclusion as to the appropriate principle that should apply, this is binding on lower courts and judges. However, the finding of judge at trial in one court, i.e. the Superior Court of Ontario, is not binding on another judge of the Superior Court. It can be, however, "persuasive". In other words, if a judge considers the reasoning and result in a similar case to be persuasive,[20] he or she may decide to "follow that case". This is consistent with an important common law principle, namely, that it is helpful for the law to be consistent and predictable. To the extent that a judge can "do justice" by following the persuasive reasoning of another judge, this reinforces the principle. To make decisions that ignore other decisions—be they binding or persuasive—is inconsistent with the principles of common law and results in principles of law that are difficult to understand and apply.

Nonetheless, in *Stefaniu*, any persuasive value to the case is quite limited.[21] Because it is a jury verdict, there are no reasons. Whereas a judge is required to provide a detailed analysis of the evidence and the reasoning that led to the particular result, there is no such obligation on a jury.[22] The jury's task is limited to deciding factual issues such as credibility and weight of evidence, along with the finding of liability. There are no "reasons' to persuade a judge in another case. Moreover, if a similar case in the future is tried by a judge and jury, the jury will not consider other verdicts. By definition, the role of the jury is limited to "fact-finding", and therefore, it does not consider, and is not provided with, legal precedents to consider in reaching its own decision. Likewise, the judge, in instructing the jury, would have no reasons or precedent from the trial decision in *Stefaniu* to employ in instructing the jury.

Consequently, not only is the decision of the Court of Appeal of no binding precedential value in determining the standard of care to be applied to mental health professionals in future cases, the trial decision contains no "reasoned decision" that would be persuasive to judges or juries in future cases.

DUTY OF CARE

While the limited import of the Court of Appeal Decision in *Stefaniu* may be reassuring to psychiatrists who are concerned about being sued in similar circumstances, it is a deficient result when one considers that this decision, if "jury deference" is the fundamental principle for which it stands, does little to guide psychiatrists in future cases. What will a court do in a future case? If the purpose of the common law is to provide consistency and predictability to citizens, how does one know how to conduct oneself in the absence of a clear precedent? How should psychiatrists and other mental health professionals measure their legal obligation in discharging patients who may have the propensity to harm themselves or others?

Some guidance to these questions can be found in a somewhat cryptic comment contained in the reasons for judgment of Justice Armstrong. Having set out the specific grounds of appeal advanced by Dr. Stafaniu in challenging the trial verdict, Justice Armstrong, before beginning his analysis, identifies an issue that he will not address.

> "It perhaps should be noted that 'duty of care' was not raised as an issue in this appeal".[23]

There is a principle of appellate review, similar to the principle that a jury's findings will not be overturned unless unreasonable, in relation to issues that are raised or not raised upon appeal. Unless a party specifically asks the court to address a particular issue, it will not do so on its own motion. It is not clear from Justice Armstrong's reasons whether this was advertant or inadvertent on the part of Dr. Stefaniu and her counsel, but it is clear that "duty of care" is something the court did not consider and was not asked to consider.

"Duty of care" suggests a legal issue and is one in which the Court of Appeal had greater appellate latitude because, as opposed to being a "finding of fact", it is a legal issue upon which the Court of Appeal was unrestricted in second-guessing the trial decision. Although we cannot know what the Court of Appeal would have decided had it been asked to address the issue of "duty of care", it is instructive to know that this issue was squarely raised by the Australian New South Wales Court of Appeal only a year earlier in the similarly-controversial case of *Hunter Area Health Service & Anor v. Presland*.[24]

In that case, a trial judge, who tried the case without a jury, awarded damages to a psychiatric patient for having been improperly discharged. The patient alleged that his psychiatrist had discharged him from a psychiatric facility in circumstances where he was a risk to himself and others as a consequence of mental illness. Six hours after the patient was released from the psychiatric hospital, he had killed the fiancée of his brother. He was subsequently acquitted of the murder of his brother's fiancée on the grounds of mental illness, but was then committed to a psychiatric facility. One of the substantive issues put before the New South Wales Court of Appeal was:

> *The nature and content of the duty of care owed* to patients presented for psychiatric assessment both at common law and under the Mental Health Act, 1900 and whether there was a breach of the duty of care. [Emphasis added][25]

In *Preslend*, the facts were unusual in that the patient sought damages he personally sustained as a result of being incarcerated in a psychiatric facility once he had been found to be not criminally responsible for the death of Ms. Laws. All three judges identified "public policy" as a consideration by which the court should be mindful. However, the decision was not unanimous. One of the appeal judges dissented and would have allowed the trial decision to stand. However, he was overruled by the majority. The length and complexity of the reasons delivered by all three judges underscore the difficulty they had in reconciling, on a principled basis, the nature and content of the duty of care in that case. In the *Stefaniu* case there was no similar debate amongst the judges of the Court of Appeal.

CONCLUSION

The response to the *Stefaniu* decision by mental health professionals can be visceral.[26] How can it be that Dr. Stefaniu was found civilly responsible for the death of the patient's sister, 59 days after the patient left her facility and after he had been assessed by two other physicians—one of them a psychiatrist—on two separate occasions, several days before the murder, and found not to be a threat to himself or others? The simple, and perhaps trite, answer is that this is the verdict the jury reached after hearing the evidence in that case.

What about the follow up question: does that mean that other mental health professionals in a similar situation will face the same civil responsibility? The answer to that question, in my respectful opinion, is: we don't know yet, but quite possibly, not. This was a jury verdict that has very limited, if any, application to other cases. While the Court of the Appeal considered the case, it did so in a narrow way and specifically stated in its decision that it did not examine the substantive legal issue of "duty of care". If it had done so, it might have reached a different conclusion. In *Presland*, the Court of Appeal of New South Wales considered this issue, and in

the circumstances of that case concluded that there was no duty of care and overturned the trial decision. An Ontario Court, in a future case, may examine this issue more closely than has occurred to date and reach a similar conclusion. .

Competing Interests: *none*

Acknowledgements: *none*

End Notes:

1. I wish to thank Gillian Wilkins, student-at-law, for her assistance in preparing this paper for publication. All errors, of course, are my own.

2. 17 Cal. 3d 425. (Sup. Ct. Cal. 1976).

3. *Supra* at 442

4. Considered in: Smith v. Jones, [1999] 1 S.C.R. 455; Referred to in: *Healey v. Lakeridge Health Corp*., [2006] O.J. No. 4277 (Ont. Sup. C.J.); *Farrows-Shelley v. Canada*, [2003] F.C.J. No. 574 (Fed Ct.) (Q.L.); and *Wenden v. Trikha*, [1991] 116 A.R. 81 (Alta. Q.B.).

5. Douglas M. Smith, "Wenden v. Trikha and Third Party Liability of Doctors and Hospitals: What's Been Happening to Tarasoff", 4 Health L. Rev. No. 2, at 12-25; Jessica Van Exan, "The legal and ethical duty to warn in the practice of psychology", (November, 2004) 18 W.R.L.S.I. at 123, and see also Adam M. Dodek "The Public Safety Exception to Solicitor-Client Privilege: Smith v. Jones", (2000) 34 U.B.C.L. Rev. at 293 – 315.

6. *Ahmed v. Stefaniu*, [2006] 275 D.L.R. (4th) 101

7. [2006] S.C.C. No 498

8. Barankin, G., National Review of Medicine, (2005) Vol. 2, No. 20.

9. Justices Gillese and Juriansz concurred in the decision and with Justice Armstrong's reasons.

10. *Gerbracht v. Bingham* (1912), 7 D.L.R. 259 (Ont. H.C.) and *Town v. Archer* (1902), 40 O.L.R. 383. The cases held that the combination of inherent complexity and perceived bias of the jurors towards the patient plaintiff made a jury trial inappropriate.

11. *Soldwisch v. Toronto Western Hospital*, [1983] 43 O.R. (2d) 449.

12. *C.N.R. v. Muller*, [1934] 1 D.L.R. 786 (S.C.C.). The justification for this limitation is that the jury was in a position to see and hear witnesses testify and were in a better position than an appeal court – which must rely upon transcripts and does not hear oral evidence or see witnesses – to make findings of credibility and to weigh and balance contradictory evidence.

13. Error: *Earle v. Smith* (1972), 22 D.L.R. (3d) 34 (N.S.C.A.); *Nielsen v. Fredrikson*, [1983] B.C.J.No. 1315(C.A) (Q.L); *Giurlando* (Litigation Guardian of) *v. Cammalleri* (1999), 30 C.P.C. (4th) 229 (Ont. C.A). Inadequacy: *Katsiroumbas v. Dasilva; Katsiroumbas v. Shack* (1982), 132 D.L.R. (3d) 696 (Ont.C.A.)

14. *Elverson v. Doctors Hospital* (1974), 4 O.R. (2d) 748, 49 D.L.R. (3d) 196 (C.A.).; affd (1976) 65 D.L.R. (3d) 382n (S.C.C.).

15. paragraph 35.

16. paragraph 35.

17. paragraph 44.

18. The trier of fact may be the judge or the jury who hears the testimony and reviews the evidence to rule on a factual issue. Bryan A. Gardner, ed., *Black's Law Dictionary*, 8th ed. (St. Paul, Minn: West Publishing, 2004).

19. A binding precedent is a principle that a court of equal or lesser jurisdiction must follow. (R. vs. Smith (1988) 44 C.C.C. (3) 385 (Ont. H.C.J.)).

20. R v. Henry, [2005] 3 S.C.R. 609

21. *Ter Neuzen v. Korn*, [1991] B.C.L.R. (2d) 125 (B.C. Sup.Ct.)

22. *R v. Pan; R v. Sawyer*, [2001] 2 S.C.R. 344

23. Paragraph 26.

24. [2005] S.W.C.A. 33.

25. Presland, ftn. 24, Headnote.

26. I presented the *Stefaniu* case to a large group, composed mostly of mental health professionals, at the *Mental Health Law Conference* held at Whitby Mental Health Centre on October 24, 2007. At the conclusion of my presentation I asked for a show of hands from those who thought the Court of Appeal got it right, i.e. upheld the decision of the jury, and from those who thought they got it wrong. As may not be surprising, I saw no raised hands in response to the "did they get it right?" question. The thrust and content of the comments and questions that followed this straw poll strongly suggested that the audience found the result highly disturbing.

Address for Correspondence:

Borden Ladner Gervais LLP, Scotia Plaza, 40 King St. W., Toronto, Canada M5H 3Y4

e-mail: *jmorris@blgcanada.com*