J. Legal Med. 21: 2

"Where the Public Peril Begins": 25 Years After *TARASOFF*

Fillmore Buckner, M.D., J.D. and Marvin Firestone, M.D., J.D.

INTRODUCTION

It has been 30 years since Prosenjit Poddar met Tatiana (Tanya) Tarasoff and 25 years since the first *Tarasoff* decision was handed down by the California Supreme Court, later modified by the second *Tarasoff* decision. [n1] The occasion of the twenty-fifth anniversary of this eventful case would seem to be an appropriate time to review and appraise the effects of this widely publicized case.

When first handed down, many observers thought it was an aberrant decision not likely to be followed elsewhere and likely to be severely modified by California courts. In addition, a myriad of commentators in the area of mental health decried the decision as undermining the practice of psychotherapy by destroying the tenets of confidentiality. These observers obviously were wrong. Less than two years later, the New Jersey Superior Court in *McIntosh v. Milano* [n2] found a psychiatrist liable using the rationale of *Tarasoff*. Since that time, the decision requiring psychotherapists to warn third parties of potentially dangerous patients has been adopted in many jurisdictions and has been expanded to include a wide variety of health care practitioners.

Because the holding in *Tarasoff* is still an active concept in the law and because it did not mark the death of psychotherapy practice, the question arises as to why the observers were wrong. In their attempt to answer this and other questions about the case, the authors have made no attempt to write the "definitive" *Tarasoff* article but, instead, have made a de novo analysis of the state of the applicable law at the time *Tarasoff* was heard, the *Tarasoff* decision itself, the subsequent adoption and expansion of the initial decision, the effect of the *Tarasoff* line of decisions on the clinical practice of psychotherapy, and the recent application of the line of decisions on infectious disease cases.

I. BEFORE *TARASOFF*

It appears obvious from reading *Tarasoff* that the California Supreme Court's decision was the result of the evolution of the court's prior decisions and the "black letter" law at the time. Three of the sources mentioned by the court are worth exploring. The first, an article by Fleming and Maximov, entitled *The Patient or His Victim: The Therapists Dilemma*, [n 3] is frequently quoted by the court. Fleming is identified in a footnote as John G. Fleming, Shannon Cecil Turner Professor of Law, University of California, Berkeley, and Maximov is identified as Bruce Maximov, Head Article Editor, California Law Review, evidently a law student. The court's decision seems to rely on Professor

Fleming's analysis of the status of the law before *Tarasoff*. How much the court relied on Fleming and Maximov becomes obvious only on reading the law review article.

Fleming and Maximov published their almost monograph-length article between the time *Tarasoff* was heard in the court of appeals [n4] and the first California Supreme Court decision. [n5] It was directed specifically to the *Tarasoff* fact situation. Fleming and Maximov begin with an analysis of the duty to protect a third party. Special relationships were exemplified by the duty of parents to control their children so that they do not pose an unreasonable risk to others. The principle was extended to persons having control over another who, by reason of some social or mental maladjustment, was a dangerous person. The cases moved closer to the subject at hand with extension of liability to the negligent control of institutional patients with suicidal and/or homicidal tendencies. Because control over a dangerous person is sufficient to establish the duty, Fleming and Maximov then argue that there is no distinction between inpatients and outpatients.

Fleming and Maximov admit that there would be a lesser degree of control over the outpatients and this would be relevant in determining what protective measures could be taken, but they do not believe it would justify a negation of the duty. They reach further by stating that the establishment of a therapist-patient relationship establishes a duty for the safety of the patient and the public, and contend such a view is invited by reason, a mature sense of social responsibility, and principles articulated in the case of *Greenberg v. Barbour.* [n6] *Greenberg* held that a state mental hospital was negligent when it denied the request for admission by an individual who suffered from homicidal delusions and afterward assaulted his private physician. Fleming and Maximov saw this as indicating that an even more compelling duty would arise if the patient had been admitted and a physician-patient relationship had been established.

The following paragraph sums up the duty analysis offered by Fleming and Maximov:

The preceding survey of relevant case law should dispel any notion that to impose on therapists a duty to take precautions for the safety of persons threatened by a patient where due care so requires, is in any way opposed to the contemporary ground rules on the duty relationship. On the contrary, there now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety not only of the patient himself but also any third person whom the doctor knows to be threatened by the patient.... While the precedents for this conclusion thus far have involved only dangerous persons under actual detention (inpatients), their rationale would almost surely seem to include also a physician's assumption of liability for outpatients. [n7]

Fleming and Maximov then proceed to consider the psychotherapist's conflicting duty to a patient. The authors contend that, although psychotherapy implies a plenary confidentiality privilege for the patient and, indeed, under California evidence statutes, psychotherapy appears to have been accorded a greater privilege than exists for other therapies, at best psychotherapy implies only a qualified privilege. Fleming and Maximov consider in detail the statutory incursion on the privilege under the California Evidence

Code and the Welfare and Institution Code. Due to this qualified privilege, Fleming and Maximov believe the therapist owes an overriding duty to obtain an informed consent from the patient. This informed consent is necessary to protect the privacy, liberty, and due process rights of the patient.

The impact of the qualified privilege on the field of psychotherapy is handled in a somewhat cavalier manner by Fleming and Maximov. The patients deterred by a lack of confidentiality are supposedly balanced by the patients who will now seek care under a "cry for help" compulsion because they know the authorities will be informed of their activities. In addition, Fleming and Maximov point to the continued success of psychotherapy in the face of the legislative inroads on confidentiality. Interference with psychotherapy is discounted further by the accounts of successful use of group therapy with resultant loss of confidentiality.

Fleming and Maximov spend more time and effort supporting the patient's rights to privacy, liberty, and due process. The gist of their argument is presented in the last paragraph of their discussion.

To summarize, vital interests of all psychiatric patients are threatened by pressures on psychotherapists to take protective action when involved with potentially dangerous patients. Often patients are unaware of these threats and assume a security which is in reality unavailable. An overriding concern, therefore, is the protection of these unwary patients from self-threatening disclosures. A requirement of full disclosure and informed consent along the lines of *Cobbs v. Grant* [n 8] and in light of *Miranda v. Arizona*, [n9] might well serve, as a start at least, to protect these vital interests. [n10]

Fleming and Maximov seem to have been better at identifying the problem than at offering a solution. In essence, they discard statutory solutions for either privilege or duty, and throw the problem into the lap of the courts on a case-by-case basis. Their conclusion is hardly reassuring for the psychotherapist.

[B]ut the ultimate question of resolving the tension between the conflicting interests of patient and potential victim is one of social policy, not professional expertise. We may sympathize with the therapist confronted with a decision at once delicate and awesome, but this is hardly unique nor sufficient for a claim to immunity. In sum, the therapist owes a legal duty not only to his patient, but also to his patient's would be victim, and is subject in both respects to scrutiny by the judge and jury. [n11]

The next pre-*Tarasoff* source to consider is *Johnson v. State*, [n12] a California Supreme Court decision that preceded *Tarasoff* by approximately eight years. The plaintiff in *Johnson v. State* brought suit for negligence against a placement officer of the California Youth Authority. The officer, fully aware of the medical, psychiatric, and institutional record of a 16-year-old parolee, failed to warn a foster parent of his homicidal tendencies and his history of cruelty to animals and humans. The parolee assaulted and injured the foster mother. The state had been granted summary judgment in superior court on the dual basis that the state was immune from liability and that the state owed no duty of care

to the plaintiff. In overturning the summary judgment, the supreme court dealt with both issues raised by the state. The court summarily dismissed the state's contention that it did not owe a duty of care to the plaintiff. After string citing some 10 cases and commentaries, the court continued: "These cases impose a duty upon those who create a foreseeable peril, not readily discoverable by endangered persons, to warn them of such potential peril." [n13]

The court's concept of the doctrine of discretionary immunity was based on the principle that, while basic policy decisions (such as standards for parole) may be discretionary and thus warrant government immunity, subsequent ministerial actions in the implementation of that policy do not. Therefore, the placement officer's actions did not rise to the level of governmental decision-making, calling for judicial restraint. In fact, the court considered the defendant's failure to warn the foster parents of the parolee's dangerous proclivities a classic case for the imposition of tort liability.[n14]

The third significant source utilized by the California Supreme Court in *Tarasoff* was *People v. Burnick.*[n15] There, an otherwise heterosexual 28-year-old man had four to six consensual homosexual acts with two boys aged 13 and 15. On the basis of these acts, the defendant was tried under the California Civil Mentally Disordered Sexual Offender Act, and on a preponderance of evidence standard; he was sentenced (committed) for an indeterminate period to Atascadero State Hospital, the California Department of Mental Hygiene's "maximum security" hospital. In a well-written and -reasoned majority opinion, Justice Mosk extended "the full panoply of the relevant" due process protections to defendants in all commitment proceedings, whether they be civil or criminal.[n16]

People v. Burnick is significant in one further way as well. The state argued that proof beyond a reasonable doubt was not needed because a crime was not being proved and the proceedings were "predictive in nature." Justice Mosk attacked the state's underlying assumption that the probability of error in predictive judgments was less than the probability of error in judgments determining that specific past events had occurred. In this attack, he developed a summary of the then-available information showing psychiatric predictions of dangerous behavior were no more accurate than those of the general public and, in neither case, were such predictions accurate enough to be meaningful. From the conclusory language used and the materials presented, one might conclude that the California Supreme Court (or at least Justice Mosk) was asserting a form of judicial notice of the inability to predict future dangerous behavior.

Thus, prior to hearing the *Tarasoff* appeal, the California Supreme Court had the advantage of a current professorial law review based on the very fact pattern it was considering (actually, the very case it was considering), and had adjudicated two previous cases that had settled issues of concern within the case. In *Johnson*, the court had established the duty to warn third parties of a psychiatrically diagnosed dangerous individual and established tort liability for discretionary ministerial duties. In *Burnick*, the court had addressed due process considerations in commitment cases and taken quasi-judicial notice of the psychotherapist's inability to predict dangerous activity. How the

court used or ignored these sources will be considered as we explore the *Tarasoff* decision.

II. *TARASOFF*

A. The Facts

The authors have always considered the California Supreme Court's rendition of the facts of *Tarasoff* too restricted and hazy to allow a reader a feeling for the true setting and background for the case. The expanded facts that are related below hopefully fill out the picture and make the case more understandable. All these related facts are taken from *Tarasoff* and the decisions below and, as far as possible, reflect the language of the courts involved.

Prosenjit Poddar was born into the Harijan (untouchable) caste in Bengal, India. He arrived at the University of California at Berkeley[n17] and resided in the International House.[n18] In the fall of 1968, he met Tanya Tarasoff while she was attending folk dancing classes at the International House. They saw each other weekly throughout the fall, and on New Year's Eve, Tanya kissed Poddar. Poddar interpreted the kiss to be the recognition of the existence of a serious relationship. This view was not shared by Tanya who, when learning of his feelings, told him she was involved with other men and otherwise indicated that she was not interested in entering into an intimate relationship with him.[n19]

As a result of this rebuff, Poddar underwent a severe emotional crisis. He became depressed and neglected his appearance, his studies, and his health.[n20] He remained by himself, frequently abed, speaking disjointedly, and often weeping. He spoke to a friend of being in love with Tanya and about killing her, in particular, by blowing up her room. He told this friend he could not control himself.[n21] His condition persisted with steady deterioration throughout the spring and into the summer of 1969. Poddar did have occasional meetings with Tanya during this period and tape-recorded many of their conversations in an attempt to ascertain why she did not love him.[n22]

During the summer of 1969, Tanya went to Brazil. After her departure, Poddar began to improve and, at the suggestion of a friend, sought psychological assistance. The exact date Poddar entered therapy is not available, but on August 18, 1969, he was a voluntary outpatient at Cowell Memorial Hospital (also called University Hospital in some reports).[n23] Although he initially had been seen by a psychiatrist, Dr. Stuart Gold, on August 18, 1969, he was under the care of a staff psychologist, Dr. Lawrence Moore. During the August 18 psychotherapy session, his ninth such session, Poddar confided in Dr. Moore that he was going to kill an unnamed girl, readily identifiable as Tanya, when she returned from Brazil.[n24]

On August 20, Dr. Moore personally notified campus police officers Everett D. Atkinson and Johnny C. Teel that Poddar was capable of doing harm to himself or others. On that same day, Dr. Moore wrote a letter to the Chief of Campus Police, William Beal, stating

that Poddar suffered from a "paranoid schizophrenic reaction, acute and severe" and was a danger to himself and to others. Dr. Moore further stated that, if the campus police would pick Poddar up and transfer him to Herrick Hospital, Dr. Moore would sign a 72-hour emergency detention order on Poddar. Finally, Dr. Moore informed the campus police that Poddar's behavior could be quite rational at times. Dr. Gold and Dr. James Yandell, Dr. Moore's psychiatric supervisor and Assistant Director of the Department of Psychiatry, concurred in Dr. Moore's diagnosis and the need for Poddar's hospitalization.

The campus police took Poddar into custody. Officers Gary L. Browning, Joseph P. Halleran, and Atkinson talked to Poddar and were satisfied that he was rational and had "changed his attitude altogether." After the officers elicited a promise from Poddar that he would try to stay away from Tanya, the campus police released him.[n25]

It would appear that the campus police released Poddar on their own initiative; however, either simultaneously with the release or shortly thereafter, Dr. Harvey Powelson, Director of Psychiatry at Cowell Memorial Hospital, learned of the attempt to institute a 72-hour emergency detention order. Dr. Powelson requested that Chief Beall return Dr. Moore's letter, and ordered Moore to destroy all copies of the letter and his therapist's notes on Poddar.[26] In addition, Dr. Powelson ordered his staff to take no further action to place Poddar in a 72-hour treatment and evaluation facility.[n27]

Tanya returned from Brazil in October. Poddar continued to follow her and reportedly heard her tell friends of an affair with a "playboy." [n28] The criminal cases indicate that in October, after Tanya had returned, Poddar stopped seeing Dr. Moore. [n29] However, the California Supreme Court, looking to the same source, stated that Poddar stopped his therapy immediately after his detention by the campus police. [n30] In any case, on October 27, 1969, Poddar went to Tanya's home to speak to her. Tanya was not at home and her mother told Poddar to leave. Poddar returned later armed with a pellet gun and a kitchen knife. He found Tanya alone. She refused to speak to him and, when he persisted, she screamed. At this point, Poddar shot her with the pellet gun and Tanya ran wildly from the house. Poddar caught her in the yard and stabbed her repeatedly [n31] and fatally. [n32] Poddar then returned to the house and called the police. Poddar told the police he had stabbed Tanya and asked that he be handcuffed. [n33]

Poddar was examined within 24 hours of the stabbing by Dr. Kermit Gruberg, a Berkeley Police Department psychiatrist. Gruberg confirmed the diagnosis of paranoid schizophrenia. [n34] Poddar was charged with the murder of Tanya. He pled not guilty and not guilty by reason of insanity. [n35] Some time prior to trial, Poddar was examined by Dr. Wilmer Anderson, a neurologist hired by the defense, who testified that, on the basis of neurologic tests, including an electroencephalogram, there were organic abnormalities in Poddar's brain. [n36] At trial, Dr. Philip Grossi, a psychiatrist hired by the defense, Dr. Gruberg, Dr. Anderson, Dr. Moore, and Dr. Gold testified that Poddar was insane and a paranoid schizophrenic.

Dr. John Peschau, a court-appointed psychiatrist, testified that Poddar was not a paranoid schizophrenic and that he could understand the duty the law placed upon him. [n37] During

Dr. Moore's testimony, the details of Poddar's threats against Tanya and the attempt to secure an emergency commitment were revealed in open court. [n38] If Tanya's family members were unaware of these facts previously, then they certainly became aware of them at this time. It is not possible from the case reports to establish a temporal relationship between the testimony of Drs. Moore and Gold and the filing of the civil suit. However, their presentation for the defense at trial could not have established a cordial relationship with the family.

The jury convicted Poddar of murder in the second degree. Poddar appealed the decision on multiple grounds. The court of appeals heard the case in 1972 and focused on trial court instruction errors, including a failure to reinstruct the jury as follows: "Also, if you find that his mental capacity was diminished to the extent that you have a reasonable doubt whether he did harbor malice aforethought, you can not find him guilty of murder in either the first or second degree." The court reduced his conviction from murder in the second degree to manslaughter and remanded the case to the trial court to pronounce judgment. [n39] Two years later the California Supreme Court vacated the judgment of the appeals court, holding that the instructions given by the trial court, "failed to serve the needs of the jurors to understand and properly apply the evidence of diminished capacity to the underlying issues." [n40] The court concluded that the error was prejudicial and remanded the case for retrial.

Poddar was not retried. Rather than go through another lengthy trial (the first was over three weeks), more than five years after the fact, the state released Poddar on condition he immediately leave for India and not reenter the United States. He returned to India and, according to one commentator, is happily married to an attorney. [n41]

Vitaly and Lydia Tarasoff, Tanya's parents, filed wrongful death suits against the university and the psychotherapists. They alleged four causes of action. The first cause of action was directed against the therapists' failure to detain Poddar. The second was directed against the therapists' failure to warn the Tarasoffs that Poddar was a grave danger to Tanya. The third was directed against Dr. Powelson and sought punitive damages for his actions following the therapists' attempt at 72-hour emergency detention. Dr. Powelson's actions were characterized as "malicious and oppressive abandonment of a dangerous patient." The fourth cause of action was titled "Breach of Primary Duty to Patient and the Public," and involved essentially the same allegations as the first cause of action. [n42]

The Alameda County Superior Court issued "a judgment of dismissal upon an order sustaining a demurrer without leave to amend." [n43] The Tarasoffs appealed. The court of appeals affirmed the superior court judgment, ruling the first and fourth causes of action were statutorily barred. [n44] The court could find no special relationship between the defendants and Tanya or her parents and therefore found no duty to warn. [n45] The court ruled that Dr. Powelson had no duty to commit Poddar and, even if he did, such action was discretionary and protected under statute. [n46] The Tarasoffs appealed once more.

B. The First California Supreme Court Decision

The 1976 decision by the California Supreme Court, [n47] commonly thought of as the *Tarasoff* decision, actually represented the second time the court had considered the case. The first decision was rendered in 1974 [n48] and the second decision was the result of a rehearing granted in March of 1975. It is interesting that the second decision does not mention the first, nor does it give a reason for the rehearing. Justice Tobriner authored both decisions. The first decision held that the campus police could be found liable for a failure to warn Tanya. The second decision released them from all liability. The holdings in both cases essentially were the same with respect to the psychotherapists and were predicated on the same major arguments. The second decision provided therapists greater latitude to "protect" intended victims, rather than to "warn," as the only alternative. Certain other differences should be listed at the outset so that they may be considered as one reviews the final decision.

When the two cases are compared, one is initially struck by the number of amici curae listed in the second decision. The volume of concern and controversy stirred up by the first decision undoubtedly produced some rethinking and consideration by the Justices. This is further emphasized by the referral to "amicus" in the second decision. [n49] Two other changes in te second decision likely were influenced by the amicus briefs as well. First, more time was spent discussing the difficulty in predicting dangerous behavior and, second, less time was spent on the matter of the therapists' liability if they "reasonably should have predicted dangerous conduct." This reconsideration undoubtedly made a difference to Justice Mosk who joined the majority in the first decision, but wrote his own thoughtful opinion in the second decision.

One further argument and holding of the first opinion is not found in the second opinion. That argument asserted that, by "bungling" the attempt to confine Poddar, the therapists precipitated his discontinuance of therapy and thus put Tanya at increased risk. [n50] The first opinion indicated that the court would consider a second basis for liability as arising out of that sequence of events. No trace of that reasoning is found in the later opinion.

The second opinion follows the format established by Fleming and Maximov to a much greater extent than does the first. It is almost as if the court uses their law review article as intellectual justification for reaching its decision, seemingly made more independently the first time.

C. The Second California Supreme Court Decision

The plaintiffs asserted four causes of action in the 1976 case. The first cause of action was directed against the therapists' failure to detain Poddar. The second cause of action was directed against the therapists' failure to warn the Tarasoffs that Poddar presented a grave danger to Tanya. The third cause of action, directed against Dr. Powelson, sought punitive damages for his actions following the therapists' attempt at 72-hour emergency detention. The fourth cause of action was titled "Breach of Primary Duty to Patient and the Public" and involved essentially the same allegations as the first cause of action.

The court barred the first and fourth causes of action because section 856 of the Government Code afforded public entities and their employees absolute protection from liability for "any injury resulting from determining in accordance with any applicable enactment...whether to confine a person for mental illness." [n51] The court also held that Dr. Powelson's actions fell squarely within the granted immunity, [n52] and further, California statutes barred the recovery of punitive damages in a wrongful death action. Thus, the outcome of the case hinged on the second cause of action, the therapists' failure to warn Tanya or others likely to apprise her of her danger.

In exploring this issue, the court proceeded in much the same manner as did Fleming and Maximov. The court started its analysis with a consideration of the therapist's duty to third parties, and other than using Prosser [n53] and the *Restatement (Second) of Torts* [n54] to a greater extent than Fleming and Maximov, made the same general arguments. The court then took a short look at the difficulty in predicting dangerous behavior. Lip service was given to recognizing this difficulty and the court summarized its opinion as follows: "Obviously we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances.'"[n55] This observation provides minimal judicial notice of this principle, when compared to the decision in *Burnick*.

Confidentiality, too, was given a more superficial treatment than was the case in the article by Fleming and Maximov. A public interest argument was made for the loss of privilege, but the due process considerations and the effect on psychotherapy are ignored on the face of the opinion, although reference is made to Fleming and Maximov and to *Johnson*, where the issues are discussed. The court sums up its conclusion on the matter of confidential communication with the following statement: "The protective privilege ends where the public peril begins." [n56] The court obviously liked the ring of this phrase because it is repeated in both decisions.

The court next considered the question of governmental immunity from liability for failure to warn. The court relied heavily on *Johnson* to show that the therapists' failure to warn did not fall into the discretionary basic policy decision afforded absolute protection by Government Code section 820.2. The court concluded that it was only requiring of publicly employed therapists the quantum of care required of private therapists under the common law.

After completion of this analysis, the court concluded that the therapists could not escape liability because Tanya herself was not their patient. The court held:

When a therapist determines, or pursuant to the standards of his profession, should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended

victim or others likely to apprise the victim of the danger, to notify the police or to take whatever other steps are reasonably necessary under the circumstances. [n57]

Unfortunately, the court does not elaborate on the two determinants it establishes for these different duties to protect. Nor do we find further words characterizing the specific nature or circumstances of a case that will mandate protection of a potential victim. The supreme court reversed the superior court and remanded the case for decision consistent with the supreme court's decision without further explanation. [n58]

Justices Wright, Sullivan, and Richardson joined Justice Tobriner's decision. Justice McComb joined Justice Clark's dissent, and Justice Mosk concurred in the case but dissented with respect to part of the holding. Both the dissent and Justice Mosk's opinion are provocative. Justice Mosk's decision will be considered first.

Justice Mosk agreed that, under the limited circumstances of this particular case, Poddar's therapists had a duty to warn Tanya. While Justice Mosk personally believed that the therapists' duty to warn had been satisfied by warning the campus police, he considered this a factual matter to be raised by the defense on remand and he did not dissent on this basis. He dissented from the majority opinion, however, regarding inclusion of the phrase "standards of the profession" in its holding. Justice Mosk rightfully asked: "What standards?" He obviously had been reminded of his opinion in *Burnick* and quoted from that opinion. He realized that the court had recognized in *Burnick* that psychiatric predictions of violence were inherently unreliable. He inferred further that testimony the court found so untrustworthy so as to require a change in the civil commitment standard to proof beyond a reasonable doubt, should not have been used to assess the therapist's liability. Justice Mosk's short opinion is summed up in his final paragraph:

I would restructure the rule designed by the majority to eliminate all reference to conformity to standards of the profession in predicting violence. If a psychiatrist does in fact predict violence, then a duty to warn arises. The majority's expansion of that rule takes us from the world of reality into the wonderland of clairvoyance. [n59]

Justice Clark's dissent was based on a statutory privilege argument that had been addressed extensively by the majority. Obviously, Justice Clark was fighting a rear guard action against a change to which the legal commentators, the developing case law, and the majority were committed. Because his statutory argument adds nothing new and was more than adequately countered by the majority opinion, it is not fully detailed here. However, Justice Clark seemed intuitively to recognize and express many of the qualms and dilemmas of the therapist that were missed or ignored by the majority as well as by Fleming and Maximov.

He stated that overwhelming policy considerations weighed 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 rights and increase violence." [n60] He argued that, if the majority was correct and there was no statutory privilege except for conduct after commitment, then it was anomalous for the

court to reweigh the legislative intent and assign liability for the uncommitted, that is, less dangerous patients. He then contended, given the importance of confidentiality to the practice of psychiatry, it becomes clear that the duty to warn will cripple the effectiveness and use of psychiatry.

Many people, potentially violent---yet susceptible to treatment---will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and forcing the psychiatrist to violate the patient's trust will destroy the interpersonal relationship by which treatment is effected.... This predictive uncertainty means that the number of disclosures will necessarily be large. As noted above, psychiatric patients are encouraged to discuss all thoughts of violence, and often express such thoughts.... Now confronted by the Majority's new duty, the psychiatrist must instantaneously calculate potential violence from each patient on each visit. The difficulties researchers have encountered in accurately predicting violence will be heightened for the practicing psychiatrist dealing for brief periods in his office with heretofore nonviolent patients. And, given the decision not to warn or commit must always be made at the psychiatrist's civil peril, one can expect that most doubts will be resolved in favor of the psychiatrist protecting himself. Neither alternative open to the psychiatrist is in the public interest. [n61]

Justice Clark's last comment is literally the end of the *Tarasoff* decision: "We should accept legislative and medical judgment, relying on effective treatment rather than on indiscriminate warnings." [n62]

III. OTHER CASES

The duty to protect, which was enunciated in the *Tarasoff* case, was interpreted more broadly by several courts that purported to follow *Tarasoff*, so that the duty to protect is not uniform throughout the United States. The broadest interpretation occurred in 1980, in the case of *Lipari v. Sears, Roebuck & Co.* [n63] There, a patient attacked strangers with a shotgun in a crowded nightclub, without any advance warning given to his care providers. The patient was being treated in a Veterans Administration Hospital day care center. He never threatened any specific person, but did make it clear to his care providers that he was unhappy with the care he was receiving. He purchased a shotgun from Sears, Roebuck & Co., while still in treatment in the day care program; however, Lipari informed none of the members of the treatment team that he had bought the shotgun. He terminated his psychiatric treatment three weeks after the purchase and, a month or so later, he shot up the nightclub, blinding a woman and killing her husband. The federal district court in Nebraska allowed the plaintiffs to proceed in a lawsuit against the hospital. The court held that it was for the jury to decide whether the therapist knew or should have known of the patient's dangerous propensity. The court rejected the *Tarasoff* limitation to an identified victim. This case seemed to impose not only a duty on therapists to predict dangerousness, but a duty to protect society from "dangerous" patients.

Other progeny of *Tarasoff* broadened the duty by extending the protection to those persons who may foreseeably pose harm to persons other than the threatened victim. [n64] In *Joblonski v. United States*, [n65] the duty to protect was extended to include a therapist-patient relationship limited to the emergency setting. Under the facts of the case, a violent man was brought to the hospital by his girlfriend after he attempted to rape her mother. The psychiatrist concluded that the patient was a danger to others, but could not be committed under California's involuntary commitment statute. The past medical records of this man revealed that he was diagnosed as suffering from schizophrenia and had a long history of threatening and violent behavior; however, these records were not requested by the care providers at the time of his presentation. The girlfriend was warned to stay away from him if she feared him. He later killed her. The Ninth Circuit Court of Appeals concluded that the hospital failed to obtain important prior records and to adequately warn the victim.

The duty to warn or protect was extended to property in *Peck v. Counseling Service of Addison County*. [n66] In this Vermont case, a master's level counselor was told by his patient that he intended to burn down another person's barn. The court's opinion suggested that all mental health professionals had a duty to protect not only threatened victims, but their property as well.

While some courts broadened, others seemed to restrict the duty to protect. In *Brady v. Hopper*, [n67] a Colorado case involving John Hinckley's psychiatrist, the federal court wrote that an overt threat of violence toward a specifically identifiable victim was required before a therapist could be found liable. The Iowa court in *Votteler v. Heltsley* [n68] found no duty on the part of the therapist when the threatened victim already had reason to know of the potential danger. And, in the case of *Hosenei v. United States*, [n69] a Maryland federal court limited the duty to protect third parties only when the therapist had the right to commit the patient to the hospital.

Some courts, rather than broadening the duty, have extended the period of time between the patient's recognized potential for violence and the violent act. In *Naidu v. Laird*, [n70] the Supreme Court of Delaware found that five and one-half months after discharge from the hospital was not too long a period of time to support a finding of negligence when a psychiatrist was found liable for failing to foresee a patient's potential to act violently. George Laird was killed when Hilton Putney deliberately drove his automobile into Mr. Laird's vehicle. Mr. Putney had been diagnosed as suffering from paranoid schizophrenia some 18 years prior to the fatal accident. His psychiatric history included threats to kill his wife, attacks on hospital personnel, violent and abusive behavior, disorderly conduct, suicide attempts, intentionally ramming a police car with his automobile, driving off the road at high speed, and more than 19 mental hospital admissions. His course of treatment was marked by repeated failures to take his antipsychotic medications. In the Michigan case of *Davis v. Lhim*, [n71] the court considered a threat made by the patient two years prior to the violent act to be material. Both the *Naidu* and *Davis* courts found the foreseeability of a harm due to the patient's potential violence, rather than passage of time, to be the important issue in the reviewed cases.

Two decades after *Tarasoff*, the courts continued to reflect ambivalence about the duty articulated by the California court. In *Nasser v. Parker*, [n72] a Virginia Supreme Court decision handed down in 1995, the court found no "special relationship" between the psychiatrist and a patient who had voluntarily admitted himself to the hospital. Cases in Kansas, [n73] Missouri, n74 Mississippi, [n75] and North Carolina [n76] similarly concluded that there is a more limited duty to protect against the actions of patients voluntarily admitted to the hospital.

Some courts have required that the threat be clearly foreseeable. In the 1992 case of *Leonard v. Iowa*, [n77] the court stepped away from the *Lipari* broadly foreseeable standard in stating that the duty extended only to "reasonably foreseeable victims" and not to the general public.

More recently, courts have dismissed cases that revealed no evidence of an explicit threat. In *Leonard v. Latrobe Area Hospital*, [n78] a 1993 Pennsylvania case, a psychiatrist was found not to have a duty to protect the spouse of his hospitalized patient if no specific threats were made during the hospitalization. In this case, a patient was admitted with an overdose and expressed a great deal of hostility. However, he did not specifically identify the spouse as the intended victim. Two months after discharge from the hospital, the patient shot and killed the spouse. The facts of the case also revealed that the family was well aware of the patient's violent behavior.

Not only has the effect of the *Tarasoff* decision been profound in the field of psychiatry, but it has influenced decisions in fields far removed from psychiatry. There has been a continuum of cases based on its precedent that have promulgated a broad duty for health care practitioners to protect the general public from foreseeable harm. These cases have clustered around two central issues---the practitioner's duty to protect the public from a patient who presents a danger while driving a motor vehicle and the practitioner's failure to protect the public from a patient who may transmit an infectious disease. More recently, a third danger has appeared as a likely nidus for future cases---the practitioner's failure to protect the public from a patient who may transmit a genetically based disease. All three of these areas are worthy of discussion.

A. Driving Cases

In 1965, the Washington Supreme Court rendered its decision in *Kaiser v. Suburban Transit System*. [n79] There, Dr. Jack Faghin, a young general practitioner employed by Group Health Cooperative of Puget Sound, treated a patient with seasonal rhinitis with a then-popular antihistamine, pyribenzamine. Dr. Faghin failed to warn about the possibility of the drug inducing drowsiness. The patient was employed as a bus driver for Suburban Transit. Soon after beginning treatment, the patient fell asleep at the wheel of his bus and, in the ensuing accident, Ms. Kaiser was injured. Ms. Kaiser sued not only the bus driver and his employer, but Group Health Cooperative and Dr. Faghin as well. In affirming the physician's liability to third parties, the court instructed the jury: "[I]n the event it finds no warning was given the bus driver as to the side effects of the drug, it shall bring in a verdict against Group Health and the doctor." [n80]

The *Kaiser* court's decision was rather pragmatic. There is much discussion of the issues concerning a sleeping driver, but not much discussion of the medical-legal issues. Nonetheless, the case not only established a precedent for the duty to warn of the side effects of medication but for the physician's liability to third parties. *Kaiser* was followed in other jurisdictions both before [n81] and after [n82] the *Tarasoff* decision. A Texas court, in the case of *Gooden v. Tips*, [n83] offered an interesting explanation of the difference between the *Kaiser* decision and the *Tarasoff*-based driving cases in the following manner:

The holdings in those cases [the *Tarasoff*-based cases] were grounded on the fact that the physician had "taken charge" of a third person whom he knew or should have known was likely to cause bodily harm to others if not controlled, and thus under Restatement, Torts 2d § 319 was "under a duty to exercise reasonable care to control the third person to prevent him from doing such harm." Here there is no allegation that Dr. Tips had "taken charge" of Mrs. Goodpasture, nor is there any allegation that she was a person of violent or dangerous propensities. We hold only that, under the facts here alleged, Dr. Tips may have had a duty to *warn* his patient not to drive. [n84]

In light of the widespread adoption of the principles expounded in the *Kaiser* case, it is ironic that the Washington Supreme Court's decision in *Petersen v. State* [n85] is widely held as the first of the *Tarasoff*-based driving cases. Larry Knox was a paranoid schizophrenic with an extensive history that included depression, self-mutilation, drug abuse, and noncompliance with neuroleptic regimens. [n86] He was confined to a state mental hospital after cutting out his left testicle. He was placed on an antipsychotic drug. One day prior to the expiration of the term of his commitment, he was found driving his car in a reckless manner on the hospital grounds. His psychiatrist failed to renew his commitment and he was released to outpatient care. He promptly flushed his antipsychotic drug down the toilet and resumed his street drug use. Five days later, he drove through a red light at an excessive rate of speed (50-60 miles per hour) and hit a vehicle driven by Cynthia Petersen. Witnesses to the accident testified that Knox appeared to be under the influence of drugs. [n87] Petersen brought suit against the state charging that it negligently treated Knox by failing to protect her from his dangerous propensities and that the psychiatrist's failure either to seek additional confinement or disclose information about Knox's violation of his probation conditions was the proximate cause of her injuries. The jury agreed and rendered a verdict in her favor.

The state appealed, alleging among other issues, that: (1) the psychiatrist had no duty to protect the plaintiff from Knox's dangerous propensities; (2) the psychiatrist was forbidden by statute from communicating with Knox's probation officer or the superior court about Knox's violation of the conditions of his probation; and (3) the state was protected from liability by sovereign immunity. The court considered two questions regarding whether or not a state hospital psychiatrist has a duty to protect potential victims from dangerous propensities:

First, does a state hospital psychiatrist have a duty to seek additional confinement of a patient who remains potentially dangerous after initial hospitalization?

Second, under the specific circumstances of this case, was Dr. Miller required, or even allowed, to disclose information about the violation by Knox of the conditions of his parole to the Superior Court or to Knox's probation officer? [n88]

The Washington Supreme Court considered *Tarasoff* the seminal case in answering the first question. *Tarasoff* established the duty based on the special relationship of psychiatrist-patient to protect third parties from the dangerous propensities of the patient. The court then adopted the foreseeability standard set forth in *Lipari v. Sears, Roebuck & Co.* [n89] to hold that the psychiatrist had a duty to take reasonable precautions to protect anyone who might foreseeably be injured by Knox's drug-related mental problems.

The court answered the second question by quoting a Washington statute, which stated that information gained during involuntary commitment remains confidential, with certain specific exceptions. The psychiatrist was not allowed to communicate with the superior court or Knox's probation officer. Nonetheless, the court viewed as proper the jury instruction regarding this prohibition and found that both parties were able to argue their theory on a level playing field. With reasoning not unlike that in the *Tarasoff* case, the court ruled that the psychiatrist was not immune from liability and upheld the verdict in favor of the plaintiff.

Washington courts have addressed three subsequent driving cases in which plaintiffs have asserted *Petersen* protections: *Metlow v. Spokane Alcoholic Rehabilitation Center* [n90]; *Cox v. Malcom* [n91]; and *Johnson v. State*. [n92] The defendant in *Metlow* was a participant in the state's Driving While Intoxicated deferred prosecution program, receiving outpatient treatment at a private alcohol rehabilitation center. The Washington Court of Appeals was not persuaded that the rehabilitation center had either the duty or the control necessary to invoke the *Petersen/Tarasoff* standard. In *Cox*, the Washington Court of Appeals would not extend the duty to protect to the minor plaintiff's grandfather who had served alcohol to the driver of a car in which the plaintiff was a passenger. Finally, in *Johnson*, the defendant was on parole, conditioned on his treatment for substance abuse. Through an error in communication, the defendant was released rather than sent directly to the drug rehabilitation center. One week later, the defendant struck and killed the plaintiff. The Washington Court of Appeals did not believe the evidence supported a finding that a special relationship existed upon which a duty could be predicated. Accordingly, the plaintiff's case failed.

Although the plaintiff introduced the *Tarasoff* theory of negligence in the Oregon case of *Cain v. Rijken*, [n93] and the case is often listed as a *Tarasoff*-based driving case, [n94] the Oregon Supreme Court specifically avoided citation to the case in its decision. In 1978, Rijken was involved in a high-speed chase with the police through two Oregon counties, seriously damaging two cars when driving into oncoming lanes of traffic at 80 miles per hour. The trial court found Rijken was incompetent to stand trial and placed him in the custody of the Oregon Psychiatric Security Review Board (Board). The Board committed Rijken to the Oregon State Hospital. By 1980, Rijken was back in Portland enrolled as an outpatient at Providence Hospital. Providence cared for Rijken under a contract with the Board.

Rijken was recommitted for six weeks in April of 1980, but was released to outpatient care by the end of May. On December 26, 1980, Rijken admitted himself to Providence's residential treatment program because he feared loss of control. He was released from the facility on December 29, 1980, but called the following night and reported that he was experiencing auditory hallucinations. The next day, in a meeting with a Providence therapist, he reported having visual hallucinations. He missed an appointment on January 2, 1981, and, on January 4, 1981, he ran two red lights at over 70 miles per hour and collided with a car, killing Cain. Cain's estate then brought suit against Rijken, the State of Oregon, and Providence. The trial court granted Providence's motion for summary judgment. The court of appeals reversed and the case was appealed to the Oregon Supreme Court.

Oregon's high court first considered Providence's claim that it was an agent of the state and immune because its actions were discretionary. The court found that Providence's contracts with the state indicated that Providence acted independently of any direct control by the Oregon Psychiatric Security Review Board. Because there had been no evidence to the contrary introduced at the trial, it refused to decide the issue of immunity as a matter of law. Providence claimed it owed no duty to Cain. The court specifically refused to rest its decision on *Tarasoff* and its progeny.

We mention *Tarasoff et al.*, only to emphasize that we do not rest our decision in the case at bar on the common law principles on which those cases were founded. These decisions are essentially irrelevant because Providence's obligation is derived from the statutes defining the assignment Providence undertook for PSRB. [n95]

The court relied, instead, on Oregon Revised Statutes sections 161.336(6) and 161.336(10). The first of these statutes authorized Providence to take Rijken into custody if he was a substantial danger to others due to mental disease or defect and in need of immediate care, custody, or treatment. The second statute stated that, in determining whether or not a person should be committed, the safety of the public should be the primary concern. The court held that Providence's liability could not be determined as a matter of law and affirmed the decision of the appeals court.

The Wisconsin Supreme Court applied a foreseeability standard in adopting the *Tarasoff* decision in a driving case. The facts related in *Schuster v. Altenberg* [n96] are limited. Edith Schuster, a manic-depressive, was a patient of Dr. Altenberg, a psychiatrist. Ms. Schuster was driving and her daughter, Gwendolyn, was a passenger when a motor vehicle accident occurred. Edith was killed and Gwendolyn was rendered a paraplegic in the accident. Mr. Schuster and Gwendolyn then brought suit against Dr. Altenberg alleging: (1) negligent diagnosis and treatment; (2) failure to warn the patient's family of her condition and its dangerous implications; and (3) failure to seek commitment of the patient. The trial court dismissed the case on the pleadings and the Wisconsin Supreme Court agreed to review the case as a case of first impression.

The court considered the issues of improper diagnosis and treatment and the failure to warn to be directly related. The duty to warn the patient of dangerous side effects was

considered and both *Kaiser* and *Gooden* were cited. The court then considered the psychiatrist's duty to warn the family of Ms. Schuster's condition or its dangerous implications. The defendants argued that *Tarasoff* applied only where there was a readily identifiable victim. The court rejected that "narrow concept of duty" and found that the proper analysis of duty was the following:

A defendant's duty is established when it can be said that it was foreseeable that his act or omission to act may cause harm to someone. A party is negligent when he commits an act when some harm to someone is foreseeable. Once negligence is established, the defendant is liable for unforeseen consequences as well as foreseeable ones. In addition he is liable to unforeseeable plaintiffs. [n97]

The court held that Wisconsin negligence law precludes a holding that a psychiatrist does not have to warn third parties or to institute proceedings for the detention or commitment of a dangerous individual for the protection of the patient or the public.

The court then used *Tarasoff* to determine if there were any public policy issues to prevent the imposition of liability against Dr. Altenberg. The court considered that *Tarasoff* mandated a duty to protect, not specifically to warn, and that protection would include interventions such as reassessment, medication changes, or commitment. The court summarized its analysis as follows:

[T]here most assuredly exist meritorious public policy concerns regarding the imposition of liability upon psychotherapists for harm resulting from the dangerous acts of their patients. These arguments, including confidentiality, unpredictability of dangerousness of patients, concerns that patients are assured the least restrictive treatment and that imposition of liability will discourage physicians from treating dangerous patients, present significant issues of public policy. However, neither the possible impact that limited intrusion upon confidentiality may have upon psychotherapist-patient relations, nor the potential impact that the imposition of liability may have upon the medical community with respect to treatment decisions, warrants the certain preclusion of recovery in all cases by patients and by the victims of dangerous patients whose harm has resulted directly from the negligence of a psychotherapist. Accordingly, we find, for the reasons set forth above, that the complaint sets forth allegations as to which a jury could find negligence and cause-in-fact regarding: (1) negligent diagnosis and treatment, including failure to warn of side effects of medication; (2) failure to warn the patient's family members; and (3) failure to seek commitment. [n98]

The case was remanded to the trial court on the merits.

Myers v. Quesenberry [n99] is another California driving case that utilizes the *Tarasoff* reasoning. The defendants in this case were two physicians treating a young, pregnant, diabetic patient. The record indicates her diabetes was not under control. During a prenatal examination, the physicians failed to elicit the fetal heart beat. Fearing an intrauterine fetal death, a common complication in poorly controlled pregnant diabetics, they asked her to drive to a hospital for further tests. The patient left the office in an

emotional state and, either on her way to, or from, the hospital, she suffered a "diabetic attack" and struck the plaintiff.

The plaintiff sued the two physicians alleging that they negligently failed to warn their patient not to drive in an irrational and uncontrolled diabetic condition. The trial court dismissed the lawsuit and the plaintiff appealed. The California Court of Appeals heard the appeal. The court adopted the concept that a special relationship existed between a physician and patient and supported that concept with the following dictum from *Tarasoff.*

Such a relationship may support affirmative duties for the benefit of third persons. Thus, for example, a hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons. A doctor must also warn a patient if the patient's condition or medication renders certain conduct such as driving a car, dangerous to others. [n100]

The court went on to reason that the fact the plaintiff was a foreseeable, even though not a readily identifiable, victim of the patient's driving did not foreclose his cause of action against the two physicians. The court also gave credence to the point that, because the patient had been following the defendants' medical care advice, she also might have heeded their warning concerning driving. The court used the *Tarasoff* remedy to instruct the defendants on how to avoid liability. The physicians should have taken whatever steps were reasonable under the circumstances to protect the plaintiff and other foreseeable victims of their patient's dangerous driving. The court held that the physicians' alleged failure to give warning was sufficient legal basis for the plaintiff's lawsuit.

Finally, the case of *Mostert v. CBL & Associates* [n101] is considered by some to be a prime example of the extension of *Tarasoff* beyond the realm of psychiatry. The Mostert family was attending an evening movie in a Cheyenne movie theater owned by American Multi Cinema (AMC), located in a mall owned by CBL. While the Mosterts were in the theater and unaware of the happenings outside the theater, the National Weather Service, Cheyenne Civil Defense, and local law enforcement authorities were issuing warnings of severe thunderstorms, flash flooding, and tornadoes. Local officials ordered all citizens to stay inside and off the streets to avoid being injured or killed. AMC was aware of the warnings but did not communicate them to its patrons.

The Mosterts left the theater directly to the parking lot and their car unaware of the warnings. Only minutes later, their car was struck with flood waters and the Mosterts' seven-year-old daughter drowned while escaping from the car. The Mosterts brought suit against AMC and CBL. AMC argued that it had no duty to act or warn their patrons of an off-premises danger and the trial court dismissed the lawsuit. The plaintiffs stipulated to the dismissal of CBL to expedite appeal. The appeal was heard by the Wyoming Supreme Court.

The court conceded that landowners historically owed no duty to warn or take action to prevent harm to invitees when the risks involved were outside their premises. However,

the court found that there is no simple definition of duty and decided to depart from this traditional view. The court applied the factors used by the *Tarasoff* court to determine duty, foreseeability, closeness of the connection between the defendant's conduct and the injury suffered, the degree of certainty that the plaintiff suffered injury, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of burden on the defendant, consequences to the community and the court system, and the availability, cost, and prevalence of insurance for the risk involved.

Applying these factors, the court found that all the factors except the availability and cost of insurance for the risk justified imposition of a duty on AMC in favor of the Mosterts. The court refused to impose the same duty on CBL. AMC had possession and control of the theater and knowledge of the storm. A landowner cannot be held to be an insurer of every person who enters onto its property, which is exclusively under the possession and control of a tenant. The court reversed and remanded the case to the trial court as to AMC.

B. Infectious Disease Cases

Legal commentators have long considered the application of *Tarasoff* to infectious disease cases and specifically to AIDS cases. [n102] It was not until 1995, in the case of *Reisner v. Regents of the University of California,* n103 that the California Court of Appeals directly applied *Tarasoff* to such a case.

In April of 1985, 12-year-old Jennifer Lawson underwent surgery at the UCLA Medical Center. During the surgery or immediately thereafter, Jennifer received transfusions of blood and blood products (blood). The day following surgery, Jennifer's physician, Dr. Fonklesrud, and UCLA Medical Center, were informed that the blood given to Jennifer was contaminated with human immunodeficiency virus (HIV). Neither UCLA nor Dr. Fonklesrud told Jennifer or her parents about the HIV contamination or about the possibility of developing AIDS. Dr. Fonklesrud continued to treat Jennifer.

About three years later, Jennifer began dating Daniel Reisner. A short time later, the couple began sexual relations. Almost five years after the surgery, Jennifer was diagnosed with AIDS and informed about the UCLA transfusion. Jennifer and her parents immediately informed Daniel and his parents. Daniel was immediately tested for HIV. Approximately one month later, Jennifer died and Daniel was informed that he was HIV positive.

Daniel sued Dr. Fonklesrud and UCLA Medical Center for damages. The defendants conceded there was a duty to warn, but maintained that there was no duty to warn unidentifiable third parties. The defendants then moved for judgment on the pleadings (summary judgment) and the trial court granted the motion on the basis that no duty was owed to an unidentifiable third party. Daniel appealed from this judgment.

The appeals court held that the duty to warn established in *Tarasoff* dictated the result in *Reisner*. The court supported Daniel's claim that the defendants did not have to warn Daniel specifically but that they did have to warn Jennifer and her parents, who were

likely to apprise him of the danger. The fact that Jennifer and her parents had done just that when they learned of the diagnosis did much to confirm Daniel's contention.

The *Reisner* court next addressed the defendant's contention that, even if there were a duty to warn identifiable third parties, there was no duty to unidentified third parties. The court looked at the line of third-party liability cases and determined that third-party liability was not conditioned on the potential victims being readily identifiable as well as foreseeable. The court noted that Dr. Fonklesrud had continued to maintain a physician-patient relationship with Jennifer until she died, which occurred after Daniel's injury. The court considered this continued relationship and the foreseeability of Jennifer's likelihood of entering an intimate relationship as bases to negate the defendant's efforts to avoid liability due to the time lapse between the negligent act and Daniel's injury.

The *Reisner* court also considered relevant case law articulating the standard of care in communicable and infectious diseases. In *DiMarco v. Lynch Homes-Chester County*, [n104] a Pennsylvania hepatitis B case, the court affirmed a duty to third parties as follows:

Physicians are the first line of defense against the spread of communicable diseases, because physicians know what measures must be taken to prevent the infection of others.... Such precautions are taken not to protect the health of the patient whose well-being is already compromised, rather such precautions are taken to safeguard the health of others. Thus, the duty of a physician in such circumstances extends to those "within the foreseeable orbit of harm." ...If a third person is in that class of persons whose health is likely to be threatened by the patient, and if erroneous advice is given to that patient to the ultimate detriment of the third person, the third person has a cause of action against the physician, because the physician should recognize that the services rendered to the patient are necessary for the protection of the third person.

The *Reisner* court summarily dismissed several of the defendant's minor issues and, as a final analysis, considered the defendant's contention that finding a duty was owed to Daniel would open the floodgates of litigation by allowing fourth and fifth parties to sue. The court rejected the argument because the facts that favor Daniel in this case evidence how unlikely it is there are dozens of other Daniels waiting in the wings. Moreover, liability to fourth and fifth persons would, by its nature, be limited by traditional causation principles. The court went on to state the following:

However, the possibility of such an extension does not offend us, legally or morally. Viewed in the abstract (and *not* with reference to Jennifer or Daniel), we believe that a doctor who knows he is dealing with the 20th Century version of Typhoid Mary ought to have a very strong incentive to tell his patient what she ought to do and not do and how she should comport herself in order to prevent the spread of her disease. [n105]

The judgment of the trial court was reversed and the case was remanded for trial. Daniel was awarded his appeals costs.

Bradshaw v. Daniel [n106] is another case example of the application of *Tarasoff* to an infectious disease case. Elmer Johns was admitted to the hospital with complaints of headaches, muscle aches, fever, and chills. Although Rocky Mountain Spotted Fever was considered in the differential diagnosis and chloromycetin therapy started, the diagnosis was not confirmed until after Johns' death. Although the treating physician communicated with Johns' wife, he never mentioned the danger of exposure to Rocky Mountain Spotted Fever or that the disease had been the cause of Johns' death. One week after Johns' death, his wife was admitted with similar symptoms. The diagnosis of Rocky Mountain Spotted Fever was made but, despite treatment, she died three days later. There was no physician-patient relationship between Mr. Johns' physician and Mrs. Johns.

Mrs. Johns' son brought suit against Mr. Johns' physician, alleging that the physician's negligence in failing to advise Mrs. Johns that her husband died of Rocky Mountain Spotted Fever and her risk of exposure proximately caused her death. The defendant made both a motion to dismiss and a motion for summary judgment, arguing that, because there was no patient-physician relationship, there was no duty owed to Mrs. Johns and, therefore, no cause of action. Both motions were denied and the case went to trial. The jury found for the plaintiff and awarded $ 50,000. Both parties appealed and the question of the duty owed to Mrs. Johns eventually reached the Tennessee Supreme Court.

The court first noted that there is a general reluctance to countenance nonfeasance as a basis for liability and, therefore, the general rule is that one has no affirmative duty to warn those endangered by the conduct of another. The court then pointed out the "special relationship" exception in *Tarasoff* as it carved out an exception to this general rule. Next, the court discussed the myriad of liability cases involving either the physician's failure to diagnose a contagious disease or failure to communicate the contagious nature of the disease to those foreseeably at risk of exposure. The court conceded that Rocky Mountain Spotted Fever is not a contagious disease in the usual sense of the word. However, Mrs. Johns was as much at risk of contracting the disease as she would have been had it been a classic contagious disease. The court analyzed the case as follows:

Thus the case is analogous to the *Tarasoff* line of cases adopting a duty to warn of danger and the contagious disease cases adopting a comparable duty to warn. Here, as in those cases, there was a foreseeable risk of harm to an identifiable third party, and the reasons supporting the recognition of the duty to warn are equally compelling here. [n107]

The court concluded that the existence of the physician-patient relationship is sufficient to impose upon a physician an affirmative duty to warn identifiable third persons in the patient's immediate family against foreseeable risks emanating from a patient's illness. The court held Mr. Johns' physician owed Mrs. Johns a legal duty to warn of the risk of Rocky Mountain Spotted Fever.

C. Genetic Cases

Although, to date, there have been no applications of *Tarasoff* to genetic cases, the New Jersey case of *Safer v. Pack* [n108] makes that eventuality probable. There, the father was diagnosed with polyposis of the colon with carcinoma. Long after the father died, the daughter developed carcinoma of the colon with metastases. It was only after her father's records were examined that the daughter became aware of the details of her father's illness and its genetic propensities. The daughter sued the father's treating physician and the court found for the daughter.

The court held that the physician had a duty to warn family members of genetically transmissible diseases. The court found no impediment to warning those at risk of genetically transmissible diseases. This duty to protect third parties from potential patient-generated harm appears to be a natural forum for further application of *Tarasoff*.

IV. *TARASOFF*'S IMPACT ON THE PRACTICE OF PSYCHIATRY

Tarasoff has opened the doors of the judiciary to expanding concepts of duty and foreseeability beyond the expectations of either Justice Andrews or Justice Cardozo in their eloquent opinions in *Palsgraff v. Long Island R.R. Co.* [n109] There, a defendant's duty is established if his or her act or omission caused foreseeable harm. The minority opinion of Justice Andrews in this case expressed that, once negligence is established, the defendant is liable for unforeseeable harm and unforeseeable plaintiffs, as well. The *Reisner* case, in particular, is significant in that it increases the duty to avoid foreseeable harm to third persons whose identities are unknown to the physician and are not readily ascertainable. In addition to *Tarasoff*, the *Reisner* court cited *Myers*, which extended the duty to a foreseeable but not readily identifiable victim.

The duty of health care providers to third parties now goes well beyond the exclusive duty under earlier common law merely to their patients. The courts have extended the duty to situations that were unforeseeable, even by the *Tarasoff* court. The initial concerns regarding the psychiatrist's inability to predict violent behavior of the patient and the effect of abrogation of the duty of confidentiality on the practice of psychotherapy have been overshadowed by the application of the *Tarasoff* doctrine in the driving cases and the more recent AIDS cases.

Mental health professionals have become more sensitive to this expanded duty and have become attentive to the issues raised by *Tarasoff* and its progeny. The American Psychiatric Association and its local branches have been active in promulgating model statutes addressing the legal issues in hopes of clarifying the duty for practicing mental health professionals, while preserving the sanctity of the therapist-patient relationship. Only a few studies have attempted to assess the impact of the *Tarasoff* decision on psychiatric practice. It is, however, now clear that the concerns about the potential loss of confidentiality have not had the adverse impact on psychiatric practice that the amici curiae and Justice Clark's strong dissent in *Tarasoff* predicted. Ultimately, *Tarasoff* has stimulated greater awareness of the violent patient's potential for acting out such behavior, encouraging closer scrutiny and better documentation of the therapist's examination of this issue.

The discharge of this duty to any potential victim based upon *Tarasoff II* allows the therapist far more flexibility, based upon reasonable care to protect an intended victim. The therapist may use discretion to take a variety of steps including a warning to the intended victim or to others who are likely to apprise the victim of danger. Further, the police may be notified or other steps taken, which are appropriate under the circumstances.

Alan Stone, commenting on the *Tarasoff* decision in 1976, stated that this decision would lead to more danger by discouraging patients from seeking treatment and/or chilling patients' willingness to discuss issues of violence with their therapists. [n110] Unfortunately, no definitive study has been done to test Stone's hypothesis, although the studies that have attempted to focus on these questions, discussed later in this article, have not revealed the detrimental impact that Stone prophesied.

Paul Appelbaum has stated that "no court decision in the last generation has succeeded in so raising the anxieties of mental health professionals" as has the *Tarasoff* decision. "The ill-defined nature of the duty to protect has led to great confusion about clinicians' obligations." [n111] Appelbaum opined that therapists were overreacting to *Tarasoff* and its progency in their efforts to protect threatened victims or in avoiding contact with violent patients altogether.

Based on such concerns, in 1987, the Council on Psychiatry and Law of the American Psychiatric Association (APA) developed a Model Statute as a resource for its district branch chapter members to use in stimulating legislative action. This Model Statute attempted to balance public safety with the needs and concerns of the mental health professions. It was approved by the Board of Trustees of the APA in June of 1987 and distributed to the membership. It stated, as follows:

Duty of [Physicians] to Take Precautions Against Patient Violence.

1. *Scope of cause of action*. Except as provided in paragraph 5, no cause of action shall lie against a [physician], nor shall legal liability be imposed, for breaching a duty to prevent harm to person or property caused by a patient unless a) the patient has communicated to the [physician] an explicit threat to kill or seriously injure a clearly identified or reasonably identifiable victim or victims, or to destroy property under circumstances likely to lead to serious personal injury or death, and the patient has the apparent intent and ability to carry out the threat; and b) the [physician] fails to take such reasonable precautions to prevent the threatened harm as would be taken by a reasonably prudent [physician] under the same circumstances. Reasonable precautions include, but are not limited to, those specified in paragraph 2.

2. *Legally sufficient precautions*. Any duty owed by a [physician] to take reasonable precautions to prevent harm threatened by a patient is discharged, as a matter of law, if the [physician] either a) communicates the threat to any identified victim or victims; or b) notifies a law enforcement agency in the vicinity where the patient or any potential victim

resides; or c) arranges for the patient to be hospitalized voluntarily; or d) takes legally appropriate steps to initiate proceedings for involuntary hospitalization.

3. *Immunity for disclosure*. Whenever a patient has explicitly threatened to cause serious harm to person or property, or a [physician] otherwise concludes that a patient is likely to do so, and the [physician], for the purpose of reducing the risk of harm, discloses any confidential communications made by or relating to the patient, no cause of action shall lie against the [physician] for making such disclosure.

4. *Definitions*.

a. For purposes of this [section], "patient" means any person with whom a [physician] has established a [physician]-patient relationship.

b. For purposes of this [section], ["physician"] means a person licensed to practice medicine in this state.

5. *Limited applicability of this section*. This section does not modify any duty to take precautions to prevent harm by a patient that may arise if the patient is within the custodial responsibility of a hospital or other facility or is being discharged therefrom. [n112]

Many states, before and after the promulgation of APA's Model Statute, enacted laws limiting a therapist's liability so long as certain specific actions are taken by the therapist when a patient threatens violence. California enacted a statute in 1985 wherein the therapist may gain immunity from liability if reasonable efforts are made to warn the potential victim and the local police are contacted. [n113] Such statutes have sought to reconcile the competing policy concerns for public safety, while limiting intrusion into the therapeutic relationship. Alan Stone commented on this development that "the duty to warn is not as unmitigated a disaster for the enterprise of psychotherapy as it once seemed to critics like myself." [n114]

Most of these protective disclosure (or anti-*Tarasoff*) statutes require an actual threat toward an identifiable victim, with immunity under circumstances similar to the California statute (contacting the victim, police, or both). The need for such statutes to guide therapists has been underscored by court decisions that seem to reflect no uniformity in the duty to warn or protect, and vary from a specific and clear threat of violence against an identifiable victim [n115] to the most vague, with not even a threat or designated victim revealed when violence may be foreseeable. [n116] In states where no protective disclosure statute exists, the therapist must be familiar with case law in the state where he or she practices, as reliance on *Tarasoff* alone is not enough. [n117] No litigation involving psychotherapy has been more active than the lawsuits citing *Tarasoff*. The result has been a steady expansion of the duty to protect third parties. The *Tarasoff* case seems conservative by comparison with its progeny. The driving cases and the *Reisner* case reviewed earlier in this article represent a significant overdetermination and expansion of duty originally envisioned by the *Tarasoff* court. According to Appelbaum,

the standard of care as a measure of liability has evolved into a strict liability standard. [n118]

Concern exists about the vagueness and breadth of the duty resulting from the *Tarasoff* progeny, in that the psychotherapist may believe he or she must take all reasonable steps to protect potential victims. Consequently, the therapist is left with uncertainty about whether the duty has been fully discharged. After all, strict liability might be imposed if the threatened act of harm occurs and the therapist had not taken some additional step in protecting the harmed victim.

The APA Model Statute provides some flexibility with respect to exercising that duty, including involuntary hospitalization. Most statutes addressing this issue specify how this duty may be discharged in order to acquire immunity. Appelbaum et al. had opined that such specificity "may encourage a limited repertoire of responses when other measures may be clinically indicated in the service of patients' needs." [n119] Therefore, in addressing this concern, the APA Model Statute requires the therapist to "take such reasonable precautions to prevent the threatened harm as would be taken by a reasonably prudent [therapist] under the same circumstances. [P]recautions include, but are not limited to, those specified." Although confidentiality is one of the major underpinnings of psychotherapy, the trend of cases clearly suggests that courts regard the safety of the public as superior to confidentiality in therapy when the two issues are in conflict. [n120]

A. The Surveys

Simon warned that an uncertain legal environment creates danger that an "iatrogenic liability neurosis can take hold of the therapist's professional judgment." [n121] He suggested, however, that

it is the rare legal problem in the psychiatric treatment of patients that cannot be productively addressed through the utilization of good clinical practice and knowledge of pertinent legal issues. The trick is to render unto Caesar that which is Caesar's, but to never lose sight of the primary duty of the therapist: to render good clinical care to the patient. [n122]

Appelbaum expressed these concerns in more optimistic terms: "Clinicians have learned to live with *Tarasoff*, recognizing that good common sense, sound clinical practice, careful documentation, and a genuine concern for the patients are almost always sufficient to fulfill their legal obligations." [n123]

One survey of California psychotherapists [n124] found that they increased their efforts to evaluate potential for violence in their patients after the *Tarasoff* decision. The study found that therapists had a heightened awareness of and concern about potentially violent behavior. Roth and Meisel reported the first clinical data on *Tarasoff*-type situations, wherein one of four emergency room *Tarasoff*-type cases involved warning a potential victim. [n125] They attached importance to the informed consent doctrine, indicating that they did not warn potential victims without obtaining the patient's consent. McNiel and

Binder noted that, between 1973 and 1983, there was a large increase in the use of dangerousness as grounds for civil commitment. [n126] They attributed this increase to professional sensitivity to the issue of potential violence due to the *Tarasoff* case. They intimated that psychiatrists also may have used involuntary hospitalization as a way of protecting themselves from future lawsuits.

In a later study by Binder and McNiel, of 27 cases at the University of California, San Francisco, based upon interviews of residents' experiences in situations involving *Tarasoff*-type warnings to third parties, almost half of the 46 residents in this large university program had issued *Tarasoff* warnings. [n127] Their study suggests that California law is being interpreted by clinicians in a way that encourages warnings even when the patient may be hospitalized. Their survey also found that warnings generally were appreciated by the potential victims and had little effect on the therapeutic relationship. Actually, most of the potential victims already knew of the threats and had taken steps to avoid the violent patient.

Unfortunately, there is no accepted legal standard for the assessment of the risk of potential harm to a third party by a therapist. [n128] Givelber noted that most cases, in which assessment of risk was involved, turned on whether or not the therapist failed to gather information that would have made a reasonable effort at prediction possible, rather than what action ultimately was taken. [n129] For most patients, attempts to gather such information will produce data of little clinical interest. [n130] But for some patients, according to a large survey of private practitioners, [n131] information gathered may elicit concern and lead to appropriate protective actions.

Rosenhan surveyed 1,800 California psychotherapists a decade after *Tarasoff*. [n132] Although 85% of the respondents were familiar with *Tarasoff*, there was confusion regarding what the law required, despite the fact that 90% of clinicians had warned a potential victim. Nearly all respondents indicated they would have warned potential victims due to ethical obligations even if the law did not require them to do so. The results in this survey also reflected a greater cautiousness in accepting such patients for treatment, a trend toward seeking consultation with colleagues, and a heightened anxiety about being sued.

Beck's earlier survey, soon after *Tarasoff*, did not find the *Tarasoff* duty to be an onerous task to academic psychiatrists due to relative availability of colleagues with whom to discuss the cases and the plethora of available services and facilities in a university setting. [n133] Typically, these academically based clinicians chose commitment when the threat of violence was considered imminent, and to warn the potential victim when violence was considered not imminent, unlikely, or was vague.

Assessing the effect of *Tarasoff* and its progeny upon the practice of psychotherapy is difficult. The three major surveys, [n134] two of which were done after *Tarasoff II*, [135] may be summarized as follows:

1. The Wise Survey, 1978:

a. Prior to *Tarasoff II*, 50% of therapists issued warnings; after *Tarasoff II*, 38% issued warnings.

b. Therapists had increased sensitivity to probing for violence in their patients.

c. A small minority of therapists rejected violent patients and discussion of violence for fear of liability.

2. The Givelber Survey, 1980:

a. Therapists aware of *Tarasoff* were more likely to warn potential victims.

b. Seventy to eighty percent of therapists believed there was an ethical duty to protect even before *Tarasoff*.

c. Therapists continued to treat violent patients.

d. Therapists accepted the concept that societal safety was more important than confidentiality.

e. Therapists often went beyond warning the potential victim to protect.

3. The Rosenhan Survey, 1987:

a. Eighty-five percent of therapists were aware of *Tarasoff*, but were confused about what was required by the law.

b. Ninety percent of therapists had warned a potential victim.

c. Almost all therapists believed their duty to warn was based on an ethical obligation, regardless of the law.

d. Therapists were more cautious in treating violent patients.

e. There was an increased trend among therapists toward seeking informal consultation with colleagues.

f. There was heightened fear of litigation among therapists.

Smaller studies suggest that therapy is not hindered by warranted breaches of confidentiality, so long as the patient is involved in the decision and/or appropriately informed. [n136] There has been no evidence that patients have been unnecessarily hospitalized. [n137] Nevertheless, the mechanisms recommended in protective statutes---warning the victim and police---are rarely utilized in favor of hospitalization.

B. Confidentiality

Although confidentiality is considered sacred in the psychotherapeutic relationship, two decades before *Tarasoff*, a study of the issue of confidentiality by Little and Strecker revealed that, when the possibility of imminent violence on the part of the patient existed, 32% of psychiatrists said they would report this to the police, and 18% said they would hospitalize the patient.[138] Thus, 50% were willing to breach confidentiality in the face of imminent violence to third parties even before *Tarasoff*. Also, well before *Tarasoff*, prominent psychiatrists, including Karl Menninger and Seymour Halleck, had expressed the belief that to reveal confidential information under circumstances where violence was imminent was neither a breach of trust nor unethical.[139]

CONCLUSION

Considering the current state of the law and ethical pronouncements regarding the expanded duty to society, while maintaining trust within the therapist-patient relationship, therapists today must reflect on how best to assess and document potential violence to third parties. Therapists must then consider how to warn or protect within the confines of sound clinical judgment while adhering to this new legal duty. In light of developing case law, which is articulating a near strict liability standard in the continuing trend to compensate third parties, therapists must attend to this issue with greater sensitivity and detail. Past medical records, where applicable, must be thoroughly reviewed; past therapists and referral sources must be queried where appropriate. Consultations and second opinions must be sought when threats of violence occur or when there is question about competence to drive, as part of outpatient management, as well as in-patient discharge planning.

A wide array of options must be considered in managing the risks considered, including hospitalization, warnings, more frequent therapy sessions, starting or increasing medication, and/or close monitoring. The approach should be similar to management of an acutely suicidal patient, regarding the handling of the concern for the patient's acting out the threat.

If such a careful and reasonable approach is taken, including documentation of the assessment of the pertinent issues and treatment plan, then the therapist should not be held liable, even if harm should occur to a third party. If therapists view potential violent behavior toward third persons as a therapeutic issue in alliance with the patient (for example, exploring with the patient what it would mean if the violence were to be acted upon), then not only will the risk be lowered, but the clinical issues will have been addressed. Before breaching confidentiality, all therapeutic approaches must be considered by therapist and patient. Only if such efforts seem unlikely to provide adequate protection should confidentiality be breached, and then only after advising the patient of the plan.

Based upon the case law and surveys over the past 25 years, even if confidentiality must be breached, the earlier anticipated negative effects have not materialized. There is just no evidence thus far that patients have been discouraged from coming to therapy, or discouraged from speaking freely once there, for fear that their confidentiality will be

breached. Nor is there empirical evidence that such protections instituted by therapists have been ineffective. Moreover, the majority of therapists have not been driven away from treating potentially violent patients who seek help. Patients accept the limits of confidentiality in their use of psychotherapy. Empirical data to address definitively many of these earlier questions and fears must await further studies due to the fact that the base rate of violence by psychiatric patients is so low. [n140]

Fleming and Maximov had articulated the double bind in which therapists would find themselves when there was potential of harm to a third party, believing that the therapist would be vulnerable to litigation no matter what course of action was chosen. The data so far, although not conclusive, suggest that therapists are neither abandoning their obligations to their patients nor to society in taking protective actions. Earlier concerns about disruption of treatment have been overblown. Unfortunately, the studies thus far have been based upon information primarily obtained from direct questions posed to therapists.

As Rudegeair and Appelbaum [n141] have suggested: "Given that therapists are likely to be reluctant to describe any history of abandonment' when asked on a questionnaire, the demonstration of this predicted outcome would require a more oblique research instrument." Nevertheless, from these studies thus far, it is suggested that absolute confidentiality is not a prerequisite for a trusting therapy relationship, so long as the limits of confidentiality are discussed with the patient. Although confidentiality is an integral part of therapy, patients accept therapists' legal and ethical obligations to society. As Slovenko has stated:

Trust---not absolute confidentiality---is the cornerstone of psychotherapy. Talking about a patient or writing about him without his knowledge or consent would be a breach of trust. But imposing control where self-control breaks down is not a breach of trust when it is not deceptive. And it is not necessary to be deceptive. [n142]

REFERENCES:

[n1] Tarasoff v. Regents of the Univ. of Cal., 118 Cal. Rptr. 129 (Cal. 1974) (*Tarasoff I*), *modified by* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976) (*Tarasoff II*).

[n2] 403 A.2d 500 (N.J. 1979).

[n3] John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025 (1974).

[n4] Tarasoff v. Regents of the Univ. of Cal., 108 Cal. Rptr. 878 (Cal. App. 1973).

[n5] *Tarasoff I*, 118 Cal. Rptr. at 129.

[n6] 322 F. Supp. 745 (E.D. Pa. 1971).

[n7] Fleming & Maximov, *supra* note 3, at 1030.

[n8] 104 Cal. Rptr. 505 (Cal. 1972).

[n9] 384 U.S. 436 (1965).

[n10] Fleming & Maximov, *supra* note 3, at 1060.

[n11] *Id.* at 1067.

[n12] 477 P.2d 352 (Cal. 1968).

[n13] *Id.* at 355.

[n14] *Id.* at 363.

[n15] 535 P.2d 352 (Cal. 1975).

[n16] *Id.* at 359.

[n17] Stone indicates that Poddar was studying marine architecture. None of the case sources indicate his course of study. Alan Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

[n18] People v. Poddar, 518 P.2d 342, 344 (Cal. 1974) (*Poddar II*).

[n19] *Id.*

[n20] *Id.*

[n21] People v. Poddar, 103 Cal. Rptr. 84, 86 (Cal. App. 1972) (*Poddar I*).

[n22] *Poddar II*, 518 P.2d at 344.

[n23] *Tarasoff*, 108 Cal. Rptr. at 880.

[n24] *Id.*

[n25] *Id.*

[n26] *Id.*

[n27] Although the cases do not readily reveal it, another source indicates that, shortly after his release, Poddar persuaded Tanya's brother, who was unaware of the risk Poddar posed, to share an apartment with him near Tanya's residence. Allen Wilkinson, *Psychiatric Malpractice: Identifying Areas of Liability*, TRIAL, Oct. 1982, at 74.

[n28] *Poddar I*, 103 Cal. Rptr. at 86.

[n29] *Poddar II*, 518 P.2d at 345.

[n30] *Tarasoff I*, 118 Cal. Rptr. at 135.

[n31] He stabbed her 17 times into the lung, kidney, and liver. *Poddar I*, 103 Cal. Rptr. at 91.

[n32] *Poddar II*, 518 P.2d at 345.

[n33] *Poddar I*, 103 Cal. Rptr. at 86.

[n34] *Poddar II*, 518 P.2d at 348.

[n35] *Id.* at 344.

[n36] *Id.* at 348.

[n37] *Id.* n.13.

[n38] *Poddar I*, 103 Cal. Rptr. at 93.

[n39] *Id.*

[n40] *Poddar II*, 518 P.2d at 350.

[n41] Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L. J. 263 (1982).

[n42] *Tarasoff*, 108 Cal. Rptr. at 881.

[n43] *Id.* at 880.

[n44] *Id.* at 881-86.

[n45] *Id.* at 886.

[n46] *Id.* at 887.

[n47] *Tarasoff II*, 551 P.2d at 334.

[n48] *Tarasoff I*, 118 Cal. Rptr. at 129.

[n49] *Tarasoff II*, 551 P.2d at 345.

[n50] *Tarasoff I*, 118 Cal. Rptr. at 131.

[n51] *Tarasoff II*, 551 P.2d at 351.

[n52] *Id.* at 352.

[n53] WILLIAM L. PROSSER, THE LAW OF TORTS (3d ed. 1967 & 4th ed. 1971).

[n54] RESTATEMENT (SECOND) OF TORTS (1965).

[n55] *Tarasoff II*, 551 P.2d at 345.

[n56] *Id.* at 347.

[n57] *Id.* at 350.

[n58] The case never actually went to trial, but was settled on terms "within the range for wrongful death of a college girl" on July 1, 1977, one year to the day after the second *Tarasoff* decision. Merton, *supra* note 41.

[n59] *Tarasoff II*, 551 P.2d at 354.

[n60] *Id.*

[n61] *Id.* at 361.

[n62] *Id.* at 362.

[n63] 497 F. Supp. 185 (D. Neb. 1980).

[n64] *See, e.g.*, Hedlund v. Superior Court of Orange County, 669 P.2d 41 (Cal. 1983).

[n65] 712 F.2d 391 (9th Cir. 1983).

[n66] 499 A.2d 422 (Vt. 1985).

[n67] 570 F. Supp. 1333 (D. Colo. 1983).

[n68] 327 N.W.2d 759 (Iowa 1982).

[n69] 541 F. Supp. 999 (D. Md. 1982).

[n70] 539 A.2d 1064 (Del. 1988).

[n71] 335 N.W.2d 481 (Mich. App. 1983).

[n72] 455 S.E.2d 502 (Va. 1995).

[n73] Hokenson v. United States, 868 F.2d 372 (10th Cir. 1989).

[n74] Matt v. Burrell, 892 S.W.2d 796 (Mo. App. 1995).

[n75] Burchfield v. United States, 750 F. Supp. 1312 (S.D. Miss. 1990).

[n76] King v. Durham County Mental Health and Devel. Disabilities and Substance Abuse Auth., 439 S.E.2d 771 (N.C. App. 1994).

[n77] 491 N.W.2d 508 (Iowa 1992).

[n78] 625 A.2d 1228 (Pa. Super. Ct. 1993).

[n79] 398 P.2d 14 (Wash. 1965).

[n80] *Id.* at 15.

[n81] *See* Freese v. Lemon, 210 N.W.2d 576 (Iowa 1973).

[n82] *See* Watkins v. United States, 589 F.2d 214 (5th Cir. 1979); Davis v. Mangelsdorf, 673 P.2d 951 (Ariz. App. 1983); Meyers v. Quesenberry, 193 Cal. Rptr. 733 (Cal. App. 1983); Joy v. Eastern Maine Medical Center, 529 A.2d 1364 (Me. 1987); Welke v. Kuzilla, 375 N.W.2d 403 (Mich. App. 1985); Wharton Transport v. Bridges, 606 S.W.2d 521 (Tenn. 1980); Gooden v. Tips, 651 S.W.2d 364 (Tex. App. 1983).

[n83] *Gooden*, 651 S.W.2d at 364. In the case of Praesel v. Johnson, 967 S.W.2d 391 (Tex. 1998), the validity of the court's ruling in *Gooden* was substantially undermined. Nevertheless, other state courts have relied on *Gooden* in establishing common law.

[n84] *Gooden*, 651 S.W.2d at 370.

[n85] 671 P.2d 230 (Wash. 1983).

[n86] Larry Knox also was a convicted burglar who was on probation at the time of his hospital admission. A condition of his probation was that he refrain from using controlled substances. Knox's treating psychiatrist was well aware of his continued use of controlled substances. *Id.* at 234-35.

[n87] Subsequent to the accident, Knox killed Mr. and Mrs. Hibberd and raped their daughter. The trial court allowed this information to be introduced as rebuttal to the treating psychiatrist's testimony. *Id.* at 243.

[n88] *Id.* at 236.

[n89] 497 F. Supp. 197 (D. Neb. 1980).

[n90] 781 P.2d 498 (Wash. App. 1989).

[n91] 808 P.2d 758 (Wash. App. 1991).

[n92] 841 P.2d 1254 (Wash. App. 1992).

[n93] 717 P.2d 140 (Or. 1986).

[n94] *See* Roderick Pettis, Tarasoff *and the Dangerous Driver: A Look at the Driving Cases*, 20 BULL. AM. ACAD. PSYCH. & L. 427, 429 (1992); Roderick Pettis & Thomas Gutheil, *Missapplication of the* Tarasoff *Duty to Driving Cases: A Call for Reframing the Theory*, 21 BULL. AM. ACAD. PSYCH. & L. 263, 271 (1993).

[n95] *Cain*, 717 P.2d at 147.

[n96] 424 N.W.2d 159 (Wis. 1988).

[n97] *Id.* at 164.

[n98] *Id.* at 175.

[n99] 192 Cal. Rptr. 583 (Cal. App. 1983), *republished*, 193 Cal. Rptr. 733 (Cal. App. 1983).

[n100] *Myers*, 193 Cal. Rptr. at 735.

[n101] 741 P.2d 1090 (Wyo. 1987).

[n102] *See* Kenneth Labowitz, *Beyond* Tarasoff: *AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495 (1990).

[n103] 37 Cal. Rptr. 2d 518 (Cal. App. 1995).

[n104] 583 A.2d 422, 424 (Pa. 1990).

[n105] *Reisner*, 37 Cal. Rptr. 2d at 523.

[n106] 854 S.W.2d 865 (Tenn. 1993).

[n107] *Id.* at 872.

[n108] 677 A.2d 1188 (N. J. Super. 1996). *Cf.* Pate v. Threkel, 640 So. 2d 183 (Fla. App. 1994) (declining to find a duty to warn a child of a genetically transferable disease;

because the Florida Supreme Court did not publish its decision and *Tarasoff* was not followed by the court of appeals, it is not discussed here).

[n109] 162 N.E. 99 (N.Y. 1928).

[n110] Alan Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

[n111] Paul Appelbaum et al., *Statutory Approaches to Limiting Psychiatrists' Liability for Their Patients' Violent Acts*, 146 AM. J. PSYCHIATRY 821 (1989).

[n112] *Id.* at 827-28.

[n113] CAL. CIV. CODE § 43.92.13 (1985).

[n114] ALAN STONE, LAW, PSYCHIATRY AND MORALITY: ESSAYS AND ANALYSIS 181 (1984).

[n115] Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984).

[n116] Lipari v. Sears, Roebuck and Co., 497 F. Supp. 185 (D. Neb. 1980).

[n117] Alan Felthous, *Duty to Warn or Protect: Current Status for Psychiatrists*, 21 PSYCHIATRIC ANNALS 591 (1991).

[n118] Paul Appelbaum, *The Expansion of Liability for Patients' Violent Acts*, 35 HOSP. COMM. PSYCHIATRY 13 (1984).

[n119] Appelbaum et al., *supra* note 111, at 826.

[n120] Jerome Beigler, Tarasoff *v. Confidentiality*, 2 BEHAV. SCI. & L. 273 (1984). *But see* Thapar v. Zezulka, 994 S.W.2d 635 (Tex. 1999) (holding no duty to warn where Texas Health and Safety Code mandates confidentiality).

[n121] ROBERT SIMON, CLINICAL PSYCHIATRY AND THE LAW xxiv (1987).

[n122] *Id.* at xxv.

[n123] PAUL APPLEBAUM, *Implications of* Tarasoff *for Clinical Practice*, *in* THE POTENTIALLY VIOLENT PATIENT AND THE *TARASOFF* DECISION IN PSYCHIATRIC PRACTICE 94-106 (James Beck ed. 1985).

[n124] Toni Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165 (1978).

[n125] Loren Roth & Alan Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508 (1977).

[n126] Dale McNiel & Renee Binder, *Violence, Civil Committment, and Hospitalization*, 174 J. NERV. & MENTAL DIS. 107 (1986).

[n127] Renee Binder & Dale McNiel, *Application of the* Tarasoff *Ruling and Its Effect on the Victim and the Therapeutic Relationship*, 47 PSYCHIATRIC SERV. 1212 (1996).

[n128] Daniel Givelber et al., Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443.

[n129] *Id.* at 443.

[n130] John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511 (1992).

[n131] Wise, *supra* note 124.

[n132] David Rosenhan et al., *Warning Third Parties: The Ripple Effects of* Tarasoff, 24 PAC. L.J. 1165 (1993).

[n133] James Beck, *When the Patient Threatens Violence: An Empirical Study of Clinical Practices After* Tarasoff, 10 BULL. AM. ACAD. PSYCH. & L. 189 (1982).

[n134] Wise, *supra* note 124; Givelber et al., *supra* note 128; Rosenhan et al., *supra* note 132.

[n135] Wise, *supra* note 124; Givelber et al., *supra* note 128.

[n136] Beck, *supra* note 133; James Beck, *Violent Patients and the* Tarasoff *Duty in Private Psychiatric Practice*, 13 J. PSYCH. & L. 361 (1985); Binder & McNiel, *supra* note 127; Dale McNiel et al., *Management of Threats of Violence Under California's Duty to Protect Statute*, 155 AM. J. PSYCHIATRY 1097 (1998).

[n137] Paul Appelbaum, *The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence*, 145 AM. J. PSYCHIATRY 779 (1988).

[n138] R. Little & E. Strecker, *Moot Questions in Psychiatric Ethics*, 113 AM. J. PSYCHIATRY 455 (1956).

[n139] KARL MENNINGER, A MANUAL FOR PSYCHIATRIC CASE STUDY 40 (1952); SEYMOUR HALLECK, LAW IN THE PRACTICE OF PSYCHIATRY: A HANDBOOK FOR CLINICIANS 76-77 (1980).

[n140] Beck, *supra* note 133.

[n141] Thomas Rudegeair & Paul Appelbaum, *On the Duty to Protect: An Evolutionary Perspective*, 20 BULL. AM. ACAD. PSYCH. & L. 419 (1992).

[n142] Ralph Slovenko, *Psychotherapy and Confidentiality*, 24 CLEVE. ST. L. REV. 375, 395 (1975).