

The Treating Professionals' Duty to Warn Potential Victims: Prediction of Dangerousness and the Law By Huei-huang Lin

The topic of this article may be rarely discussed among the legal professionals here in Taiwan. However, it already has been highly developed in the United States. The discussion in this article is meant to introduce the current developments in this area of forensic psychiatry in the United States. It is hoped that this article would stimulate thinking among those interested in and eager to help develop forensic psychiatry in this country.

The article will address certain important issues arising from the celebrated California case of Tarasoff v. Regents of the University of California¹ and also review the legal trends towards them. These issues are the following: Should a duty be created for treating professionals to warn potential victims? If so, on what rationale? How should the scope of this duty be defined? Who should be given the warning if the treating professional cannot identify the potential victim, or if the threat is made against a class of people, such as women or blacks. On what basis can the professional reconcile the obligation of confidentiality with the duty to warn potential victims? Even after the development of the Tarasoff case, the answers to these questions remain unsettled.

By treating professionals I refer to medical professionals, such as psychotherapists, who engage in the treatment or therapy of mentally ill patients.

The article will cover the following six topics: (i) The new, case-created duty to warn and the rationale for the creation of such a duty; (ii) the scope of the duty--specific dangerousness to identifiable victims; (iii) the standard of care required -- higher standards for specialists; (iv) the duty to warn vis-a-vis the duty of confidentiality -- an exception and its troublesome situations; (v) risky situations and legal liability -- good-faith defense applicable here; and (vi) the conclusion -- the legal perspective.

I. A New, Case-Created Duty--the Duty to Warn

Under common-law rule, an individual normally is not under an obligation to control the conduct of a third party, or to warn another of possible danger from a third party.² Up to the recent past, this general rule was applied to treating professionals as well, and they were not held responsible for their patients' violent acts. In the last decade, however, this has been

changed by the Tarasoff case, the first case holding an out-patient therapist responsible for a patient's violence.³

In Tarasoff, Poddar confided to his therapist his intention to harm Tarasoff. Convinced of the seriousness of the threat, his therapist consulted with two psychiatrists and arranged to have the police detain Poddar as the first step in a commitment, according to the requirements of California's Lanterman-Petris-Short Act. But the police felt that Poddar was lucid, accepted his promise to stay away from Tarasoff and released him. Poddar never returned to treatment and two months later shot and stabbed Tarasoff to death. The Supreme Court of California found the defendants (the university regents, the police, and the doctors in the university hospital) guilty of negligence on a charge of "failure to warn." The court noted that a psychotherapist treating a dangerous client, just as a doctor treating physical illness, bears a duty to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment.⁴

The grounds underlying the creation of the duty to warn are the special psychotherapist-patient relationship and the presumption of the professional's ability to predict the patient's potential violent conduct. These are allegedly interwoven.

The court reasoned that a duty to protect or control others is found only where there exists what the law refers to as a "special relationship."⁵ Thus, parents have a duty both to protect and control their children, and authorities in mental hospitals have a duty to protect and control their patients.⁶ Since the therapeutic relationship is a fee-for-service relationship, this implies a contractual obligation for the therapists to prevent their patients from any liabilities arising from harmful acts caused by mental illness.⁷ The crux of the Tarasoff decision lies in its holding that the above mentioned "special relationship" exists between a therapist and a client.

The court also reasoned that the treating professional's knowledge to predict dangerousness is being used every day, for example, in child abuse cases, to determine whether parents are dangerous to their children, and in commitment cases, to assess culpability and likelihood of future crime.⁸

Central to establishing whether a special relationship exists are the elements of control and of foreseeability of risk.⁹ The concept of foreseeability of harm in tort law is taken from the theory of culpability. This concept also has been used to define duty in negligence law.¹⁰ Foreseeability involves a prediction (at a time prior to the occurrence of an injury) of the probability that such an injury will occur.¹¹ Culpability then links with the professional's ability to predict the patient's potential violence.¹² Such predictability has always been presumed by law on the ground that clinical psychiatrists possess a special knowledge that enables them to predict dangerousness and hence makes the risk foreseeable.¹³ Thus, the Tarasoff court reasoned

that a therapist has a special relationship with a patient because of his ability, in inpatient settings, to predict, and therefore, to physically control a patient. However, since the patient was in therapy on an outpatient basis, how was the duty derived? A 1977 Pennsylvania case specifically addressed this issue. In Greenberg v. Barbour,¹⁴ a patient, known to be violent, was refused admittance to an emergency service, and then assaulted someone. This case established that the duty could be predicted on the potential ability to control the patient. In outpatient therapy, that potential power is the power to commit.

Intensive controversy within the professional community arose over the presumption of predictability. Serious questions have been raised as to the competence of psychiatrists, indeed anyone, to identify who is dangerous.¹⁵ A task force of the American Psychiatric Association concluded that "the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists or any other professional to reliably predict future violence is unproved."¹⁶ In 1978, a task force of the American Psychological Association reached a similar conclusion.¹⁷ In the same year, the American Civil Liberties Union (ACLU) handbook, The Rights of Mental Patients, states that "it now seems beyond dispute that mental health professionals have no expertise in predicting future dangerous behavior either to self or others. In fact, predictions of dangerous behavior were wrong about 95 percent of the time."¹⁸ A conference held on October 27, 1979, at the annual meeting of The American Academy of Psychiatry and the Law, entitled "The Great Debate," brought together a number of authorities in psychiatry and the law, who expressed their opinions on whether or not psychiatrists could determine dangerousness.¹⁹ The following table²⁰ presents the various viewpoints tabulated according to two dimensions: (1) prediction of dangerousness is possible or not; and (2) whether or not psychiatric expertise pertaining to dangerousness is demonstrable in the courtroom.(Table 1)

The conclusion of the debate is that the validity of prediction remains unestablished.²¹

In 1980, Kahel and Sales surveyed several hundred practicing psychiatrists, clinical psychologists, and mental health lawyers in a national study of attitudes toward prediction of dangerousness in civil commitment. They asked the respondents to estimate the "percentage of accurate predictions which are made with current methods of predicting dangerousness to others." The group did not differ significantly; the mean estimates of predictive accuracy were 40 percent to 46 percent.²² One commentator,²³ reviewing the research evidence on professionals' ability to predict dangerousness, summarized it in this way: "The consensus of opinion by responsible, scientific authorities is that the treating professionals are incapable of accurately predicting the dangerousness of mental patients."²⁴

These results of empirical research recently developed by the professional community, that is, that accurate prediction is impossible, undermine the legal presumption of the treating

professionals' ability to predict the patients' potential violence. The underlying reasons established in the Tarasoff case to create a duty to warn are therefore vulnerable to criticism.

True as it is that there is a special relationship between the treating professional and the patient, there is, in fact, none at all between the treating professional and the potential victim. No fee-for-service relationship is required for the therapeutic relationship. The Tarasoff court's holding that a special relationship gives rise to a duty of care owed by the therapist not only to clients but also to third parties is therefore questionable. Basing the duty to warn on the presumption of a predictability that has been found to be empirically impossible can be readily subjected to the constitutional attack of due process and equal protection. Justice Stanley Mosk, in his opinion, addressed this point when he said that adherence to the concept of a standard of care (the degree of knowledge ordinarily possessed and exercised by therapists in similar conditions) when no skill exists would "take us from the world of reality to the wonderland of clairvoyance."²⁵ The grounds set forward to justify the creation of the duty to warn seem unwarranted.

Furthermore, many psychiatrists have made dire predictions about the effects of the duty to warn, as it is articulated in Tarasoff, upon their practices. Dangerous patients might be deterred from disclosing their feelings to their therapists, so more third parties would be injured. The therapist's anxiety about the duty to warn would be so great that the therapeutic relationship would suffer or certain patients would be turned away. Other concerns include a projected rise in unnecessary commitments because of an overprediction of dangerousness, increases in malpractice insurance premiums, and damage to the therapeutic alliance, thwarting effective treatment.²⁶ Many psychiatrists believe that creating a duty to warn would threaten the sanctity of the therapeutic relationship and convert the therapist into a policeman, more concerned with keeping the peace than with healing troubled minds.²⁷

Despite these serious criticisms, the Tarasoff decision has been adopted as precedent by a substantial number of state courts, creating a duty to warn.²⁸ For example, Tarasoff was later affirmed in McIntosh v. Milano,²⁹ a 1979 New Jersey case. In McIntosh, Lee Morgenstein, a patient of Dr. Milano's, murdered Kimberly McIntosh, a girl with whom he once had a relationship. Miss McIntosh no longer wished to see him. Morgenstein demonstrated his dangerousness by firing a gun at Kimberley's car, verbally threatening her and her dates, bringing a knife to a therapy session, and discussing fantasies of violent retribution. The court held that a therapist "may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when, a patient of Dr. Milano's, murdered Kimberly McIntosh, a girl with whom he once had a relationship. Miss McIntosh no longer wished to see him. Morgenstein demonstrated his dangerousness by firing a gun at Kimberley's car, verbally

threatening her and her dates, bringing a knife to a therapy session, and discussing fantasies of violent retribution. The court held that a therapist "may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine, in the appropriate factual setting, and in accordance with the standards of his profession, that the patient is or may present a probability of danger to that person."³⁰

The court outlined three factors as components of a duty to warn: the relationship of the parties, the nature of the risk, and the public interest in imposing the duty under the circumstances.³¹ The legal trend towards the creation of the duty to warn seems to run in a direction opposite to the increasing professional criticisms. Thus, a duty to control and a duty to warn have emerged from case law as potentially expansive sources of tort liability. It is now likely that a person harmed by a psychiatric patient will attempt to hold the psychiatrist responsible for the patient's violent acts. As a result, a sound well-grounded rationale should be sought to justify this new case-created duty to warn.

As a matter of fact, a survey³² by the staff of the Stanford Law Review in 1979 attempted to explore the impact³³ of the Tarasoff decision upon California psychiatrists and psychologists. The survey's goal was to determine whether therapeutic practice had been affected by the decision, whether therapists gave more warnings to potential victims, and whether predictions of damage to the therapeutic relationship had in fact occurred. The survey sample consisted of 1,272 therapists, of whom over 80 percent reported treating at least one potentially dangerous patient a year. About 96 percent reported that they had heard of the Tarasoff decision. Among the therapists who gave warnings, a larger number warned potential victims after the Tarasoff decision than prior to it.

In general, the ultimate impact of Tarasoff and Milano among therapists is likely to be positive overall, in spite of the anxiety produced by the decision.³⁴ First, potential victims are much more likely to be warned by therapists who do give warnings, so that the victims may have an opportunity to take precautions.³⁵ Second, therapists will attempt to predict dangerous behavior with greater precision because of increased pressure on each therapist to keep up to date with research findings on dangerousness, correlations between personality disorders and the likelihood of violence, and other emerging evidence. Such pressure can only improve the quality of psychotherapy, albeit at the cost of the increased anxiety and effort on the part of therapists.³⁶ Third, increased consultation with other professionals, including attorneys, is likely. Consultation with other mental health professionals may serve a useful purpose in aiding the uncertain therapist in his treatment of a difficult patient.³⁷ This would be a healthy development indeed.

Another criticism is that predicting dangerousness destroys the essentially helping roles of the mental health professions by turning psychiatrists and psychologists from healers of psychic pain into agents of social control. However, it is true that all human service professions have a social control component to them.³⁸ Teachers, for example, whose role is to improve the welfare of their students, surely view themselves as transmitters of knowledge and culture. Yet they frequently function as disciplinarians whose tasks include expelling those whose conduct is detrimental to the school environment and acting as society's gatekeepers by withholding diplomas needed for jobs and further education from those who do not meet socially defined standards of academic performance. It is as the agent of society, not as the benefactor of the individual pupil, that the teacher performs these functions.³⁹

Currently, strong public policy requires laymen as well as nonpsychiatric physicians to perform a variety of social control functions with little adverse effect on their primary helping roles. For instance, they can resort to involuntary detention of persons who through no fault of their own carry contagious disease. Also they are bound in many states to report to the police suspected child abuse as well as threats of high crime and misdemeanor.⁴⁰ Failure to report constitutes a misdemeanor. The duty to report is based not on the particular person's ability to accurately predict dangerousness but on a "reasonable suspicion," which means that it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse.⁴¹ Although one would hope that the community protection role of mental health professionals would be minimal in relation to their helping functions (as with teachers and physicians), it does not seem unreasonable of society to demand a limited social control function.⁴²

This article would argue that the duty to warn should be based upon this strong public policy of protecting the community, rather than the special psychotherapist/patient relationship. The underlying rationale is not that the treating professionals are able to accurately predict potential violence. Rather, the creation of the duty to warn is based on the recognition that the treating professionals are in a better position to detect possible violence because they possess increasing medical technologies and statistics. This knowledge increases the therapists' predictive power so that the public at large may reasonably expect them to prevent the occurrence of potential violence by imposing a duty to warn upon them.

Professor John Monohan's conclusion in his recent article, "The Prediction of Violent Behavior: Developments in Psychology and Law", sufficiently supports the above argument on the justification of prescribing a duty to warn.

He concluded:

"we are not talking in this context of psychology and psychiatry being manipulated to play an improper role in controlling more-or-less harmless deviations from social norms. We are talking of murder, rape, robbery, assault, and other forms of violent behavior. There is a wide-spread social consensus -- a consensus that transcends political, radical, and economic groupings -- that such activities tear at the already frayed social bonds that hold society together. When we lend professional assistance, however marginal, to improve society's control of those who will murder, rape, rob, and assault -- provided that we do not let the nature of that assistance be overstated or distorted -- we have nothing for which to apologize."⁴¹

This new, case-created duty must further be expanded into a statutory duty through state law enactment. This expansion will occur once the legislature recognizes that the public duty to warn outweighs the private duty of confidentiality. Further discussions of the matter is in the part of Duty to Warn vis-a-vis the Duty of Confidentiality.

II. The Scope of the Duty-- The "Specific Dangerousness to Identifiable Victim" Test

Although the duty to warn was created by a substantial number of state courts, the authorities are split on the scope of the duty. The majority of them have gone beyond Tarasoff to hold psychiatrists liable for violent acts committed by their patients against persons not identifiable in advance.⁴⁴ For example, in Lipari v. Sears, Roebuck and Co.,⁴⁵ the plaintiff had been injured and her husband killed when a patient (who 30 days earlier against medical advice had discontinued day treatment at a VA hospital) fired a gun into a night club. The victims alleged that the doctors should have tried to commit the patient. The court refused to dismiss the suit. Noting the broad language in Tarasoff, the court refused to rule that "a reasonable therapist never be required to take precautions other than warnings, or that there is never a duty to attempt to detain a patient." The legal authorities clearly impose a brauder and potentially more troubling obligation on the psychiatrist. The rationale behind such opinion is the importance of the duty to protect society in general from violent patients. They further argue that when there is a duty to an identifiable victim, it may be discharged through a warning. But when the duty is imposed in order to prevent random violence toward unidentified members of the public, a warning will no longer suffice. There is no victim to warn and most police departments feel their hands are tied if no crime has been committed. Instead, the psychiatrist will have to reconsider treatment decisions regarding commitment, passes, discharges, and the use of restraint, etc., and may have to adopt a treatment that otherwise would have been rejected.⁴⁶

The minority of legal authorities have held that a "precondition to liability" is a "readily identifiable" intended victim.⁴⁷ The decisions of the California Supreme Court in Thompson v. County of Alameda,⁴⁸ are illustrative. In Thompson, parents of a boy murdered by a juvenile offender within 24 hours of his release sued the county. Neighborhood residents had not been warned despite the fact that the offender was known to have violent tendencies towards children and had "indicated that he would, if released, take the life of a young child residing in the

neighborhood." He had not said which, if any, child was his target. The court found no duty to warn the police, the public, or the offender's mother because the victim was not identifiable.

The minority view should be recognized as the proper one. The nature of and the rationale behind this new case-created duty should decide the issue. The public policy requiring treating professionals to assist in protecting potential victims should not be overstated or distorted. The extension of the duty to non-identifiable victims is not a reasonable expectation of public policy. The overextension of the duty would thwart its imposition. The majority view would cause, as pointed out above by many commentators, negative effects.

The "specific dangerousness to identifiable victims" test states a workable, reasonable and fair boundary upon the sphere of a therapist's liability to third persons for the acts of their patients.⁴⁹ Every state now has some form of reporting statutes which require both non-professionals and professionals who have personal knowledge about certain dangerous instances to report to authoritative agencies. For example, Section 11166 (b) of Article 2.5 of California Penal Code (Report; duty; time) provides: "Any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or who reasonably suspects that mental suffering has been inflicted on a child or his or her emotional well-being is endangered in any other way, may report such known or suspected instance of child abuse to a child protective agency." Specific threats to non-identifiable victims should be covered by this type of statute.

Related to the specific dangerousness to specific victim test are limitations on recovery. Recovery should be denied for property damage and to a victim who was already aware of the danger. The patient in Heltsey v. Vottelan,⁵⁰ for example, had threatened the plaintiff and tried to run her down. The plaintiff admitted this and her knowledge of the patient's prior aggressive behavior but contended that only a warning by a professional, such as a psychiatrist, would have made her appreciate the gravity of the situation. The Iowa Supreme Court rejected the argument and refused to impose liability.⁵¹

However, recovery should not distinguish between intentional and unintentional foreseeable harm, thereby establishing probably the broadest potential for psychiatric liability to date. For instance, the patient in Peterson v. Washington,⁵² had been discharged from a state hospital after emergency detention and short-term commitment occasioned by a schizophrenic reaction to drugs. Five days after discharge, while under the influence of drugs, the patient ran a red light at an estimated speed of 50 to 60 miles per hour and struck the plaintiff's automobile, injuring the plaintiff. The Supreme Court of Washington concluded that the psychiatrist incurred a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by the patient's drug-related problems.

III. Standard of Care Required -- Higher Standard for Specialists

Whatever the extent of the duty imposed by a court, a treating professional will not be held liable for a patient's violent acts unless a court or jury finds both that (i) he determined or should have determined that the patient posed a danger to another and that (ii) he did not take adequate steps to prevent the violence. Courts are consistent in upholding the specialist's standard of care required for the duty to warn. A specialist, such as a psychotherapist of a particular school of therapy, is expected to adhere to a certain standard of care - that of a reasonable prudent and careful specialist, that is, the average specialist in that particular field.⁵³

Therapists, as specialists, must comply with a higher standard of skill and knowledge as possessed by other specialists. Thus, a psychotherapist must (i) possess the degree of professional learning, skill, and ability which others in similar situations ordinarily possess; (ii) exercise reasonable care and diligence in the application of his knowledge and skill in the patient's case; (iii) use his best judgment in prediction of the potential violence, thereby deciding whether to give warnings. The specialist is judged by an objective standard of the average member of the profession, considering professional advances and to some extent available medical resources.⁵⁴ Under this standard, expert testimony is generally required to determine if the treating professional in performing his duty to warn conformed to the appropriate standard of care.⁵⁵ Thus, in McIntosh v. Milano, supra, the New Jersey Superior Court held that the family of a woman killed by an outpatient could sue the patient's psychiatrist (because a duty to warn did exist), but remanded the case for determination of whether the psychiatrist should have known that the patient presented a danger to the woman in question. The evidence showed that although the patient had shown strong feelings of jealousy towards the woman and had revealed that he had fired a BB gun at her automobile, he had never disclosed any violent feelings towards her or an intention to harm her. The jury decided in favor of the psychiatrist.⁵⁶

- However, courts apparently tend to find that the psychiatrist knew or should have known that the patient posed a danger to another. For example, in Davis v. Yong-Oh, Lhim, the evidence that the patient posed a threat to his mother consisted of a hospital record of his making reference to "threatening his mother for money," which had been made at another hospital two years earlier.⁵⁷

The study of the relevant cases and the practice of the professional community yields the following six important steps to prevent violent acts from occurring, to provide additional information and input that will assist the psychiatrist in deciding what to do and to refute allegations that the psychiatrist was negligent (i.e., that he or she should have determined that the patient was dangerous, or should have taken some step that he or she failed to take).⁵⁸

- (1). Obtain prior treatment records. This will generally give the treating professional

more information to work with and may help place a threat or a single act of violence in context.

(2). The decision making process should be well documented. A complete record can help establish that all relevant sources of information were consulted and all relevant factors considered in deciding whether the patient posed a risk and if so, what steps were appropriate. A record that includes this information and explains why a decision was made will help establish that the decision was reasonable even if it turns out to have been wrong.

(3). When in doubt about whether to issue a warning or take other steps to avert harm, a psychiatrist should arrange (and document) a consultation with second clinician and/or an attorney. A psychiatrist's liability in this context will be determined by reference to the standard of the profession. Consulting another psychiatrist -- setting out the facts and seeking advice as to the degree of danger -- should, therefore, provide some extra protection. Consulting an attorney as to legal standards and obligations thereunder should also assist in decision making and help establish that due care was taken.

(4). When a psychiatrist determines that there is a danger to an identifiable person, all appropriate warnings should be made, even if the psychiatrist is certain that the victim is aware of the danger. Each case should be considered separately to determine if others, such as parents or spouses should be contacted in addition to (or instead of) the identified victim.

(5). When in doubt about whether a patient poses a danger to the public, it is advisable to initiate commitment proceedings when reasonably possible. Responsibility then passes to the judge, who will not be held liable if he or she decides not to commit a patient who later harms someone. Where a judicial process is available, it is important to remember that the decision to commit is a judicial matter, not a psychiatric matter. The responsibility of psychiatrists in this circumstance is to present the facts and medical conclusion as they know them.

(6). Upon discharging a patient who has shown a potential for violence, a psychiatrist should make certain that any treatment plan developed is actually followed and, if it is not, decide whether the patient should again be restrained. Too often psychiatrists determine that a patient may be safely discharged if outpatient therapy continues, or if the patient stays on medication, but neglect to check that these steps are taken. At least some effort should be made to follow up on a discharged patient -- by asking the outpatient psychiatrist or community mental health center to contact you if the patient stops coming.

IV. Duty to Warn Vis-a-vis Duty of Confidentiality -- An Exception and Its Troublesome Situations

Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient.⁵⁹ Here confidentiality refers to the duty of the physician not to disclose information learned directly or indirectly from the patient to anyone not directly involved in the patient's case. The Tarasoff dissent persuasively argue that there should be no affirmative duty to disclose threatened future acts of the patient⁶⁰ because communications made in the psychotherapist-patient relationship should remain confidential and privileged.⁶¹ Thus, still some other courts that have considered Tarasoff-type situations have refused to follow the case.⁶² For example, Hopewell v. Adetrimple⁶³ was brought against a psychiatrist who was concerned about Tarasoff and therefore warned his patient's employer that the patient felt harassed by her work

situation and had threatened "to hurt somebody very seriously if the harassment does not stop." The patient sued for breach of confidentiality and the doctor defended on the basis of Tarasoff. The court held that the psychiatrist had an absolute obligation not to disclose confidential communications without the patient's written consent. These cases, resulting in diametrically opposed decisions, point to the inconsistency between the duty to warn and the duty of confidentiality.⁶⁴

Courts have been reasonably receptive in disclosure cases to the defense of an overriding public interest. Psychiatrists who have warned third parties of potential patient violence have usually not been held liable for breach of confidentiality. Disclosures have also been found justified when necessary to protect the general public or a third party from other dangers. The rationale is that protective confidentiality ends where the public peril begins.⁶⁵ While protection of therapist-patient relationship confidentiality is important, confidentiality must yield in order to protect the public. Society's paramount interests in safeguarding human life require only that confidentiality be qualified.⁶⁶

Disclosures may be justified on the ground that they are necessary to protect the patient only where the duty of confidentiality is derived from common law. In a number of states, however, there are mental health confidentiality statutes maintaining patient confidence.⁶⁷ Under such circumstances, the duty to warn conflicts with the statutory duty of confidentiality. The public interest defense, justifying the exculpability from breach of confidentiality, seems no longer applicable here.

No court has had the opportunity to decide this issue. As a general rule, statutes are to be harmonized so as to reconcile apparent inconsistencies.⁶⁸ There are no ready-made solutions to the psychiatrist's dilemma in facing conflicts between the case-created duty to warn and the statutory duty of confidentiality.

However, commentators suggest certain alternatives which may be feasible to either the courts or the legislature.⁶⁹ One alternative for the legislature would be to amend the mental health confidentiality statute to include a dangerous patient exception.

Another option would be to repeal the statutory cause of action which allows a patient to recover damages for disclosure of confidential information. A third alternative, which may be an adequate compromise, is to allow the legislature to add immunity provisions to mental health confidentiality statutes. The last alternative, which is supported by the American Psychiatric Association, is to limit the Tarasoff decision and hold that involuntary commitment applies to the Tarasoff facts.

This article's position is that while the case-created duty to warn may outweigh the common-law-created duty of confidentiality, the current statutory duty of confidentiality does

not yield to the duty to warn on the ground of a public interest defense. In view of the more compelling interest in creating a duty to warn, legal trends should raise the duty to warn from a case-created duty to a statutory duty. Once a statutory duty to warn is established by state law enactment, it may outweigh the statutory duty of confidentiality by balancing the conflicting interests between them on a case-by-case basis.

V. Risky Situations for Legal Liability -- Good Faith Defense Applicable

To date, the duty to warn was properly created by case law in many states. Failure to give warning to potential victims of the potential violence would probably incur legal liability on the part of the treating professionals. Likewise, legal liability may result from warnings which precede no violence at all.

In the following configuration, there are three conceivable situations which yield situations of risk of legal liability in the context of forming the duty to warn. The following table is descriptive of risky situations for legal liability.⁷⁰

State of Therapists' Knowledge of Patient's Dangerousness	Actions by Therapist	Actions by Patients	Plaintiff	Likely Forms of Suits
Convinced	Unsuccessful Commitment or a warning to intended victim	No violent act	Patient	Negligent Diagnosis Defamation of character Malicious Prosecution Invasion of privacy
			Victim	Negligent Diagnosis Infliction of Emotional Distress
Convinced (Tarasoff situation)	Unsuccessful Commitment No warning	Violent Assault	Patient	Negligent Diagnosis Negligent Care
			Victim	Negligent Diagnosis Negligent Care
Should have known	No action	Violent Assault	Patient	Negligent Diagnosis Negligent Care
			Victim	Negligent Diagnosis Negligent Care

According to Dr. Benjamin M. Schurtz's analysis,⁷¹ in the first situation, the therapist is convinced of danger and has been unable to contain the situation within the therapeutic frame. He therefore decides to rupture the therapeutic frame and commit the patient or warn the victim. If he were successful via commitment in heading off the violence, the patient would have a hard time proving that, given his freedom, he would not have hurt anyone. Also, if the warning averted a tragic outcome from an attempt, it would be seen as justified. However, when the therapist's commitment action is unsuccessful and the patient subsequently commits no violent act, or when the therapist warns the victim and, again, the patient commits no violent act, liability is likely to ensue. In the second situation, a description of the characteristics of the Tarasoff case, the therapist is convinced of danger and attempts to avert it by committing the patient but is unsuccessful in his commitment attempt; and he fails to warn the victim. In this situation, liability is likely to ensue if the patient kills or injures the victim. The third situation is a should-have-known situation. If the therapist did not know of the risk, but should have known of it, and he failed to act, liability might arise if the patient did do violence.

This article agrees with the analytic results of the second and the third situations holding the therapist legally responsible. However, the result of the first situation would put the therapist in a dilemma. Case law requires a therapist who reasonably believes that his patient is dangerous to give warning to the intended victim. The opinion that, on the one hand, a therapist might incur liability if he fails to give warning, while, on the other hand, he might also incur liability if he did give warning but his patient turns out to commit no violence, is unreasonable and would thwart the creation of the duty to warn. This article would argue that the due care of the reasonably prudent and careful specialist in the particular field should be the guideline. The risk that unnecessary warnings might be given is a "reasonable price to pay for the lives of possible victims that may be saved."⁷² This article would suggest that good faith warning should serve as an affirmative defense to legal liability under such circumstances. Many states, in their reporting statutes, also allow or encourage others to report, extending to such persons the same insulation from civil damages for good faith reporting accorded those required to notify the states.⁷³ Good faith defense conforms to the fundamental concept of equity, and is conducive to the development of this policy-oriented duty to warn.

VI. Conclusion

In the United States today, the policy-oriented duty to warn is properly created by case law in a substantial number of states. The traditional grounds that the special therapist-patient relationship and the presumption of the therapist's ability to predict dangerousness justify imposing on treating professionals the duty to warn, is inconsistent with the factual situation and is unable to justify the creation of the duty to warn. It should therefore be revised by the policy-

oriented doctrine.

The legal trend as to the development of the duty to warn and the vigorous criticism flowing from both legal and psychiatric professional levels seem to run in the opposite directions.

Although it is a healthy development, the scope of the duty to warn should not be extended too far. To fear that the imposition of this duty would put the psychiatrists in a position in which they have to respond to even idle threats is reading the duty to warn far too broadly. The creation of this duty does not require a warning in response to every threat, but only those which in the psychiatrist's professional and skilled judgment present a real danger to an identifiable person. The "specific dangerousness to identifiable victims" test serves as a proper intermediate scope. This offers a viable compromise that may protect human lives while preventing any wholesale erosion of the psychiatrist-patient relationship. A warning of a threat to an unknown person or a class of people should be covered by the state reporting statutes.

A higher standard of care is required for the treating professionals to perform the duty to warn. The therapist must comply with the national standards of the average member of the profession both in prediction of dangerousness and in issuing a warning. A higher standard for a specialist is consistently accepted as the proper test.

The duty to warn create a dilemma for the therapist. If he fails to issue a warning when he believes his patient is potentially violent, he will be held liable. Yet, if the therapist issues a warning and the patient does not turn violent, the therapist may still be held liable. Such risky situations for legal responsibility should be mitigated. A good-faith defense, analagous to that in reporting statutes, should be available for this purpose.

Conflict between the duty to warn and the duty of confidentiality is the most troublesome question. In balancing these two conflicting duties, one may conclude that the public interest in protecting society attached to the duty to warn generally outweighs the private interest adherent to the common-law duty of confidentiality. However, each state in the United States now has certain requiremnts for breaking confidentiality, and liability may ensue if the therapist fails to conform to them. Under this circumstance, the public interest defense is fuctionless, and creation of a duty to warn will be unrealistic.

Converting this case-created duty to warn to a statutory one by state law enactment may be the best method for solving the troublesome question. Once the statutory duty to warn is established, conflicting interests between a duty to warn and a duty of confidentiality will be balanced on the same statutory level, on a case-by-case basis. This suggested solution waits for the wisdom of future legislatures in the individual states.

Footnotes

- 1.33 Cal. 3d 275 (1973), 529 P 2d 553 (1974), 351 P 2d 334 (1976)
2. Restatement (Second of Torts section 314, Comment C (1965))
3. The case was heard four times at various levels and ultimately settled out of the court for an undisclosed sum of money.
4. 529 P 2d 553 (1975)
5. Restatement, Id., sections 314A, 316, 319. Regarding liability for harm resulting premature release of institutionalized mental patients, see Annot., A.L.R. 3d 699 (1981)
6. Restatement, Id. section 315
7. B.M. Schutz, Legal Liability Affecting Psychotherapists, in Legal Liability in Psychotherapy 13, (1982)
8. B.M. Schutz, The Dangerous Patient - Tarasoff and Beyond, Id., p. 55
9. Id., p. 54
10. Id., P. 54
11. See Learned Hand's famous statement of the negligence calculus in United States v. Carroll Towing Co., 159 F.1. 2d 169
12. B.R. Furrow, Theory of Strict Liability, in Malpractice in Psychotherapy 85 (1980)
13. Id., pp. 87-88
14. 332 H. Supp. 74S (E.d. Pa 1971)
15. Coccozza & Steadman, Prediction in Psychiatry: An Example of Misplaced Confidence in Experts, Social Problems 25 (February), 3:265-276, 1978
16. American Psychiatric Association, Clinical Aspects of the Violent Individual. Washington, D. 4., Sutton, P. 30, 1974
17. "It does appear from reading the research that the validity of psychological predictions of dangerous behavior, at considering, is extremely poor, so poor that one could oppose their use on the strictly empirical grounds that psychologists are not professionally competent to make such judgments." American Psychological Association, Report of the Task Force on the Role of Psychology in the Criminal Justice System, American Psychology, 1973, p. 1110
18. Ennis & Emery, The Right of Mental Patients -- An American Civil Liberties Union Handbook, 20, 1978.
19. Sadoff, R.L., Steadman, H.J., Perlin, M.L., Shah, S.A., Heller, M.S., Lion, J.R., Brooks, A.D., and Pollock, S., The Great Debate: Determination of Dangerousness by Psychiatrists. Tenth Annual Meeting of the American Academy and the Law, October 27, 1979, Baltimore, Maryland
20. Grain, P.M., Assessing Dangerousness, in Rosner, R., Critical Issues in American Psychiatry and the Law, 45 (1982)

21. *Id.*, p. 33
22. Kahel & Sales, *Due Process of Law and the Attitudes of Professionals toward Involuntary Civil Commitment*, 1980. p. 279
23. Olsen, *Imposing a Duty to Warn on Psychiatrists - A Judicial Threat to the Psychiatric Profession*, Colo. L.R. 288, 1977
24. Detailed Discussion as to the predictability of violence, see "The Prediction of Violent behavior: Development in Psychology and Law", in Scheirer, C.J., & Hammonds, B., coedited, *Psychology and the Law*, 1983, pp. 151-174
25. Schutz, *Id.* 55
26. Stone, "The Tarasoff Decision: Sueing Psychotherapists to Safeguard Society", 90 *Harv. L. Rev.* 358 (1976); Gurevitz, "Tarasoff's Protective Privilege versus Public Peril", 134, *Am. J. Psych.* 289 (1977); Slavenko, "Psychotherapy and Confidentiality", 24 *Clev. St. L. Rev.* 375, 391 (1975); Note, "Imposing a Duty to Warn on Psychiatrists -- A Judicial Threat to the Psychiatric Profession", 48 *U. Colo. L. Rev.* 283 (1977); Gregory, "Critical Cases: Duty to warn Potential Victims Spreads", *Legal Aspects of Medical Practice* 44 (December 1979). See comments of Clark, dissenting in *Tarasoff II*: "Overwhelming policy considerations weigh against imposing a duty on psychotherapists to warn a potential victim against harm. While offering virtually no benefit to society, such a duty will frustrate psychiatric treatment, invade fundamental patient rights, and increase violence. 551 p. 2d at 358
27. The professional attack on prediction was led by Alan Stone in his highly influential monograph, *Mental Health and the Law: A System in Tradition* (1975). Stone proposed a new medical model of civil commitment, openly based on paternalistic concern for the patient's welfare rather than on concern for society's protection. His thank-you theory "divests civil commitment of a police function; dangerous behavior is returned to the province of the criminal law. Only someone who is irrational, treatable, and incidentally dangerous should be confined to the mental health system."
28. The *Tarasoff* case was followed by courts of Kansas, Washington, Florida, Iowa, Maryland, Massachusetts, Michigan, Missouri, Texas, New Jersey.
29. 168 N.J., Sup. 466, A. 2d 500
30. The New Jersey Court considered the defendant's initial argument that therapists cannot predict dangerousness with sufficient reliability, and stated: "It may be true that one cannot be 100 percent accurate in prediction of dangerousness in all cases. However, a therapist does have a basis for giving an opinion and a prognosis based on the history of the patient and the course of the treatment. Where reasonable men might differ and a fact issue exists, the therapist is only held to the standard for a therapist in the particular field in the particu-

lar community. Unless therapists clearly state when called upon to treat patients or to testify that they have no ability to predict or even determine whether their treatment will be efficacious or may even be necessary with any degree of certainty, there is no basis for a legal conclusion negating and all duty with respect to a particular class of professionals. This is not to say that isolated or vague threats will of necessity give rise in all circumstances and cases to a duty." 168 N.J. Sup. 482, 403 A. 22d at 508

31. Id

32. Comment, "Where the Public Peril Begins?: A Survey of Psychiatrists to Determine the Effects of Tarasoff", 31 Stan. L. Rev. 265 (1978)

33. Impact is defined, Id., at 173 (n. 47)

34. Furrow, Duty to Third Parties, Id. p. 55

35. Id. p. 55

36. Id. p. 56

37. Id. p. 56

38. Monahan, J. "The Prediction of Violent Behavior: Development in Psychology and Law", in Scheirer, C. J. & Hammonds, B. L. Psychology and the Law, p. 173 (1983)

39. d. p. 173

40. Every state now has some form of reporting statute. Typically they mandate reporting by certain persons likely to have personal or professional contact with children who have been injured through abuse. Teachers and health care professionals are examples. Many statutes also allow or encourage others to report, extending to such persons the same insulation from civil damages for good faith reporting accorded those required to notify the state. California Penal Code Article 2.5., section 11166 Report; duty; time, is illustrative. See Wadlington, W. Domestic Relations, 1984, pp. 538-546

41. California Penal Code Article 2.5., section 1117 22 (b) provides: any person who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist, as required by this article, is guilty of misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than five hundred dollars (\$500) or by both

42. Monahan, J. Id. p. 173

43. Monahan, J. Id. p. 174

44. Leverott v. Ohio, 61 Ohio App. 2d 35, 399 N.E. 2d 106 (1978); Bradley Center, Inc. v. Wessner, 296 S.E. 2d 693 (Ga. 1982); Johnson v. United States, 409 F1. Supp. 1283 (M.d. F1. 1976). All courts have ruled similarly

45. 497 A. Supp. 185 (D. Neb. 1980)

46. Klein, J.I. & Macbeth, J.E. & Onek, J.N., *Legal Issues in the Private Practice of Psychiatry*, 1984, pp. 16-17
47. *Christe v. United States*, No. 81-83944, F. Supp. (E.D. Mich., May 26, 1983); *Davis v. Yong Oh-Lhim*, No. 5-9284 (Mich. Ct. App., March 1, 1983); *Durflinger v. Articles*, No. 75-63-66 (D. Kan. 1981). See also *Jablonski v. United States*, F 2d (4th Cir. 1983)-F2d-(4th Cir. 1983)
48. 27 Cal. 3d 741, 614 P 2d 728 (1980)
49. See, respectively, *Bellak v. Greenson*, 141 Cal. Rptr. 92 (Cal. App. 1977) and *Cole v. Taylor*, 301 N.W. 2d 766 (Ia 1981). To date, these are the only courts that have ruled on this issue
50. 327 N. W. 2d 759 (Ia 1982)
51. See also, *Court v. State*, 323 N.W. 2d 20 (Minn. 1982); but contra, *Jablonski v. United States*, supra, *Davis v. Yong Oh-Lhim*, supra
52. No. 49490-8 (Wash. Oct. 20 1983)
53. *Christie v. Saliterman*, 288 Minn. 144, 166 n.1, 179, N. W. 2d 288, 302, n.1 (1970); See also *Prosser, W.*, *Handbook of the Law of Torts*, section 321 at 164-165
54. *Bune v. Belinkoss*, 354 Mass. 102, 235 N.E. 2d 793 (1968)
55. *Edward v. United States*, 519 F.2d 1137 (5th Cir. 1975)
56. The Psychiatrist was exonerated for similar reasons in *Johnson v. United States*, supra
57. See also *Jablonski v. United States*, supra
58. *Furrow, B.R.*, supra pp. 18-19
59. American Psychiatric Association section 4, Annot. 1
60. 118 Cal. Rptr. at 142, P 2d at 566 (1974)
61. The dissent conceded that under Cal. Evid. Code sections 1010-26 (West 1966), only a qualified privilege exists, but it still maintained that the statute imposes no affirmative duty to act in spite of the qualified nature of the privilege. 18 Cal. Rptr. at 144-45, 529 P 2d at 568-569
62. See also *Shaw v. Glickmon*, 415A. 2d 625 (Md. Ct. Spec. App. 1980)
63. 130 P.H.L.J. 107 (Pa. Ct. Com. p.1, 1981)
64. See, e.g., *Simonson v. Swenson*, *Hafman v. Blackmon*, 241 So. 2d 752 (Fla. App. 1970); *Chatter v. Spicer*, 295 N.W. 2d 134 (S. Dak. 1974); *Berry v. Moench*, 8 Utah 2d 191, 331 P 2d 814 (1958)
65. *Tarasoff case, Id.*, at 402, 551 P 2d, 347, 131 Cal. Rptr, at 27
66. In other areas where a privilege exists, there has been a recognition that the privilege must fail when higher interest is involved. See, e.g., *United States v. Nixon*, 418 U.S. 683, 707 (1974), where the court stated: "[T] he legitimate needs of the judicial process may outweigh presidential privilege..."; Cal. Evid. code sections 956-962 (West 1966) (exceptions to the attorney-client privilege); id. sections 981-987 (West 1966) (exceptions to the privilege for

- marital communications); *id.* sections 996-1007 (West 1966) (exceptions to the physician-patient privilege). At least one commentator, however, argues that the psychotherapist-patient privilege should be absolute by comparing this privilege with the clergyman-penitent privilege where no exceptions inure. See *Psychotherapeutic Professions* 632. An important policy basis for clergyman-penitent privilege is that the tenets of a clergyman's religious order often impose a duty to keep penitential communication absolutely secret. There are situations, however, in which it is ethically permissible for a psychotherapist to disclose confidential information. *Id.* at 633. This fact negates the analogy
67. See e.g., California Welfare and Institution Code section 5328; Illinois Mental Health and Development Disability Confidentiality Act, chapter 91-1/2 section 801, et seq, District of Columbia Mental Health Information Act, D. C. Code Ann. 6-201, et seq.
68. *Hough v. McCarthy*, 54 Cal. 2d 273, 353 P 2d 276, 1 Cal. Rptr. 168 (1960)
69. Cohen, R.N. NOTES, *Tarasoff v. Regents of the University of California*, "The Duty to Warn: Common Law & Statutory Problems for California Psychotherapists", 14 California Western Law Review, pp. 171-181
70. Shutz, B.M. *Id.*, p.58
71. Schutz, B.M. *Id.* pp. 57-58
72. The measure of performance is to be reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Within the broad range of reasonable practice and treatment in which professional opinion and judgement may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is sufficient to establish negligence.
73. California Penal Code Article 2.5. section 11172, "... Any other person reporting civil or criminal liability as a result of any report authorized by this article unless it can be proven that a false report was made and the person knew that the report was false..." See also Waldington, W., *Id.* NOTE 1, p. 594

Table I
 VIEWPOINTS FROM THE GREAT DEBATE
 "Can Psychiatrists Determine Dangerousness?"

I	II	III
Psychiatric Expertise Not Demonstrable	Psychiatric Expertise Not Decided Yet	Psychiatric Expertise Demonstrable

Section A: Prediction Not Possible

<p>No objective empirical evidence exists for clinical predictions at acceptable levels of reliability and validity (Steadman, Shah Pefloff)</p>	<p>Dangerousness can be defined by factors other than prediction, involving a sociopolitical decision. Psychiatrists can present data, which may or may not aid the court in its essentially legal decision. (Brooks)</p>	<p>(1) Mental disorders manifesting certain impairments can produce a "potential for harm." (Pollock) Certain states of mind are intrinsically more "explosive" than others. (Quen). (2) The impairments of mental disorder are not in themselves dangerous, but rather their copresence with past violent behavior can be identified. "Conditions" which either Facilitate or inhibit these impairments can be assessed. (Sadoff)</p>
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Section B: Prediction Possible

<p>Clinicians are already intuitively identifying dangerous individuals; they do not know how to discuss the basis of their assessment. (Heller)</p>	<p>(1) Not all data is in; it has not yet been shown whether or not short-term predictions can be made. (Brooks). (2) Current studies of prediction lack validity. (perr, Halpern)</p>	<p>Parameters do not exist that can aid clinicians in identifying dangerousness. This assessment leads to a "high index of suspicion." (Lion.)</p>
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