



Moral State of Reasoning and the Misperceived "Duty" to Report Past Crimes (Misprision)

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Even without practicing a forensic specialty, general psychiatrists are frequently called upon to make decisions about important ethical and legal obligations regarding such issues as confidentiality and the duty to protect third parties from patients' violent acts. Two dimensions of the interaction between the legal and the clinical are captured in the questions: (a) Should the doctor-patient confidentiality ever be breached? If so, under what circumstances, and what justifies those circumstances? If not, what are the reasons? (b) In dealing with patients' potential danger to others, how can we employ both sensitivity to the rights of patients as well as to the rights of perceived potential victims of patients?

Therapists have their own perspectives as to when the confidentiality of the doctor-patient relationship can be violated. These perspectives translate into professional judgment through a process of reassessing. Exploring the perceptions of various therapists regarding these issues and the reasoning employed in making these decisions is a first step towards understanding both the decisions about confidentiality of patients and rights of patients and consideration for potential victims of perceived dangerous patients. Several questions arise concerning confidentiality and rights in therapy:

1. How and to what extent do health professionals use clinical and legal reasoning in dealing with breaches of confidentiality?
2. What benefits do health professionals perceive from preservation or breach of confidentiality?

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3. What harms result from either breaking or protecting confidentiality?
4. Regarding confidentiality, what actions do health professionals on the whole take? How do they think their colleagues should behave?
5. Is there a role for informed consent by the patient in decisions about confidentiality?
6. How does a subject's moral stage of development (Gilligan, 1981; Kohlberg, 1984) account for the choices made by the health-care professionals?

In the medical context, moral development perspective taking is necessary both for assessing the *competence* of the patient to make *autonomous* decisions and for understanding the patient's preferences (Commons, Sonnert, Gutheil, & Bursztajn, 1991). Only if physicians understand how the patient views the symptoms, illness, treatment, and life situation—the patient's perspective—can they respond most appropriately; that is, physicians have to understand the patient's wants and needs by looking at the doctor-patient interaction from the patient's side as well as their own. The theory of social perspective taking can be helpful in identifying the stages in the development of physician's perspective taking. At high stages, for example, physicians are proficient in understanding their patients and therefore relate to them successfully. In contrast, lower stage perspective taking may seriously hamper social decision making through inattention to the patient's perspective. As the physician's stage of perspective taking increases, the patient's role in the decision process also increases. We here present our (Commons, Sonnert, Gutheil, & Bursztajn, 1991; Sonnert & Commons, 1994) brief overview of the stages of moral development (Gilligan, 1981; Kohlberg, 1984) as they might apply to the issues in our study.

Stages of Moral Development

Abstract perspective-taking skill (Stage 3, GSM Stage 4a—Abstract) is required in order to grasp that patients form opinions of physicians based on how the physicians relate to the patients (see *Scoring* section). Physicians at this stage thus understand that they have a reputation among patients, staff, and other physicians about how caring, understanding, and competent they are.

Taking another's perspective in a *logical* fashion requires *logical* perspective taking (Stage 3/4, GSM Stage 4b—Formal). Physicians operating at this stage may see the patients as rational or irrational, logical or illogical, but can only attend logically to either the rational aspects or the affective aspects of patients' situations at one time: On the one hand, communications that are logically organized may not address patients' affective reactions or idiosyncratic choices; on the other hand, affectively appropriate communications may not address patients' needs for empirical data about their situations. Thus, people performing at this stage cannot integrate the two variables, emotions and interests.

Stage 4 (GSM Stage 5a—Systematic) systems perspective taking requires the integration of two or more variables into a system. At that stage, the

doctor-patient interaction is seen as a network of interactive causes—for example, emotional or rational self-interests. Physicians reasoning at this stage understand that society regulates their relationships with patients. They work to understand the legal and professional norms within the system. These physicians may see that the quality of their relationships with patients may even affect the likelihood that they will be sued for malpractice.

At Stage 4 (GSM Stage 5a), although doctors may *know* the other's perspective in an interaction, they may still prefer to view interactions from their own perspective. They may see themselves as an individual system in conflict with the hospital or professional system. In the social context, the preferred perspective of physicians at this stage often depends on their own position in the social hierarchy. New residents, for example, may prefer the perspective of the patient over the perspective of the chief of medicine at the hospital. They may defend the patients' behavior and not hold them accountable. The assistant chief might, in turn, prefer the perspective of the chief of medicine. In sum, doctors' and institutions' perspectives of patients' concerns and problems are more complex and informed than at Stage 3/4 (GSM Stage 4b).

A person's reasoning may move into Stage 5 (GSM Stage 5b—metasystematic) by assuming multiple vantage points; for example, physicians report that they see their relationships to their patients in a new light after they have been patients themselves, suffering from a serious illness. People reasoning at Stage 5 (GSM Stage 5b), are proficient at taking and integrating *multiple perspectives*. This often leads to the insight that everyone—from the most difficult patient to the easiest, from the lowliest patient to the most influential—needs and benefits from respect, care, and concern. The hierarchical arrangement of the validity of perspectives characteristic of Stage 4 (GSM Stage 5a) is replaced by the view that *all* perspectives have equal validity; thus, the views from any person's vantage point are potentially valid. The person reasoning at Stage 5 constructs a new perspective that integrates all the perspectives. Here, physicians may separate themselves from their patients fully, while at the same time they understand their interdependence and remain empathic. This is because doctors understand that the patients' wishes may be quite different from their own; their patients' decisions to live or die are not reflections on their competence as doctors. The skill of taking multiple perspectives and integrating these perspectives is, then, a developmental achievement.

At Stage 5, physicians strive to fit points of view with their own, as well as with the wider societal perspective in which doctor-patient interactions are embedded. By coordinating the patients' perspectives with their own, doctors construct a new "super system." In this context, then, a treatment plan should be most effective when it integrates both the patients' and the doctors' perspectives: patients will understand their role in the treatment; doctors will understand the patients' problems and their proficiency in dealing with those problems.

Here we examine clinicians' sensitivity to the rights of patients in two domains: the false duty to report past crimes (misprision) and the duty to report patients' future potential for violence. We explore these two domains concurrently, since many health care providers and clinicians consider past violent crimes as an indication of future potential for violence.

The Concept of Misprision

Appelbaum, Lidz, and Meisel (1987) reviewed the notion of *misprision of a felony* (defined as citizens' failure to fulfill their presumed obligation to report unreported and/or unprosecuted felonies that come to their attention). They concluded that a therapist's simply hearing of a patient's past felony and not reporting same was not sufficient to convict the therapist of misprision of a felony. The authors also noted that, conversely, reporting a patient to legal authorities could constitute a breach of confidentiality. This breach itself could be subject to civil suit for breach of confidentiality since the therapist could not claim a duty to disclose, but such suits are unlikely. Appelbaum, Lidz, and Meisel's review clearly concludes that a therapist does not have a legal obligation to report statements of a patient's past unreported and/or unprosecuted felony.

Despite Appelbaum, Lidz, and Meisel's findings, the misprision issue continues to cause confusion among health professionals. Indeed, the most frequently asked question at law and psychiatry seminars is whether clinicians have obligations to report past crimes.

The present study was undertaken to document how professionals reason about the issue of misprision. From a pragmatic point of view, the results of this study might be used to alert doctors to issues of duty and confidentiality and to document for liability insurance companies the economic benefits of further educating doctors in this area. From a scientific perspective, the present analysis will give us a better idea about how doctors reason and make decisions, especially in relation to perceptions of dangerousness in patients.

Methods

Subjects ($N = 149$) were mental health professionals (psychiatric nurses, psychiatrists, psychologists, and social workers) who attended a variety of psychiatry and law seminars given around the country.

Procedure

The questionnaire was handed out at the beginning of a session. The subjects were asked to fill it out immediately. We estimate about 95% of the participants at each seminar answered and returned the questionnaires. Because of the brevity of the questionnaires, professional status was not obtained. Four different versions of a clinical vignette were randomly circulated to subjects. Subjects filled out answers to two questions about the vignette. These questions addressed legal and ethical reporting obligations. This process required around 5–10 min and was performed before a given lecture to avoid influence from that lecture.

Instrument

The variations of the vignette were male versus female perpetrator, embezzlement versus murder as crimes. Of the 149 subject protocols, 74 referred to a

female as the perpetrator of the crime and 75 referred to a male; 74 referred to murder as the crime committed, 75 to embezzlement. None of the four scenarios in fact created a legal duty to report the patient to anyone. Despite this fact, we hypothesized that a majority of respondents would answer as though a reporting requirement *did* exist and that they would infer this duty. We further hypothesized that this perception of duty and requirement would be perceived most often for a male murderer and least often for a female embezzler. (See Appendix for the questionnaire model.)

Scoring

Two researchers independently scored the stage of each subject's statements (See Table 1 for list of scored statements). We used the General Stage Scoring System (GSSS) to classify subject's statements into one of five stages of reasoning as shown in the Table (Commons, Johnstone, Straughn, Meaney, Weaver, Lichtenbaum, & Krause, 1995; Commons, Trudeau, Stein, Richards, Krause, in press; Johnstone, Commons, Straughn, Meaney, Weaver, Lichtenbaum, & Krause, submitted; Lam, 1995). This form of stage scoring was derived from both Piaget's (Inhelder & Piaget, 1958) and Kohlberg's (Colby & Kohlberg, 1987a, 1987b; Kohlberg, 1981, 1984, 1990a, 1990b) scoring schemes whose reliability and validity have been widely discussed. This scoring system is the application of the General Stage Model (GSM), which is a universal stage system that classifies development in terms of the task-required hierarchical organization of response (Commons, Trudeau, Stein, Richards, Krause, in press). An action is at a given stage when it successfully completes a task of a given hierarchical order of complexity. Hierarchical complexity refers to the

TABLE 1
Stage of Reason

Stage of Reason, 3

"All we have is no obligation to report." This is an unsupported assertion.

Stage of Reason, 3/4 Probability, probable

"No one is in imminent risk." The use of *imminent*, a probabilistic word, is relational and therefore formal operational. This may be restated as an if-then statement, "If someone is at imminent risk, then report."

Stage of Reason, 4

"She made no threat to anyone else or to herself. Reporting would violate confidentiality." Confidentiality refers to the professional role of therapist, which is part of the professional system.

Stage of Reason, 5

"See if anyone is in danger—have to do assessment—social contract between you and 'pt.—help pt.'" Upholds a universal social contract to treat patient confidentially. Patients could not be expected to "spill their guts" if it caused them to get arrested. They are not confessing crimes but discussing their problems. They might not come to therapy if they thought their treaters would report on them.

number of recursions that the coordinating actions must perform on a set of primary elements. Actions at a higher order of hierarchical complexity (a) are defined in terms of the actions at the next lower order of hierarchical complexity, (b) organize and transform the lower order actions, (c) produce organizations of lower order actions that are new and not arbitrary and cannot be accomplished by those lower order actions alone.

Results

A Legal Obligation to Report a Patient?

Irrespective of the type of crime and sex of the perpetrator, 19.18% of the subjects strongly indicated that they *did* have a legal obligation to report the patient for past crimes (a rating of 1), whereas 55.48% believed strongly that they did *not* have a legal obligation to report the patient (a rating of 4 with $M = 3.12$, $SD = 1.16$).

We identified six major categories in the 149 subjects' reasons for reporting or not reporting the patient to a legal authority. Note, however, that 20.13% of the total subjects gave no reasons. The subjects' responses were distributed among the six categories as follows: (a) 4.2% of the total subjects believed they should or should not report the patient to a legal authority based on whether the patient was not telling the truth, (b) 15.97% of the total subjects stated that safety to others was their greatest consideration concerning the question of whether to report or not report a patient, (c) 37.82% stated that in considering their obligations to report, the dominant consideration was their professional obligations, (d) 15.13% answered that legal obligations were the greatest influence, (e) 0.84% answered that liability risk was the greatest consideration, (f) 15.97% reported that their greatest consideration in deciding whether or not to report the patient was safety not only to others but to the health care providers themselves.

The plurality of subjects' statements justifying whether or not there was a legal obligation to report the patient to a legal authority were systematic stage. Nearly 8.94% of the subjects reasoned at stage 3 (abstract), 35.77% at stage 3/4 (formal), and 55.28% at stage 4 (systematic). No subjects reasoned at stage 5 (metasystematic) on this question as to whether there was a legal obligation to report a patient to a legal authority. This was probably due to the stage 4 nature of such laws, which require only the systematic stage "legalisms" for an adequate answer.

A Professional Obligation to Report a Patient?

The majority (55.64%) answered that they felt strongly that they did *not* have a professional obligation to report the patient to a legal authority, a rating of 4. A significant number of subjects (21.05%) strongly believed they had a professional obligation to report, by giving a rating of 1, 6.77% rated 2, 15.04% rated 3, and 55.64% rated 4—no professional responsibility to report.

If the subjects were to report, to whom would they report? The 83 subjects' answers fell into four categories. Eleven percent (20.48%) of the subjects an-

swered that they would report the crime to a legal authority, 24.46% would talk to their attorney, 10.48% would talk to their supervisor, and 49.40% would try to find out more from the patient about the alleged crime committed. Thus, a plurality of subjects elected to keep the problem within the therapeutic relationship.

How Should They Respond to This Situation?

When the subjects answered how they would respond in dealing with the patient, their answers fell into seven distinguishable categories: (a) 2.68% of subjects would institutionalize the patient, (b) 23.21% each would help patients turn themselves in, (c) 4.46% would refer the patient to another therapist, (d) 2.68% would continue therapy at a more intense level, (e) 46.43% would continue therapy at the same level, (f) 4.46% would decrease therapy, and (g) 24.83% of the subjects did not answer this question.

In addition to assessing the stages of *reasoning*, we evaluated a subject's stage of *action*, determined from how subjects stated they would deal with the patient. Of the 134 who answered the question, 18.66% of the subjects' actions were scored stage 3 (abstract), 7.46% stage 3/4 (formal), 67.16% stage 4 (systematic), and 6.72% stage 5 (metasystematic). Some subjects did not reply to this question (10.07%). Note that when defending what they would do, there were some subjects who gave stage 5 (metasystematic) reasons. The issue of what to do clinically and ethically did not limit them to giving "legalistic or professionalistic" answers. They could transcend those norms.

Did They Believe the Patient?

Finally, we studied whether subjects would assume the statements of the patient in this scenario to be true or untrue. We coded the answers from 1 through 5, 1 being strongly yes and 5 being strongly no. Of the 149 subjects, 75.59% rated that they would strongly assume the patient's statement to be true, 7.87% gave a rating of 2, 11.81% gave 3, 1.57% gave 4, and 0.79% give 5, strongly assuming the patient's statement to be untrue. 14.77% of the subjects did not answer this question.

Our primary hypothesis about the correlation amongst the various variables is as follows: First, there exists a correlation between a subjects' developmental stage of reasoning and their decision whether to report the patient to a legal authority. With higher stages of reasoning, we would see an increase in respect for patients' right to confidentiality. Additionally, we predicted a link between subjects' developmental stage of action and whether or not and in what way they would report the patient to others (to a legal authority, an attorney, a supervisor, or a colleague). Our analysis of the data confirms these hypotheses.

The predicted result could be interpreted as meaning that respondents are balancing harm to society versus harm to the individual in the most local sense. The professional clinical considerations are pitted against the conventionally interpreted perceived legal obligations to report, the latter being in reality at variance with the actual law. At higher developmental stages of reasoning and action, subjects increasingly considered the damage to therapy that could result

from breach of confidentiality without prior mutual patient-provider agreement to do so.

There were 105 subjects who provided complete data needed for an analysis of variance (ANOVA). Subjects' developmental stage of reasoning strongly affected their stated obligations to the legal and professional system, $F(1, 101) = 5.483$, $p < .0213$. The higher the subjects' stage of reasoning, the more they tended to value professional clinical obligations over conventionally-interpreted legal obligations.

Subjects' stage of action affected their stated obligations to the legal and professional system, $F(1, 101) = 13.976$, $p < .0004$, even more so. With higher developmental stage of action, we again found a tendency toward higher valuing of professional clinical obligations over conventionally interpreted legal obligations.

We also found that the type of crime committed—murder versus embezzlement—predicted what subjects stated as their legal and professional obligations, $F(1, 101) = 11.264$, $p < .0012$. The lower degree of crime (embezzlement) was associated with a higher valuing of professional clinical obligations. In contrast, a higher degree of crime (murder) was associated with a higher valuing of perceived legal obligations to report the patient. This polarity supported our initial hypothesis on this point.

Contrary to our hypothesis that subjects would be more likely to report males over females, we found that sex of the patient did not predict subjects' stated legal and professional obligations to report, $F(1, 101) = 0.006$, $p < .9386$. We hypothesized that subjects would be more likely to report male murderers than female embezzlers. In a series of ANOVAS, we investigated the interaction of sex and crime as a predictor of (a) subjects' perceived obligation to report, both legal and professional, (b) subjects' reasons for reporting or not reporting a patient, (c) subjects' perceptions of how truthful the patient is, and (d) how the subjects proposed to deal with the patient. The interaction of crime and gender had no effect either on subjects' perceived professional obligation to report, $F(1, 129) = 0.001$, $p < .9818$, or on subjects' perceived legal obligation to report, $F(1, 142) = 0.407$, $p < .5244$. Its effect on subjects' reasons for reporting was also insignificant, $F(1, 115) = 0.007$, $p < .9313$. So, too, was its effect on subjects' evaluation of the patient's degree of truthfulness, $F(1, 123) = 0.982$, $p < .3237$. Nor did the interaction between sex and crime have any impact on how the subjects proposed to deal with the patient, $F(1, 108) = 0.569$, $p < .4525$. In each case, the difference between the subjects' evaluation of male murderers and female embezzlers was always due to the effect of crime, rather than to that of gender or to that of the interaction between gender and crime.

Discussion

While this study only begins to touch on the complex and critical issue of misprision, many acutely relevant questions emerge from it. (For an extended theoretical discussion, see Goldman & Gutheil, 1994.) What is the relation between stage of reasoning and stage of action? Does increasing stage of reasoning positively correlate with increasing stage of action? Or are perceptions

of the intellect (stage of reason) and actions weakly related? Naturally, varying connections between stage of reason and action lead to very different paths for cultivating higher stage actions.

What is the relation between stage of reasoning with commitment to the well-being of patients amongst mental health care professionals across, for example, different socioeconomic and cultural groups? How do “nonspecialists,” those who are not professionals in mental health care, particularly patients themselves (though, of course, some patients may also be mental health care professionals), view the ideal mental health care ethic? If there are significant differences between how different populations view mental health care, then perhaps what we need is to promote dialogue between, for example, mental health care professionals and patients, people of diverse cultural heritages and socioeconomic status, and both genders as a means to promote higher stage of reasoning and action.

If higher stage of reasoning increases the well-being of the clinician-patient relationship, then how can we further increase our developmental stage of reasoning and action? Is it through creating culturally and socioeconomically diverse mental health care staffs—thus truly promoting democracy and dialogue? Is it through training in perspective taking? Or could the development of stage of reasoning rely more on changing policy and regulations for mental health care workers? (And if so, by whom?) Perhaps the well-being of the clinician-patient relationship depends most heavily on amending mental health care educational institutions—i.e., admissions, costs, curriculum.

For now, our study concludes that the exercise of higher stages of reasoning in mental health care professionals correlates with a greater commitment to the integrity and well-being of the patient. While the gender of a patient as we constructed the accompanying vignette does not seem to affect how a subject responds to or deals with the hypothetical patient, the seriousness of the “crime” does make a difference. To contribute positively to the well-being of patients, we must now go on to ask what paths we can pursue in order to promote higher stage reasoning.

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Appendix 1

Misprision Instrument

It is your first session with a patient who has called for an appointment saying (she, he) has something urgent to discuss. (She, He) shifts in (her, his) chair uncomfortably for the initial half-hour, responding to your questions with only vague generalities. Finally, (she, he) exclaims, "I can't take this anymore! [I used to work as an accountant for a supermarket chain, and last week before I left my job, I embezzled \$10,000. I fixed the books so no one will ever find out that the money is missing] OR [I killed my (ex-wife's; ex-husband's) lover last week. The body is hidden where no one will find it and the police don't even know (he's, she's) missing yet]. You are the only person I've told. I don't want you to tell anyone else."

For the rest of the session, you barely listen to the patient, as you try to figure out how to handle this. The patient is adamant about your not revealing the (embezzlement, murder) and says firmly that (she, he) has no intention of turning (herself, himself) in. At last, the session ends.

Questions

1. a. Do you have a legal obligation to report the information that you have obtained about the (embezzlement, murder) to the police? (Circle Number)
 Yes No
 1 2 3 4
 b. Why or why not?
2. Taking into account whatever legal obligations you might or might not have, along with your ethical obligations as a mental health professional, how would you respond to this situation?