ARTICLE
FRONTLINE PERSPECTIVE

Duty of Care Versus Safety of a Colleague

Mary V. Seeman MD, Professor Emerita
Department of Psychiatry, Institute of Medical Science, University of Toronto, Canada

The health of my patient will be my first consideration; My colleagues will be my brothers. Declaration of Geneva of the World Medical Association. (adopted 1948, amended 1966 and 1983)

ABSTRACT

This case describes a psychiatric patient who stalked and harassed her former psychiatrist. Balancing the safety risk to her physician against the duty to continue to treat this vulnerable patient, what should the current psychiatrist and the treating institution do?

Key Words: *duty to treat, stalking, safety, continuity of care.*

Arras (1991) has made the case for individual case-based reasoning to address ethical dilemmas. He and others have shown how the circumstances of a case can often clarify the ethical principles behind difficult decisions. The following case illustrates the tension between the duty to treat and continuing treatment that causes distress to a colleague.

Case Report

Patient AC had been an outpatient at a psychiatric hospital since the hospital opened in the late 1960s. She had had several inpatient admissions at that hospital and was being treated there as an outpatient. Despite comprehensive psychosocial treatment and depot medication, she had never been free of auditory, olfactory, and somatic hallucinations, nor of delusional thinking. That being said, she had functioned, on the whole, well. After her parents' death, she successfully lived on her own, maintained a clean and attractive apartment, took care of her own health (she was diabetic), grooming, finances, and sustenance. She also looked after her cat. She went to church, occasionally entertained her one and only friend, and visited with her sister and her nephews.

AC first became ill at age 16 and had had no opportunity to engage in a social or intimate life. She made up for this with an active imagination and flights of romantic fancy that focused on different men at different times. Whenever her fantasies anchored themselves to a specific male, AC became relatively insistent and importunate in her pursuit. The man at the receiving end of her advances was usually a fellow patient and, much to his embarrassment, she would frequently shout his name down the corridor, proclaiming undying love. AC was not a woman who stirred reciprocating fantasies in the men she so admired. They usually fled when they heard her approaching and some were quite distressed by her pursuit but, over the years, no lasting harm had come from her periodic "crushes."

AC's doctor initially changed every six months, as the psychiatric residents rotated through the service. It was then decided that it would be best for her to have one permanent staff psychiatrist, Dr. J, and that regimen at first worked well, until he became the object of her fantasy. AC became preoccupied with Dr. J and convinced herself that he reciprocated her interest. Various events and conversations on TV confirmed this for her. Whenever a program included a wedding, she deduced that one was in store for her and Dr. J; whenever there was an allusion to babies, she experienced a pseudopregnancy. When pressed as to how she could be pregnant, she explained that the depot injection she received monthly had implanted Dr. J's seed and that she was about to give birth to his child. This delusion brought treatment to an impasse so Dr. J transferred the care of AC to a woman doctor (Dr. M) on his same floor. AC was quite content to be transferred, believing that the doctor-patient relationship had been an obstacle to a more intimate relationship with Dr. J.

AC attended treatment visits with Dr. M but continued her preoccupation with Dr. J. She even bought herself an engagement ring, which she wore and showed to her family. Before or after her appointment with Dr. M, she often knocked on Dr J's door, interrupting his psychotherapy sessions; but most annoying to him were the very frequent phone calls she left on his voice mail system. He was not the only one to receive voice mail from AC. Dr. M received an average of 10 calls per day, which she deleted without listening to them because they tended to be all of a kind – musings about Dr. J. AC's case manager received daily calls, as did the emergency department of the hospital. While most of these calls were greeted with annoyance mixed with fond amusement (because AC was well known to the hospital staff), Dr. J, who was the target, felt harassed and stalked.

He followed the explicit recommendations in the burgeoning stalking literature. He clearly and repeatedly told AC that their relationship had been a strictly professional one in the past and, now that she had another doctor, a relationship no longer existed.

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He was firm and unequivocal. He told AC that she was not to call him and she was not to knock on his office door.

The patient's intrusions continued. Months passed, with Dr. J feeling ever more harassed. There was no escalation in AC's behaviour with time but it seemed to fluctuate, depending on what she saw and heard on TV. Well-publicized movie star weddings invariably re-inflamed her fantasies. As per standard advice, Dr. J began to document each incident, noting the time, place, and duration of harassment. He asked Dr. M to stop seeing AC, and to transfer her to another doctor in another hospital.

Dr. M, much as she empathized with Dr. J, felt she could not acquiesce because AC had a right to continuity of care in "her" hospital and she, Dr. M, had a duty to treat. Dr. J asked Dr. M to only see AC on the day that he was out of the office, and this she did, until her schedule changed and the patient again began to attend on days when Dr. J was there. Dr. J had the hospital transcribe AC's phone messages on the grounds that they could contain threats. He contacted the hospital administrator to review the chart, which was done, and it was concluded that the patient's behaviour did not constitute a physical threat to Dr. J, much as it was annoying and distressing. As the behaviour continued, the hospital guards were told to escort AC off the floor whenever she knocked on Dr. J's door. The hospital administration wrote her an official letter emphasizing that she was not to go to Dr. J's side of the floor and, if found there, would be immediately escorted out.

Although she had no history of aggression or violence, and made no physical threats, Dr. J became increasingly uncomfortable with AC's romantic pursuit of him. He was substantially larger and stronger than AC and would have been at an advantage should a struggle have ever broken out. Nevertheless, he was anxious and insisted that pressure be applied to stop AC's harassing behaviour. Verbal pressure in the form of explaining cause and effect produced no appreciable effect on AC; indeed, it reinforced her preoccupation.

Ultimately, the hospital lawyers were called in and, in their view, Dr. J was being victimized by a stalker, with physical threat always implicit in such a situation. "Think," they wrote, "if the doctor were a relatively weak woman and the patient a relatively strong man. We cannot treat this case differently just because the sexes are reversed."

Numerous letters were written to AC telling her to stop and desist, or the hospital would be forced to take legal action. She was told she could only come to the hospital on certain days, could not go to Dr. J's floor (she was to meet with Dr. M on another floor at first; subsequently, since she did not obey the injunction against phone calls, she and Dr. M were told they would have to meet outside hospital grounds). Appeals to the administration and the lawyers (it was winter and meeting outside the hospital was logistically difficult) did not alter this decision. AC's telephone habits did not change. Technical ways of stopping calls from AC's number reaching Dr. J's voice box were judged too expensive to try. Finally, by administrative fiat, AC was transferred to another psychiatrist at another hospital. Dr. M was torn between her loyalty to her patient and her allegiance to her colleague and her hospital. The outcome for the patient was that she died of a cerebrovascular accident one month after transfer, an event probably unrelated to the move. The outcome for Dr. M was that she was left with an unresolved ethical dilemma.

Ethical Issue

Staying with one's patient through difficult times is a central ethical obligation of physicians (Pellegrino, 1995; Quill & Cassel, 1995), particularly relevant to the care of the chronically mentally ill. The concept is related to the patient's right to continuity of care and to a hospital's mission of client-centered care, meaning that a patient's needs come first, above competing loyalties.

Nonabandonment means fulfilling one's duty to care (Clark, 2005), although a physician, as an autonomous agent, can ultimately decide whom to treat (Clark, 1996). Care is frequently withheld under various circumstances when, for instance, a patient's behaviour becomes intolerable to the physician – erotic transference, missed appointments, nonadherence to the therapeutic regimen, failure to pay fees. It happens when patients do not keep up their end of the patient-physician contract from which, as morally responsible agents, they are not exempt. (Draper & Sorell, 2002; Gauthier, 2005). But the judgment of how responsible patients must be is difficult to make in the case of psychiatric illness where behaviour may not be fully under the patient's control. The tendency would be to tolerate greater infractions of contract from the mentally ill and, therefore, for nonabandonment to be of special import to psychiatrists. (Groves, 1978; Lipsitt, 1997; Sharpe et al., 1994; Strous et al., 2006)

Patients, and not only mentally ill patients, may on occasion pose a direct threat to their care providers. The Canadian Medical Association (CMA), citing virtue ethics, the principle of beneficence, patients' rights, and the fiduciary contract between physicians and patients, is of the opinion that a professional duty to treat continues to exist even at times of substantial risk to the provider (during epidemics or bioterrorist attacks, for instance). (CMA, 2004) This opinion is shared by the American College of Physicians (ACP). (ACP, 2002) Sokol (2004), however, argues that, as human beings assuming a variety of moral obligations, healthcare professionals (and institutions) have responsibility to persons other than their patients. Depending on circumstances, they need to consider the well being of the wider population of the ill and the potentially ill as well as their obligations to their families and to themselves. (Dickens & Cook, 2006) From a utilitarian perspective, a decision would be ethically correct when it does the most good for the most people. (Robertson et al., 2007)

Clinical loyalties do sometimes have to be sacrificed for the greater good (Bloche, 1999; Toulmin, 1986), but being abandoned by one's doctor is not a trivial event for patients (Clarke et al., 2007; Sampson et al., 2004). When it comes to changing hospitals, the issue is even more complicated. Healthcare organizations have fiduciary duties of care to patients. In 1987, a physician discharged a patient from his hospital practice because the patient, who had kidney problems and additional substance abuse problems, verbally threatened the doctor and did not comply with recommended treatment. (Friedman, 2001) The patient sued the doctor for abandonment. Psychiatrists at the hospital were on the patient's side. The Department of Psychiatry filed an amicus curiae on behalf

of the patient. Ethicists and clergymen at the hospital also supported the patient. Their position was that no physician had a right to refuse treatment to a patient who required it. The New Orleans Fifth Circuit of Appeals, however, ruled in favour of the doctor. The judge concluded that requiring a doctor to provide treatment against his will violated his 13th Amendment rights against involuntary servitude. The court also ruled, however, that the medical center where the physician worked had to continue to provide treatment even if the physician did not. The justification for the decision against the medical center was that it was a federally funded institution and, as such, was required by the US Public Health Service Act to provide service to all patients residing in its jurisdiction.

More recently, however, the crime of stalking has emerged as a significant social problem. Restraining orders or protective injunctions are frequently advised because of the potential for violence, although that is more relevant to intimate partner stalking than to morbidly infatuated stalking which tends, on one hand, to be impervious to legal sanctions and, on the other, to be associated with a low incidence of violence. (Gentile et al., 2002; Hoffman & Sheridan, 2005; Kienlen et al., 1997; Mohandie et al., 2006; Mullen et al., 1999)

There is no question, in the case illustrated above, but that the subjective feelings of the physician victim had to be respected. His safety and freedom from harassment needed to be assured by as many means as possible: ***arranging escort for the patient, blocking incoming telephones to the victim voice mail from the patient's telephone number, intensifying case management for the patient, and involving family members. Two recent articles (Galeazi et al., McIvor & Petch, 2006) advise healthcare organizations to adopt formal educational programs that help staff recognize stalking behaviour and to develop risk management strategies that consider the personal history of the patient involved in the stalking behaviour, and the best interests of that patient.***

Conclusion

If the safety of the victim can be assured, then it is not consistent with the principle of a physician's duty of care to abandon her patient. If a duty to treat exists in situations such as epidemics and bioterrorist attacks, then it also exists for patients who exhibit harassing behaviours, especially when these patients have little control over such behaviours.

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Address for Correspondence: Mary.seeman@utoronto.ca