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Currie v. United States and the Elusive "Duty to Commit" Dangerous Mental Patients: Conflicting Views of North Carolina Law From the Federal Courts

On a hot August afternoon in 1982, a mentally ill outpatient of the Durham Veterans Administration Hospital launched a one-man invasion of the IBM offices in North Carolina's Research Triangle Park. Armed with bombs and a .45 caliber semi-automatic rifle and wearing Army fatigues, Leonard Avery stormed the building that housed the company's medical facility. During his rampage he shot several IBM employees, killing Ralph Augustus Glenn, Jr.[1] In the wake of the disaster, Glenn's widow Linda Currie filed a lawsuit against the United States government. In *Currie v. United States*[2] she alleged that the negligence of the Veterans Administration psychotherapists in failing to commit Avery was responsible for her husband's death.[3] North Carolina had not previously recognized a tort of this nature.[4]

Specifically, Currie asked the federal court to find that North Carolina law would recognize a cause of action first brought in *Tarasoff v. Regents of the University of California*[5] and now adopted by a large majority of jurisdictions that have considered the issue.[6] In *Tarasoff* the California Supreme Court held that a psychotherapist who treats a dangerous outpatient owes a duty to protect foreseeable third parties against whom his patient has threatened violence. That duty to protect may be discharged either by warning the victim or taking whatever measures are "reasonably necessary."[7] In her lawsuit against the government, Currie urged that in some circumstances the *Tarasoff* duty can require

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1. Currie v. United States (*Currie II*), 836 F.2d 209, 210-11 (4th Cir. 1987).

2. 644 F. Supp. 1074 (M.D.N.C. 1986), *aff'd on other grounds*, 836 F.2d 209 (4th Cir. 1987). Currie brought suit as administratrix on behalf of her husband's estate. Because the federal government was named as defendant in the action, the suit necessarily was brought in federal court under the Federal Tort Claims Act, 28 U.S.C. § 1346(b) (1982).

3. *Currie II*, 836 F.2d at 212.

4. Under the Federal Tort Claims Act, the United States government is subject to the same liability as private persons for personal injury caused by the negligence of its employees acting within the scope of their employment. 28 U.S.C. § 2674 (1982). Section 1346(b) stipulates that when determining the government's liability, a federal court must apply the law of the state in which the tort occurred. *Id.* § 1346(b).

After Currie's suit was underway, two plaintiffs in Nash County brought a strikingly similar suit against the United States government arising out of an unrelated incident involving another Vietnam veteran. Cantrell v. United States, No. 86-854-CIV-5 (E.D.N.C. filed Aug. 12, 1986). Plaintiffs in *Cantrell* were the victims of an armed attack by John G. Puckett, a Rocky Mount veteran who had sought treatment and admission at Veteran's Administration (VA) hospitals in Durham and Fayetteville for dissociative episodes and violent tendencies. In an unusual coincidence, Puckett's attack in Rocky Mount occurred just three weeks before Avery's unrelated assault seventy miles away in Research Triangle Park. *See* Plaintiffs' Memorandum in Opposition to Defendant's Motion to Dismiss or, in the Alternative for Summary Judgment at 2-10, *Cantrell* (No. 86-854-CIV-5) [hereinafter cited as *Cantrell* Plaintiff's Memorandum]. Additional facts in *Cantrell* are briefly stated *infra* note 58.

5. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). *Tarasoff* is discussed *infra* notes 51-63 and accompanying text.

6. Currie v. United States (*Currie I*), 644 F. Supp. 1074, 1078 (M.D.N.C. 1986).

7. *Tarasoff*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

a doctor to seek his patient's involuntary commitment.[8]

The opinions that Currie's complaint inspired were almost as unusual as the facts of her case. The United States District Court for the Middle District of the state found that North Carolina would recognize the *Tarasoff* duty to protect. It further held that in cases such as *Currie* this duty could require a psychotherapist to initiate commitment proceedings.[9] The court qualified its holding, however, by declaring that this newly recognized duty to seek commitment could not be breached by simple negligence. So long as a competent therapist exercised his best judgment and acted in good faith, he would be protected from any liability for the patient's acts.[10] The Fourth Circuit Court of Appeals upheld the district court's result, but on quite different grounds. It completely bypassed the *Tarasoff* rationale and held that as a general rule no doctor could ever be held liable for failing to commit a dangerous mental patient.[11]

This Note examines the Fourth Circuit's opinion as it relates to *Tarasoff* and to North Carolina law. The Note explores the rationale behind the special duty to provide protection for third parties and outlines its application in the field of psychotherapy. The Note concludes that the Fourth Circuit misinterpreted the nature of the duty to provide protection owed by the Veteran's Administration (VA) psychotherapists and that a proper understanding of the *Tarasoff* doctrine dictates that a duty to commit should have been found in *Currie*.

Leonard Avery was an IBM employee and a Vietnam veteran. Seventeen months before his rampage, he had turned to the Durham VA hospital for help in coping with "rage attacks."[12] The VA psychotherapists diagnosed him as suffering from "Post-Traumatic Stress Disorder"[13] and began treating him on an outpatient basis with group therapy sessions supplemented by a variety of anti-psychotic medicines. His condition gradually deteriorated, however, and at one point, his group leader described him as posing a "significant homicidal

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8. *Currie I*, 644 F. Supp. at 1080; *see* Brief in Opposition to Defendant's Motion for Summary Judgment at 8-12, *Currie I* (No. C-85-0629-D) [hereinafter cited as Plaintiff's Summary Judgment Brief].

9. *Currie I*, 644 F. Supp. at 1077, 1081.

10. *Id.* at 1083. For a discussion of the rationale behind the district court's finding of a legal duty, see *infra* notes 20-23 and accompanying text.

11. *Currie II*, 836 F.2d at 212. The Fourth Circuit's decision is discussed in full *infra* notes 24-40 and accompanying text.

12. *Currie I*, 644 F. Supp. at 1075. A less complete recitation of the facts may be found in the Fourth Circuit's opinion. *Currie II*, 836 F.2d at 210-12.

13. *Currie I*, 644 F. Supp. at 1075. Post-traumatic Stress Disorder (PTSD), a psychological disorder that may arise following a distressing event outside the range of normal human experience, commonly afflicts combat veterans. Events such as experiencing a threat to one's life, killing another, and witnessing the violent death or injury of another are examples of stressors that may trigger PTSD. The disorder may occur with varying degrees of severity. For a description of the characteristics of this mental illness, see AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 247-51 (1980) ("In more severe cases [of PTSD], particularly in cases in which the survivor has actually committed acts of violence (as in war veterans), . . . the reduced capacity for modulation may express itself in unpredictable explosions of aggressive behavior. . ."). For a discussion of the interrelationship of PTSD and criminal behavior, see Erlinder, *Paying the Price for Vietnam: Post-Traumatic Stress Disorder and Criminal Behavior*, 25 B.C.L. REV. 305 (1984).

risk."[14] Avery's absenteeism from work and irregular attendance at group sessions became increasing problems. When IBM finally called him in to account for his absences, Avery threatened to blow up the company's medical facility and personnel. IBM contacted his VA psychotherapists who informed the company that Avery was capable of such violence and that his threats should be taken seriously. After he refused to admit himself voluntarily to a hospital, IBM fired him. Avery spoke with his doctors on two occasions after being fired, and both times he reiterated his threats.[15] His psychotherapists promptly relayed the threats both to IBM and a host of law enforcement agencies.[16] Three times his doctors discussed whether they could involuntarily commit Avery and each time they concluded they could not.[17] At their final meeting, the doctors decided that, because they had warned IBM, they had discharged any duty they might owe under *Tarasoff*. A few hours later, in an attempt to blow up the IBM medical facility, Avery shot and killed Ralph Augustus Glenn, Jr.[18]

After the tragic events of August, 1982, Linda Currie filed her lawsuit against the United States, alleging the VA doctors were negligent in failing to seek Avery's commitment. The government moved for summary judgment.[19] The federal district court found that the North Carolina Supreme Court would place a *Tarasoff* duty on psychotherapists to protect foreseeable third parties

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14. *Currie I*, 644 F. Supp. at 1075. This observation was made after Avery "became upset over a child support dispute with his former wife." *Id.* At this point, one of Avery's doctors convinced him to hospitalize himself. After talking with his lawyer, Avery calmed down. The hospital allowed him to be discharged the next day. *Id.*

15. *Id.* at 1075-77. After Avery's initial threat against IBM, his doctors had managed to persuade him to voluntarily admit himself. Avery subsequently changed his mind, however. In a later phone conversation with his chief doctor, he claimed, "It's too late for me to start over. There's nothing to be done. You'll read about it in the papers." *Id.* at 1076. In a subsequent phone conversation, he declared "I'd like to get all you guys in the same place at the same time. I'd blow your asses away." *Id.* The VA doctors regarded this as a threat against their lives as well as against IBM. *Id.* at 1077.

16. *Id.* The doctors believed the situation to be serious enough to merit notifying the United States Attorney, the VA District Council and security force, the Federal Bureau of Investigation, and the Durham County Police Department. They also obtained protection for Avery's chief psychotherapist. *Id.*

17. *Id.* at 1076-77. The VA doctors determined that Avery could not be committed because they believed he failed to meet the statutory requirements for commitment. Although they agreed that he met the test of "dangerousness," they thought he was not sufficiently "mentally ill" to be committed. *Id.*; *see* N.C. GEN. STAT. § 122C-261 to -272 (1986) (procedure and standards for involuntary commitment). The doctors believed that Avery's dangerousness derived from his anger at IBM and not any mental illness that would justify commitment. *Currie I*, 644 F. Supp. at 1076.

The doctor's apparently were acting under the mistaken belief that a patient must be "psychotic" or "out of touch with reality" before he can be considered for involuntary commitment. *Id.* at 1085. This interpretation of "mentally ill" does not square with the statutory definition of "mental illness" as "an illness which so lessens the capacity of the individual to use self control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control." N.C. GEN. STAT. § 122C-3(21) (1986). "Psychosis" has never been the standard for commitment, and the VA doctors were simply wrong in their analysis of the options open to them in treating Avery. *Currie I*, 644 F. Supp. at 1085 ("[T]he court agrees with plaintiff that the plain meaning of the statute would appear broader than the definition given by the psychotherapists in this case."); Lecture of Dr. Seymour L. Halleck, Professor of Law and Professor of Psychiatry, University of North Carolina at Chapel Hill, at University of North Carolina School of Law (Jan. 27, 1988); *see* Plaintiff's Summary Judgment Brief, *supra* note 8, at 17-20.

18. *Currie I*, 644 F. Supp. at 1077.

19. *Id.*

threatened by a violent patient.[20] It further held that this duty could require the doctor at times to petition for the patient's involuntary commitment.[21] Because the psychotherapist must balance conflicting policies in making a decision to commit, however, the court ruled that a competent doctor could not be held liable for failing to initiate commitment proceedings so long as she used her best judgment and acted in good faith.[22] Finding the VA psychotherapists to have been highly qualified and to have acted in the utmost good faith, the court granted summary judgment for the government.[23]

On appeal the Fourth Circuit affirmed the result but on an entirely different theory of law. It held that under no circumstances would the North Carolina Supreme Court impose a duty on psychotherapists to seek a patient's involuntary commitment.[24] The court first noted that, as a general rule of law, an individual owes no duty to protect others from danger posed by a third party.[25] It acknowledged a relevant exception, however, when an individual has a right of control over another.[26] In such a case the individual may be held liable to third parties harmed by that person if the individual has failed to exercise his control

20. *Id.* The court cited as authority two North Carolina cases that it claimed indicated the likelihood that the state supreme court would approve the *Tarasoff* result. *Id.* See *infra* notes 107-23 and accompanying text for a discussion and analysis of these cases. The court also noted that "the vast majority of courts that have considered the issue have accepted the *Tarasoff* analysis." *Id.* at 1078.

21. *Id.* at 1080-82.

22. *Id.* at 1082-84. The court analogized the liability it would assign to psychotherapists to that of corporate directors protected by the business judgment rule. Such a limited standard of review for commitment decisions is justified, it maintained, by the unusual circumstances under which such decisions are made, the difficult burden placed on the doctor who must balance the conflicting interests of the patient's liberty and society's need for protection from danger, and the court's lack of professional expertise in "an area in which the answers are never easy." *Id.* at 1083. Under this limited standard, the psychotherpaist would not be held liable for "simple errors in judgment." *Id.* Instead, the district court held that courts reviewing commitment decisions should consider the competency and training of the therapist, the adequacy of his review of the patient's case, the degree to which he sought outside opinions, whether the therapist's decision was made in accord with the proper legal standards, and "other evidence of good faith." *Id.* In light of all the circumstances, if the court finds the doctor's decision to have been made in good faith with due regard for the public interest, he should not be held liable. *Id.* at 1083-84.

The unusual holding in *Currie I* was shaped by the language of a North Carolina statute conferring immunity on doctors and hospitals when making decisions concerning the treatment, commitment, and release of mentally ill patients. *Id.* That statute grants immunity so long as "professional judgment, practice and standards" are followed during the treatment process. N.C. GEN. STAT. § 122C-210.1 (1986). *See infra* notes 40, 125-26, 164-65 and accompanying text.

23. *Currie I*, 644 F. Supp. at 1084-85. The district court accorded great significance to the fact that Avery had threatened the VA psychotherapists and not just IBM. Because the doctors' commitment decision involved a "serious personal risk to themselves," the court reasoned it must have been made in "the utmost good faith." *Id.* at 1085.

24. *Currie II*, 836 F.2d at 210.

25. *Id.* at 212.

26. *Id.* The Fourth Circuit also acknowledged a second exception to the general "no duty" rule. When a special relationship exists between an individual and a third party, the individual may have a duty to control the actions of others with whom he has no special relationship for the protection of the third party. As an example, the court cited the duty a landowner owes to protect his invitees from harm and the duty owed by a carrier to protect its passengers. *Id.* Because no relationship of this sort existed between the VA doctors and Ralph Glenn, the court did not further discuss this exception to the "no duty" rule. For a brief discussion of this branch of the affirmative obligation doctrine, see *infra* note 47.

with due care.[27] As an example the court cited a mental hospital with custody of involuntarily committed patients. If the hospital negligently releases a dangerous patient who then harms an unsuspecting person, the hospital will be liable.[28] The court claimed that this exception to the general "no duty" rule "fits comfortably in established tort doctrine" and was adopted in *Pangburn v. Saad*[29] by the North Carolina Court of Appeals.[30]

According to the court, such a control based duty does not imply the existence of a duty "to acquire the right of control or to have such a right vested in another."[31] Neither is it related to "the duty to warn threatened third persons such as that declared in [*Tarasoff*]."[32] A duty to warn, the court maintained, "is an expression of humanitarianism and the spirit of the good Samaritan."[33] It extends only to identifiable third parties "within a recognizable zone of danger" and requires no power of control over a patient.[34] The court concluded that because a duty to seek commitment runs to unidentifiable members of the public and would require a control element it found absent in a psychotherapist-outpatient relationship, this duty could never exist.[35]

The court added that policy considerations which might support a duty to warn militate against a duty to seek commitment. A psychotherapist's warning to a threatened victim, the court claimed, "may well remain unknown to the patient" and thus not interfere with his treatment,[36] but initiating commitment proceedings "necessarily will be disclosed to the patient with great likelihood that the psychiatrist's potential for constructive influence over the patient will be destroyed."[37] Furthermore, a patient's "constitutionally-protected liberty interest" would be at stake in duty to commit situations.[38] The court maintained that

27. *Id.* One example of such a relationship, the court explained, would be the master-servant relationship, in which the master has a right to control the servant and is liable to anyone harmed by the servant's negligence in the scope of his employment. *Id.*

28. *Id.* at 212-13. Liability on these facts has been traditionally referred to as liability for "negligent release." *See infra* notes 49-50 and accompanying text; *see also* Note, *Psychiatrists' Liability to Third Parties for Harmful Acts Committed by Dangerous Patients*, 64 N.C.L. REV. 1534, 1536-37 (1986) (discussing traditional liability for negligent release).

29. 73 N.C. App. 336, 326 S.E.2d 365 (1985). *Pangburn* is discussed *infra* text accompanying notes 116-26.

30. *Currie II*, 836 F.2d at 213.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* For a discussion of this interpretation of *Tarasoff*, see *infra* text accompanying notes 139-42.

35. *Currie II*, 836 F.2d at 213; *see infra* notes 129-38 and accompanying text. "A duty to warn potential, identifiable victims of violence is not dependent upon a power of control of the conduct of the violent actor, but a duty to seek voluntary [sic] commitment necessarily treats the one subject to the duty as having the essence of the power to control." *Id.* It should be noted that "voluntary commitment" was not at issue in *Currie*—"involuntary commitment" was. Presumably this reference by the court was an error. The term possesses the peculiar quality of an oxymoron and is not mentioned in the North Carolina mental health statutes, which speak of the "voluntary admission" process as distinguished from "involuntary commitment." *Compare* N.C. GEN. STAT. § 122C-211 (1986) (voluntary admissions of mentally ill patients) *with id.* §§ 122C-261 to -277 (involuntary commitment procedure).

36. *Currie II*, 836 F.2d at 213.

37. *Id.*; *cf. infra* note 110.

38. *Id.*

North Carolina law abrogating the doctor-patient privilege in involuntary commitment proceedings and granting psychotherapists the power to initiate involuntary commitment proceedings "bears little" on the issue of whether a doctor may be held liable for failing to seek a patient's commitment.[39] Finally the court noted that because North Carolina grants statutory immunity from simple negligence to all hospitals and their employees "in dealing with mental patients," it would be unlikely that the state supreme court would hold the highly qualified VA doctors liable for their good faith mistake in failing to commit Leonard Avery.[40]

As the conflicting opinions in Currie suggest, the idea that psychotherapists might be liable to victims of their dangerous outpatients is fairly new.[41] Uncertainty as to when an individual must control the conduct of a person to protect third parties is not unique to the field of psychotherapy, however. The law of torts historically has treated the whole issue of affirmative obligation much like a troublesome cousin—not particularly welcome, but part of the family nonetheless.[42] Professor Harper and Judge Kime explained the origin and nature of this

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39. *Id.* The Fourth Circuit was referring to *In re Farrow*, 41 N.C. App. 680, 255 S.E.2d 777 (1979), and the state's involuntary commitment statutes. N.C. GEN. STAT. §§ 122C-261 to -272 (1986). *Farrow* is discussed *infra* at text accompanying notes 107-12.

40. *Currie II*, 836 F.2d at 213-14. The court was discussing N.C. GEN. STAT. § 122C-210.1 (1986) which provides in pertinent part:

> No facility . . . or any physician or other individual who is responsible for the examination, management, supervision, treatment, or release of a client and who follows accepted professional judgment, practice, and standards is civilly liable . . . for actions arising from these responsibilities or for actions of the client.

Id.

At the time of Avery's attack, only those facilities under state management and those doctors employed by the state were immune from liability arising out of commitment decisions. *See id.* § 122-24. In 1985 the immunity statute was rewritten to apply to all doctors and hospitals, public or private. *See* N.C. GEN. STAT. § 122C-210.1 (1986). The Fourth Circuit argued (correctly, it would seem) that the language and public policy of the new statute suggest that the immunity provided in 1982 should have extended to the actions of the VA doctors, even though they were not employed by the State of North Carolina. *See Currie II*, 836 F.2d at 213-14; *see also Cantrell* Plaintiffs' Memorandum, *supra* note 4, at 17 n.1 (describing evolution of current immunity statute).

After passing that initial hurdle, the Fourth Circuit ascribed a dual significance to the immunity statute. First, it argued that the current statute suggests a state policy of public and private immunity for good faith professional decisions. Therefore, the VA doctors could not be sued for their actions even if they had been negligent in failing to commit because they had clearly acted in good faith. Second, the court suggested that the existence of the new immunity statute in such a broadened form "strongly suggests the North Carolina courts would not sanction any great enlargement of [the negligent release doctrine found in *Pangburn*]." *Currie II*, 836 F.2d at 214. It is not clear from this comment whether the Fourth Circuit meant to suggest that North Carolina courts would reject the *Tarasoff* doctrine, but that appears to have been the implication. The Fourth Circuit's use of this statute is discussed *infra* notes 163-64 and accompanying text.

41. In fact, the whole concept of regulation and liability in the psychiatric profession has become common only in the past twenty-five years. Prior to that time, psychotherapists managed the treatment and commitment of their patients with very little oversight by the courts or legislatures. They were perceived as performing an important social control function by managing society's mentally ill, and their decisions were accorded considerable deference by the law. In the 1960s and 1970s, however, as the courts and legislatures became more conscious of patients' rights and the enormous impact which the profession was making on those rights, a substantial body of mental health law arose to protect the rights of the public. A portion of that law attempted to deal with liability to third parties. S. HALLECK, LAW IN THE PRACTICE OF PSYCHIATRY 1-2, 117-21 (1980).

42. *See* PROSSER AND KEETON ON THE LAW OF TORTS, § 56 at 373-75 (W. Keeton 5th ed. 1984) [hereinafter cited as PROSSER & KEETON].

branch of tort law in a seminal article published over fifty years ago.[43] The common law, they noted, traditionally assigned liability by distinguishing between a person's misfeasance and his nonfeasance. The former was actionable; the latter generally was not.[44] This distinction led to the rule that an individual has no general duty to take action to control the conduct of others for the protection of third parties.[45] Exceptions exist, however, when an individual's course of action brings him into certain socially significant relationships that are of such a character that the law requires him to control the conduct of another for the protection of a third party.[46] A relationship between an individual and a person who threatens harm to some third party may give rise to this duty.[47] If society deems the relationship sufficiently important, the individual may be required "to attempt to control the other's conduct."[48]

A relevant example of such a special social relationship, cited by Harper and Kime, would be that between a mental institution and a dangerous inpatient in its custody.[49] In this particular "forced custody" situation, psychotherapists or hospitals who negligently release such patients traditionally have been held liable for the injuries their patients inflict on others.[50]

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43. Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886 (1934).

44. *Id.* at 886-87.

45. *Id.* Typically referred to as the "no duty" rule, this concept is expressed in RESTATEMENT (SECOND) OF TORTS § 315 (1965) ("There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another . . .") [hereinafter cited as RESTATEMENT].

46. Harper & Kime, *supra* note 43, at 887.

47. Harper & Kime, *supra* note 43, at 887. A different type of special relationship that may give rise to a duty to control the conduct of another is one between an individual and the person exposed to harm. Relationships in this category are purely protective in nature, such as that between an innkeeper and his guest. *See id.* at 887-88. Both of the exceptions to the "no duty" rule of affirmative obligation, as expressed by Harper and Kime in 1934, are reflected in the Restatement (Second) of Torts:

> There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or (b) a special relation exists between the actor and the other which gives rise to the right of protection.

RESTATEMENT, *supra* note 45, § 315.

48. Harper & Kime, *supra* note 43, at 887. Examples of certain specific relationships that require an individual to control the conduct of another, including parent-child, master-servant, and custodian-charge, follow the general principle expressed in § 315. RESTATEMENT, *supra* note 45, §§ 316-19.

49. Harper & Kime, *supra* note 43, at 897-98. This relationship falls specifically under § 319 of the Restatement:

> One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.

RESTATEMENT, *supra* note 45, § 319. Liability in the negligent release situation is even used to illustrate an application of this section. RESTATEMENT, *supra* note 45, § 319 illustration 1.

Section 319 clearly covers more relationships than those in negligent release cases, however. It appears to serve as a sort of catch-all for a variety of relationships that create a duty on one party to protect persons from a risk posed by another over whom he has "taken charge." *See* PROSSER & KEETON, *supra* note 42, § 56, at 383-84 (listing numerous relationships claimed to be "custodial by nature").

50. *See* Merchants Nat'l Bank & Trust Co. v. United States, 272 F. Supp. 409 (D.N.D. 1967); Jones Co. v. State, 122 Me. 214, 119 A. 577 (1923); Pangburn v. Saad, 73 N.C. App. 336, 326 S.E.2d 365 (1985); *see also* Semler v. Psychiatric Inst. of D.C., 538 F.2d 121 (4th Cir.), *cert. denied sub nom.*

In 1976 the California Supreme Court, in its landmark *Tarasoff* decision, recognized another special relationship that could create an affirmative obligation. It held the relationship between a psychotherapist and an outpatient was of sufficient social importance to place a duty on the doctor to protect third parties when his patient threatens violence to foreseeable victims.[51] The facts in *Tarasoff* have become almost legendary. Prosenjit Poddar, an outpatient at a California university hospital, informed his psychotherapist that he intended to murder a young woman, readily identifiable to the therapist as Tatiana Tarasoff. At that time Tatiana was residing in South America and planning to return to California.[52] Believing Poddar capable of such violence, the psychotherapist and his colleagues notified the campus police of his threat in an effort to obtain the patient's commitment. The police detained Poddar but, finding him rational, released him after he promised to stay away from Tatiana.[53] No attempt was made to warn Tatiana or her family of the danger. When she returned to the United States, Poddar murdered her.[54] On these facts, 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.[55]

This legal duty could require the therapist to take various steps depending on the circumstances. "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."[56] The

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Folliard v. Semler, 429 U.S. 827 (1976) (hospital required by court order to control patient's conduct even when not held on physical confines of grounds and liable to those whom the patient injures while away). *But see* Sherrill v. Wilson, 653 S.W.2d 661 (Mo. 1983) (doctors releasing mental patient are engaged in "discretionary function" and not liable for negligence if patient poses a foreseeable danger and injures others).

Harper and Kime noted that courts have tended to confuse the duty issue with proximate cause in negligent release cases. When a confined patient is clearly a danger to others "the negligent or criminal intervening act of [the patient] will not cut off the necessary causal relation between a [defendant hospital's] negligence and a plaintiff's harm if the intervening criminal act was forseeable by the defendant." Harper & Kime, *supra* note 43, at 897. An early North Carolina case involving a mental patient who escaped an institution and murdered a victim six months later appears to reflect this misperception, although the court based its holding primarily on statutory immunity. Ballinger v. Rader, 151 N.C. 383, 66 S.E. 314 (1909).

51. *Tarasoff*, 17 Cal. 3d at 437, 551 P.2d at 344, 131 Cal. Rptr. at 24. The California Supreme Court decided the case first in 1974. Tarasoff v. Regents of Univ. of Cal., 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974) [hereinafter cited in notes as *Tarasoff I*]. The court granted a rehearing however and handed down a second opinion that differed in some respects from the first, but still imposed liability on defendant psychotherapists. Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) [hereinafter cited as *Tarasoff II* in notes and as *Tarasoff* in text]. Differences between the two decisions are noted *infra* note 56.

For a seminal examination of the issue before the *Tarasoff* courts, see Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025 (1974).

52. *Tarasoff II*, 17 Cal. 3d at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

53. *Id.* Three doctors had concurred that Poddar's commitment should be sought. Following their unsuccessful effort to initiate the commitment process, the director of the psychiatry department at the hospital ordered that their notes and correspondence regarding Poddar be destroyed and that no further action be taken to detain the patient. *Id.*

54. *Id.* at 433, 551 P.2d at 341, 131 Cal. Rptr. at 21.

55. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

56. *Id.* The scope of this holding in *Tarasoff II* is somewhat broader than that in *Tarasoff I.*

court specifically found that this duty arose because of the special relationship between psychotherapist and patient.[57]

Although *Tarasoff* obviously expanded the scope of a psychotherapist's potential liability, its holding crystallized several affirmative duties already owed by doctors— most notably, the duty to protect the public from a patient bearing a contagious disease[58] and the duty to restrain a dangerous mental patient who

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The latter simply held that "a psychotherapist treating a mentally ill patient . . . bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment." *Tarasoff I*, 13 Cal. 3d 177, 529 P.2d at 559, 118 Cal. Rptr. at 135. The *Tarasoff I* court also found that the "bungled attempt" to confine Poddar increased the danger to Tatiana and provided a second grounds for liability. *Id.* at 555, 118 Cal. Rptr. at 131.

Tarasoff I and *II* both contained claims alleging liability for the doctors' failure to detain or confine Poddar. The court in both decisions clearly held that doctors were protected by statutory immunity for any liability arising out of decisions concerning commitment of a patient. *Tarasoff II*, 17 Cal. 3d at 447-49, 551 P.2d at 351-52, 131 Cal. Rptr. at 31-32; *Tarasoff I*, 529 P.2d at 563-64, 118 Cal. Rptr. at 139-40.

57. *Tarasoff II*, 17 Cal. 3d at 436, 551 P.2d at 343, 131 Cal. Rptr. at 23. "Such a relationship may support affirmative duties for the benefit of third persons." *Id.* *See* Fleming & Maximov, *supra* note 51, at 1026-31.

The court cited § 315 of the Restatement (Second) of Torts for authority that special relationships between parties can create a duty on one party to control another's conduct. *Tarasoff II*, 17 Cal. 3d at 436, 551 P.2d at 343, 131 Cal. Rptr. at 23. This section, however, states only a general principle. The comment following this section explains that sections 316 through 319 state the specific types of relationships in which this principle is applied. RESTATEMENT, *supra* note 45, § 315 comment c. Because *Tarasoff II* clearly does not fit under sections 316 through 318, *see infra* notes 131-32 and accompanying text, it must be described as a § 319 relationship, created when one person "takes charge" over another. For further discussion of this issue, see *infra* note 135. *See also* PROSSER & KEETON, *supra* note 42, § 56 at 384 n.24 (citing *Tarasoff* as a custodial relationship).

58. *Tarasoff II*, 17 Cal. 3d at 436-37, 551 P.2d at 343-44, 131 Cal. Rptr. at 24. In addition to the contagious disease decisions, the court also cited cases that have required a doctor to protect the public from a patient whose medication or whose inadequate treatment makes his conduct a threat to public health and safety. *Id.*

Opinions in these areas represent an intriguing application of tort law. Communicable disease cases typically involve a doctor who fails to diagnose a contagious illness or diagnoses a disease but fails to warn his patient (or those with whom the patient would associate) of its contagious nature. The patient goes out into the world and infects others, often family members, who then sue the doctor. Fosgate v. Corona, 66 N.J. 268, 330 A.2d 355 (1974) (failure to diagnose tuberculosis), *limited on other grounds sub nom.* Tisdale v. Fields, 183 N.J. Super. 8, 433 A.2d 212 (1982); Freese v. Lemmon, 210 N.W.2d 576 (Iowa 1973) (failure to diagnose epilepsy gave rise to cause of action for persons injured when patient later had seizure while driving); Hofmann v. Blackmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (failure to diagnose tuberculosis); Wojcik v. Aluminum Co. of Am., 18 Misc. 2d 740, 183 N.Y.S.2d 351 (1959) (failure to warn of tuberculosis); Davis v. Rodman, 147 Ark. 385, 227 S.W. 61 (1921) (failure to warn of typhoid fever); *see also* Peter & Sanchez, *The Therapist's Duty to Disclose Communicable Diseases*, 14 W. ST. L. REV. 465 (1987) (discussing duty to warn of patient infected with AIDS virus).

Although Harper and Kime did not discuss this duty in their 1934 article, such a cause of action would seem compatible with their analysis and would presumably arise under the § 319 relationship between doctor and patient; a doctor has taken charge over a patient whose conduct (interacting with others while infected) will likely cause bodily harm to third parties if the doctor fails to take steps to control the patient's interactions. Typically, the "control" will be accomplished by informing the patient of his illness or informing those likely to be in contact with him.

Similar cases have held doctors liable to third parties for injury resulting from the doctor's failure to treat a patient properly. Gooden v. Tips, 651 S.W.2d 364 (Tex. Ct. App. 1983) (doctor prescribing Quaalude without cautioning against driving would be liable to persons injured by patient driving under the drug's influence); Wharton Transp. Corp. v. Bridges, 606 S.W.2d 521 (Tenn. 1980) (trucking company may sue doctor for injury arising out of doctor's negligent physical examination of driver); Renslow v. Mennonite Hosp., 67 Ill. 2d 348, 367 N.E.2d 1250 (1977) (doctor who negligently transfused wrong blood into thirteen year old girl held liable to brain-damaged child conceived by patient thirteen years later); Kaiser v. Suburban Transp. Sys., 65 Wash. 2d 461, 398

has been involuntarily committed.[59]

In reaching the decision to impose the duty of protection, the court balanced the public interest in protecting innocent victims from violent assault against the public interest in confidential patient-therapist communication and found "[t]he protective privilege ends where the public peril begins."[60] It stressed, however, that the psychotherapist's duty to act is defined by the particular facts of each case. Different circumstances could require different measures of protection,[61] and the duty to act would depend upon the foreseeability of the victim.[62] Because the doctors in *Tarasoff* knew the victim's identity and could have effectively contacted her, the court found that a warning to the victim, and not just to the police, was required to discharge their duty.[63]

P.2d 14 (1965), *modified*, 65 Wash. 2d 461, 401 P.2d 350 (1965) (doctor who failed to inform patient bus driver that medication prescribed to him would induce drowsiness held liable to persons injured when driver lost consciousness at wheel).

Plaintiffs in the recently filed action Cantrell v. United States, No. 86-854-CIV-5 (E.D.N.C. filed Aug. 12, 1986), advanced an interesting argument along these lines in the context of psychotherapists' liability for the actions of their dangerous patients. They claimed that the United States was negligent in treating John G. Puckett, a mentally ill Vietnam veteran who sought treatment at and admission to a VA hospital for his violent tendencies and fear of losing control. Plaintiffs, who were victims of one of Puckett's attacks, claimed that their injury at his hands was the result of the VA's negligent failure to treat him in accord with their written procedures (their procedures indicated that hospitalization was the appropriate course of treatment) and their failure to warn them of the risk he posed. *Cantrell* Plaintiff's Memorandum, *supra* note 4, at 17-29; *accord* Sharpe v. South Carolina Dep't of Mental Health, 281 S.C. 242, 315 S.E.2d 112 (1984) (doctors who were statutorily immune from liability arising out of release of mental patients found liable for injury caused by a released patient because of their negligence in course of patient's treatment and their failure to notify the public of his dangerous nature); *see also* Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983) (separate acts of "malpractice" by VA psychotherapists in failing to record and communicate warnings given them by police, to secure patient's prior records and to warn victim were proximate cause of victim's injury). It should be noted that the court in *Tarasoff II* considered a claim cast in language similar to that in *Cantrell, Sharpe* and *Jablonski* to be "legally indistinguishable" from one based on "failure to detain a dangerous patient." *Tarasoff II*, 17 Cal. 3d at 433, 551 P.2d at 483, 131 Cal. Rptr. at 21.

In *Cantrell*, filed shortly before the district court's *Currie* decision, Puckett, a Rocky Mount Vietnam veteran, was receiving outpatient treatment at a VA hospital in Fayetteville for violent tendencies and dissociative episodes. While apparently experiencing one of these dissociative states or blackouts, he severely injured his girlfriend and killed her companion. Puckett, who had feared he might lose control of his increasingly violent impulses toward his girlfriend, had sought admission at VA hospitals in Fayetteville and Durham. His doctor, lacking pertinent information from Puckett's family and from other VA doctors and personnel whom Puckett had seen, had chosen to treat him as an outpatient. He failed to warn Puckett's girlfriend and others of the danger the veteran posed to them. *Cantrell* Plaintiff's Memorandum, *supra* note 4, at 2-13.

59. *Tarasoff II*, 17 Cal. 3d at 436-37, 551 P.2d at 343-44, 131 Cal. Rptr. at 24. *See supra* notes 49-50 and accompanying text.

60. *Tarasoff II*, 17 Cal. 3d at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27. Defendants had argued strongly against imposition of a duty on the grounds that psychiatrists lack the ability to predict violence with sufficient accuracy and that abrogation of the therapist-patient relationship would wreak havoc on the profession. The court found these arguments unpersuasive. *See id.* at 437-42, 551 P.2d at 344-48, 131 Cal. Rptr. at 24-28. *But cf.* S. HALLECK, *supra* note 41, at 80-81 (predicting that *Tarasoff*'s impact upon the profession will not live up to its opponent's dire expectations).

61. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

62. *Id.* at 438-39, 551 P.2d at 345, 131 Cal. Rptr. at 25. The *Tarasoff II* court rejected defendant's argument that the victim must be known to the psychotherapist before a warning must be given. "[There] may . . . be cases in which a moment's reflection will reveal the victim's identity," the court observed, and the issue of foreseeability "should not be governed by any hard and fast rule." *Id.* at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11. A more rigid foreseeability standard was ultimately imposed, however. *See infra* notes 64-68 and accompanying text.

63. *Tarasoff II*, 17 Cal. 3d. at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

In 1980 the California Supreme Court in *Thompson v. County of Alameda*[64] clarified the holding in *Tarasoff*. It explained that the duty to protect foreseeable victims did not include a duty to warn "a large amorphous public group of potential targets"[65] to whom a dangerous offender had made a "generalized threat."[66] *Thompson* involved a juvenile offender, about to be released by the county, who had threatened to kill an unidentifiable small child in his neighborhood.[67] The court asserted that a duty to warn could extend only to known and identifiable victims because warning a broad segment of the population, such as all parents or children in a neighborhood, was neither feasible nor effective.[68] Other jurisdictions have not been as willing to place identifiable victim limits on the entire *Tarasoff* duty to protect, which may call for measures other than warning.[69]

The degree of foreseeability necessary to require a warning is not the only aspect of *Tarasoff* to receive a varied interpretation by the courts. Closely related to the foreseeability issue is the question of when a doctor may be required to take "whatever other steps are reasonably necessary under the circumstances" to protect a victim.[70] Other jurisdictions have had considerable difficulty resolving this question. Those courts that carry the *Tarasoff* doctrine to its logical conclusion have held that in certain situations, a doctor may have a duty to seek an outpatient's commitment or detention. This holding, however, creates a di-

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64. 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

65. *Id.* at 758, 614 P.2d at 738, 167 Cal. Rptr. at 80.

66. *Id.* at 754, 614 P.2d at 733, 167 Cal. Rptr. at 77.

67. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72.

68. *Id.* at 749-58, 614 P.2d at 732-37, 167 Cal. Rptr at 74-80. The court also found that warnings to the police and to the victim's mother would have been equally ineffective. Justice Tobriner dissented strongly from the majority's holding in *Thompson*, arguing that the presence of an identifiable victim was not an essential element of the *Tarasoff* duty to protect. He criticized the majority for taking what might be a reasonable restriction on a duty to warn victims and applying it to other measures that could have protected them, such as warning the child's mother. *Id.* at 759-61, 614 P.2d at 738-40, 167 Cal. Rptr. at 80-82 (Tobriner, J., dissenting). The majority did not completely reject Justice Tobriner's argument that the duty to protect involved more than just a duty to warn. It described the possibility that the mother might have taken special care to supervise the eighteen year old child as an "attenuated conjecture" and, therefore, the failure to warn her did not amount to a breach of the defendant's duty to protect. *Id.* at 757-58, 614 P.2d at 737, 167 Cal. Rptr. at 79.

69. Such jurisdictions seem to reflect Justice Tobriner's view. *See, e.g., Currie I*, 644 F. Supp. at 1078-79; Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 194 (D. Neb. 1980); Petersen v. State, 100 Wash. 2d 421, 427-28, 671 P.2d 230, 237 (1983). For the argument advocating a basic foreseeability standard for the *Tarasoff* duty to protect, see Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597, 614-17 (1984).

Although *Thompson* appeared to limit the *Tarasoff* duty to protect to a narrowly defined category of identifiable victims, subsequent decisions in California suggest that the scope of the duty is broader. In Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983), a federal court in California held that a psychotherapist had a duty to warn the girlfriend of a dangerous outpatient, who had not been directly threatened. The court found that because the patient had a known history of violence against his former wife, the doctor should have known that the patient's "violence was likely to be directed against women very close to him." *Id.* at 398. The court characterized the girlfriend as less easily identified than the victim in *Tarasoff*, but more so than the one in *Thompson*. *Id.* In Hedlund v. Superior Court of Orange County, 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983), the California Supreme Court further broadened the class of persons to whom a psychotherapist could owe a warning under the duty to protect to include certain foreseeable persons in a close relationship with the victim who may be injured if the threat is carried out, such as the child of a parent. *Id.* at 706-07, 669 P.2d at 47, 194 Cal. Rptr. at 811.

70. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

lemma for a psychotherapist quite different from that faced when considering the need for a warning. Commitment is a drastic procedure that requires the invasion of a patient's liberty interest. It requires the doctor to actually take control of the patient and it effectively alters the course of a patient's conduct with respect to not just a single individual, but the entire world.[71]

A federal district court first faced this difficult issue in *Lipari v. Sears, Roebuck & Co.*[72] The Liparis, guests at a crowded nightclub, were injured when a mental patient fired a shotgun blast into the room.[73] The patient had been released following a period of involuntary commitment and was participating in a VA day program. When he chose to quit the program, his VA doctors did not seek to stop him. The Liparis sued the government, alleging that the VA was negligent in failing to detain the patient or seek his commitment.[74] Following the *Tarasoff* rationale, the court agreed that the psychotherapist-patient relationship creates a duty on the part of the doctor to protect third persons from the patient's violence.[75] It then rejected the government's contention that discharge of the *Tarasoff* duty must be limited to warning alone. "[T]he nature of the precautions which must be taken depends on the circumstances," the court stated, noting that the *Tarasoff* court had stressed that discharge of the duty to protect would vary with the facts of each case.[76] "Moreover, this Court refuses to rule as a matter of law that a reasonable therapist would never be required to take precautions other than warnings, or that there is never a duty to attempt to detain a patient."[77]

In light of California's decision to limit *Tarasoff* to identifiable victims only, the *Lipari* court necessarily had to tackle the "foreseeability of the victim" issue.[78] In contrast to the post-*Tarasoff* California decisions, the court concluded the therapist's duty extends to the broader class of those third persons who reasonably could be foreseen as victims of the dangerous patient's violence.[79]

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71. *See Currie I*, 644 F. Supp. at 1080. The consequences of making the wrong decision when seeking commitment are severe. If a patient is dangerous and a doctor fails in an effort to commit, the patient's dangerous condition may be aggravated. If the patient is not a true threat to others and the doctor is successful in seeking commitment, the deprivation of the patient's liberty is unmerited. *Id.*

72. 497 F. Supp. 185 (D. Neb. 1980).

73. *Id.* at 187. It does not appear on the face of the opinion that the Liparis had any relationship to the killer, and the VA apparently was unaware of their existence prior to the shooting. *Id.* at 194.

74. *Id.*

75. *Id.* at 188-93.

76. *Id.* at 193.

77. *Id.*

78. *Id.* at 194. Arguably California law places identifiable victim limitations only on the duty to warn and does not necessarily place them on all other measures that might be "reasonably necessary under the circumstances." *See Currie I*, 644 F. Supp. at 1078-79; *Thompson*, 27 Cal. 3d at 749-58, 614 P.2d at 732-38, 167 Cal. Rptr. at 74-80; *supra* notes 69, 87-89 and accompanying text. *Thompson*, of course, did not address the prospect of placing "readily identifiable victim" limits on a duty to seek commitment of dangerous mental patients because such a question was not before the court. Furthermore, such decisions are cloaked with statutory immunity in California. *See Tarasoff II*, 17 Cal. 3d at 447-50, 551 P.2d at 351-53, 131 Cal. Rptr. at 31-33.

79. *Lipari*, 497 F. Supp. at 194. The *Lipari* court addressed only the question of whether a psychotherapist could be held liable for failure to detain or failure to seek commitment of a dangerous patient. The broad foreseeability limitations discussed in the case do not necessarily conflict,

Failure-to-commit cases are not very common, and *Lipari* is regarded as a rather controversial decision.[80] Nonetheless, the case has been cited by a number of courts which do not expressly reject its conclusion. The Washington Supreme Court in *Petersen v. State*,[81] for example, agreed that the *Tarasoff* duty should extend to all persons foreseeably endangered by a therapist's failure to control a dangerous patient, not simply to those victims who are identifiable.[82] In *Durflinger v. Artiles*[83] the Kansas Supreme Court distinguished liability in a negligent release situation from the *Tarasoff* duty to protect, but in describing the duty to protect, explained that "affirmative actions . . . for the benefit of third parties . . . involve such steps as notifying a potential victim, calling the police or instituting commitment proceedings."[84]

Most recently the federal district court in *Currie* followed *Lipari*, arguing that "it would be improper to rule that a psychotherapist would never have a duty to institute commitment proceedings against a patient."[85] The court found the psychotherapist-patient special relationship sufficient to uphold such a duty because "[t]o rule otherwise would allow a psychotherapist to act in 'careless disregard' of members of the public known to be endangered."[86] On the corollary question of the duty's scope, the *Currie* district court agreed with *Lipari* and other decisions that have held that the *Tarasoff* duty to protect should not be limited to readily identifiable victims.[87] When commitment is the only reasonable means by which to prevent a patient from injuring others, the court maintained that the doctor's duty should extend to all of the patient's foreseeable victims as well.[88] It described the *Thompson* "readily identifiable victim" rule as a policy restriction on duty, not a foreseeability restriction, and argued that, in situations that might require a duty to commit, policy considerations dictate that the duty not be limited by the lack of a readily identifiable victim.[89]

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therefore, with the readily identifiable victim limits enunciated in *Thompson*, which involved only a failure to warn situation. The *Lipari* court did not expressly draw this distinction, however.

80. "Wayward" was the adjective used by the Fourth Circuit in *Currie* to describe *Lipari*. *Currie II*, 836 F.2d at 213.

81. 100 Wash. 2d 421, 671 P.2d 230 (1983).

82. *Id.* at 428-29, 671 P.2d at 237. "In the present case, we follow the approach utilized in *Lipari* . . . . Consequently, we conclude Dr. Miller incurred a duty to take reasonable precautions to protect *anyone who might foreseeably be endangered*" by his patient. *Id.* (emphasis added).

83. 234 Kan. 484, 673 P.2d 86 (1983).

84. *Id.* at 493, 673 P.2d at 94. The court also quoted extensively from *Lipari* with apparent approval. *Id.* at 493-99, 673 P.2d at 94-99; *see also* S. HALLECK, *supra* note 41, at 63 ("It would seem that psychiatrists could in theory be sued for failing to initiate the commitment of a patient"); Mills, *The So-Called Duty to Warn: The Psychotherapeutic Duty to Protect Third Parties From Patients' Violent Acts*, 2 BEHAV. SCI. & L. 237, 250-51 (1984) ("In handling a potentially violent patient, the legal presumption should be that psychotherapists will first apply clinical remedies, such as . . . increased treatment, . . . hospitalization, or involuntary hospitalization"); Note, *supra* note 69, at 615 (listing possible measures a doctor could take to discharge his duty to protect, including "securing involuntary commitment").

85. *Currie I*, 644 F. Supp. at 1081.

86. *Id.* (citing *Tarasoff II*, 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22).

87. *Id.* at 1078.

88. *Id.* at 1079-80.

89. *Id.* at 1078-79. The court noted that *Thompson* emphasized the practical difficulties that arise if a duty to warn is extended to victims who are not identifiable and stressed the ineffectiveness of issuing general warnings to the police or public. *Id.* at 1079.

Although *Lipari* and the district court's ruling in *Currie* represent a minority view, they appear to be the only cases to apply the *Tarasoff* doctrine affirmatively to a plaintiff's argument that a doctor owes a duty to seek commitment. Other cases have found no liability for failure to commit, but not because the *Tarasoff* rationale does not support one. Rather, the courts have held that a duty to commit did not exist on the facts before them.

Tarasoff itself, for example, included an allegation by plaintiffs that the doctors had a duty to confine their patient.[90] The court held, however, that liability could not arise based on that allegation because California granted statutory immunity to public employees for injuries resulting from their decisions to confine or release mental patients.[91] Subsequent California cases reflected this holding and were decided on failure-to-warn claims only.[92]

Another case that implied the validity of a duty to commit but refused to recognize it on the facts before the court was *Brady v. Hopper.*[93] In this famed lawsuit, brought by victims of John Hinckley's assassination attempt on President Reagan, the court considered plaintiffs' allegation that Hinckley's psychotherapist should be liable for failing to take control over his patient and confine him. The court acknowledged that the psychotherapist-patient relationship was the source of a duty on the doctor to protect the patient's victims, but it stressed that the duty to protect could be owed only to specific victims of specific threats.[94] The court found that Hinckley had made no threats at all, and that if he had ever posed any foreseeable risks to third parties, his doctor could never have identified the likely victims.[95] Although the court ruled for defendant, it did not accept his argument that the psychotherapist-outpatient relationship could never require the doctor to control the patient's conduct by detaining him.[96] A close reading of the case reveals that the court did not criticize the

90. *Tarasoff II*, 17 Cal. 3d at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

91. *Id.* at 447-50, 551 P.2d at 351-53, 131 Cal. Rptr. at 31-33.

92. *See, e.g.*, *Jablonski*, 712 F.2d 391.

93. 570 F. Supp. 1333 (D. Colo. 1983).

94. *Brady*, 570 F. Supp. at 1338-39. Thus, the court accepted the readily identifiable victim limitation as applying to all possible steps that might be required under the *Tarasoff* duty of protection. The court reasoned that without specific threats to specific victims, the possibility that patient was a danger to the public was "vague, speculative and a matter of conjecture." *Id.* at 1338; *see infra* note 157.

95. *Id.* at 1339. The holding in *Brady* is somewhat clouded by the fact that not only were the assassination victims unidentifiable prior to the attack, a compelling argument existed that they were not even foreseeable in a broad sense. The pleadings suggested that Hinckley's doctor had no idea and little reason to suspect that his patient was dangerous. *Id.*

96. *Id.* Defendant in *Brady* argued that the psychotherapist-outpatient relationship lacked sufficient elements of control for the doctor to owe a duty of protection to third parties. *Id.* at 1335-36. He also maintained that, if a duty of control were imposed, the victims were not readily identifiable as required by California law. *Id.* at 1336. Plaintiffs insisted that the doctor-patient relationship did involve elements of control in the treatment process that would give rise to a duty to protect the public from the patient. They argued that the doctor possessed the ability to recommend hospitalization and that the duty of the doctor to control his patient is not bound by readily identifiable victim limits. *Id.* at 1337-38.

Although it found for defendant, the *Brady* court rejected his argument that the doctor-patient relationship lacked the requisite control needed for the duty to protect to arise. *Id.* at 1338. The Fourth Circuit in *Currie* essentially accepted the very argument that the Brady court rejected. *Compare id.* at 1335-36 *with Currie II*, 836 F.2d at 212-13.

duty to seek commitment, but rather the "ill-defined" nature of the particularly broad duty that plaintiffs had urged the court to adopt.[97]

Other courts, like the Fourth Circuit in *Currie*, have solved the "duty to commit" dilemma in a manner less delicate than that in *Brady* or *Tarasoff*. They have simply found that no duty to control or commit an outpatient can ever exist. Cases from these jurisdictions base their holdings on a theory of liability different from that employed in *Tarasoff*, and they largely misinterpret the nature of the *Tarasoff* doctrine.

Typical of these cases is *Abernathy v. United States.*[98] Plaintiffs in *Abernathy* sued the federal government, whose doctors had entered into a physician-patient relationship with a child suffering from an organic brain disorder.[99] They alleged that the doctors, who were not psychotherapists, were negligent in failing to commit the child, who had an uncontrollable and unpredictable tendency to wreak violence on others.[100] In considering whether the doctors had a duty to control their patient, the court virtually ignored the entire rationale behind *Tarasoff*.[101] It noted that an individual owes no common law duty to control another's conduct for the protection of a third party except "when a special relationship exists between the person charged with control and the person causing the harm."[102] The court cited a California Court of Appeals decision for the principle that the duty owed to third persons depends on the *ability* of the individual to control the conduct of one posing the risk of harm.[103] It then noted that a mental hospital's *ability to control* its patients forms the basis of its liability for negligent release.[104] Because the doctors lacked control over their patient, the court found they could not be held liable for plaintiff's injuries because of their failure to seek the patient's commitment.[105] The reasoning in *Abernathy* closely parallels that in several other opinions, including the Fourth Circuit's

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97. In the court's words:

> To impose upon [therapists] an ill-defined "duty to control" would require therapists to be ultimately responsible for the actions of their patients. . . . In my opinion, the "specific threats to specific victims" rule states a workable, reasonable, and fair boundary upon the sphere of a therapist's liability to third persons for the acts of their patients.

Brady, 570 F. Supp. at 1339.

98. 773 F.2d at 184 (8th Cir. 1985).

99. The child suffered from "organic brain syndrome" and epilepsy. His assaultive behavior appears to have been uncontrollable and irrational, and it apparently was the result of a physiological disorder, not one purely psychological in nature. *See id.* at 186.

100. *Id.* at 186-87. The victim in this case could never have been identified in advance, as the patient had never met the victim until the day he killed him. *Id.* at 189 n.3.

101. *Id. Tarasoff* was dismissed in a footnote as applicable only when a duty to warn has been alleged. Because the victim was completely unidentifiable, the court maintained he could not be warned and *Tarasoff* could not apply. *Id.*

102. *Id.* at 189.

103. *Abernathy*, 773 F.2d at 189. "[I]n order to take charge of a person in such a manner as will create a duty to control his conduct one must possess the ability to control that person's conduct." Megeff v. Doland, 123 Cal. App. 3d 251, 261, 176 Cal. Rptr. 467, 472 (1981).

104. *Abernathy*, 773 F.2d at 189.

105. *Id.* The court freely found that none of the patient's doctors had control over the patient's actions and that there had been no undertaking to control such as that which occurs when a mental hospital confines a violent patient. *Id.* The court apparently found no contradiction between this conclusion and earlier statements in its opinion, e.g., "[t]hree physicians under contract with [defendant] to provide health care . . . prescribed medicine to control [patient's] epilepsy and to provide

Currie decision.[106]

The conflicting body of case law dealing with the *Tarasoff* duty on psychotherapists to protect third parties from outpatient violence is reflected in North Carolina law only tangentially. At the time *Currie* was decided, only two cases had dealt in any significant way with the issue of the duties or obligations owed by psychotherapists.

The North Carolina Court of Appeals in *In re Farrow*[107] held that the statutorily created confidentiality privilege for physician-patient communication[108] is not applicable in involuntary commitment proceedings. Thus, there is no bar to the testimony of a doctor who has treated a patient whose commitment is being sought. The court maintained that the confidentiality statute itself creates a qualified privilege, not an absolute one.[109] Further, it held that the statutory scheme for commitment makes it clear that doctors who have treated a patient are expected to initiate the patient's commitment proceedings if necessary or to testify at them.[110]

Farrow obviously does not amount to an endorsement of *Tarasoff*, but the finding that North Carolina's confidentiality privilege for psychotherapist-patient communication may be abrogated is not devoid of significance. A similar point in California law helped the *Tarasoff* court reach its conclusion that a psychotherapist could owe a duty to act for the benefit of third parties.[111] *Tarasoff* is mentioned briefly in *Farrow* as an example of the "inherent conflict between a psychiatrist's duty to maintain confidentiality and his duty to disclose

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him with more control over his day-to-day behavior." *Id.* at 186. For a discussion of the control that typically exists in doctor-patient relationships, see *infra* text at notes 136-38.

The conclusion that no ability or duty to control existed on the facts followed the court's initial determination that the government's failure to seek involuntary commitment of a person who subsequently kills another is protected by statutory immunity granted for discretionary government functions. *Id.* at 188.

106. *See* Hinkelman v. Borgess Medical Center, 157 Mich. App. 314, 403 N.W.2d 547 (1987) (patient who spent several hours as a voluntary patient at a psychiatric hospital with which he had no prior contact did not enjoy a special relationship with the hospital that would support an affirmative duty on the hospital to protect third parties; relationship also lacked "control" element); Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982) (hospital-outpatient relationship lacks sufficient elements of control necessary to bring relationship under sections 315 to 319 of the Restatement; also patient's dangerousness in this case could not be predicted "with any reasonable degree of medical or psychiatric certainty"). *But cf.* Greenberg v. Barbour, 322 F. Supp. 745 (E.D. Pa. 1971) (a hospital may owe a duty to establish control over a dangerous patient who presents himself to them); Bradley Center, Inc. v. Wessner, 250 Ga. 199, 296 S.E.2d 693 (1982) (hospital had sufficient control over voluntary inpatient to be liable to patient's wife for foreseeable injury caused while patient on leave).

The general rationale behind cases such as *Hinkelman* and *Hasenei* is criticized *infra* text at notes 127-42.

107. 41 N.C. App. 680, 255 S.E.2d 777 (1979).

108. N.C. GEN. STAT. § 8-53 (1986).

109. *Farrow*, 41 N.C. App. at 681-85, 255 S.E.2d at 779-81. The statute provides that a judge may compel disclosure if he believes it "necessary to a proper administration of justice." N.C. GEN. STAT. § 8-53 (1986).

110. *Farrow*, 41 N.C. App. at 683-85, 255 S.E.2d at 779-81. The court found this to be so because an involuntary commitment proceeding is "an important step in [the patient's] medical and psychiatric treatment." *Id.* at 683, 255 S.E.2d at 780.

111. *Tarasoff II*, 17 Cal. 3d at 440-42, 551 P.2d at 346-47, 131 Cal. Rptr. at 26-27.

when necessary to protect his patient or the public from imminent danger."[112]

Closer to the issue in *Currie* would be *Pangburn v. Saad*.[113] In what might be described as a "garden variety" negligent release case, the North Carolina Court of Appeals recognized a cause of action for injuries caused by the wrongful release of a dangerous involuntarily committed patient.[114] The court described the legal duty owed in negligent release cases by quoting a similar Georgia decision, *Bradley Center, Inc. v. Wessner*:[115]

Where the course of treatment of a mental patient involves an exercise

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112. *Farrow*, 41 N.C. App. at 685, 255 S.E.2d at 781. The court's citation of *Tarasoff* cannot fairly be construed as an endorsement of the *Tarasoff* duty to protect. It stands instead as a noncritical judicial recognition that the doctrine exists.

113. 73 N.C. App. 336, 326 S.E.2d 365 (1985).

114. *Pangburn* involved a decision by a doctor in Goldsboro to release a patient, involuntarily committed at Cherry Hospital, who stabbed his sister shortly after release. The patient's parents had strongly protested his release because of his past history of attacks on family members. *Id.* at 347-48, 326 S.E.2d at 372-73.

Since the Fourth Circuit's *Currie* decision, the North Carolina Court of Appeals has addressed the separate issue of a doctor's duty to continue the detention of a patient-arrestee temporarily committed for a psychiatric examination. Paschall v. North Carolina Dep't of Correction, 88 N.C. App. 520, 364 S.E.2d 144 (1988). In *Paschall*, an arrestee was temporarily committed to a state mental hospital by a district court for a determination of competency to stand trial. A doctor employed by the Department of Human Resources examined her and found her competent. In a report to the judge in which long-term commitment typically would be recommended if needed, the doctor noted that his patient, although competent, was both ill (presumably mentally ill) and "a continued danger to the patient and to others." *Id.* at 521, 364 S.E.2d at 144. It is not clear whether the doctor recommended extended commitment. The patient-arrestee was released by court order and she subsequently injured plaintiff, apparently in the scope and course of plaintiff's employment. Plaintiff's complaint to the Industrial Commission was allowed against the Department of Human Resources for its employee's negligence in releasing the patient. Plaintiff argued that the department had owed a duty to detain the patient further. The commission found as a fact that the patient was properly examined by the department and lawfully released by the courts. It also found that at the time of release the patient was "not dangerous to plaintiff or others." *Id.* at 522, 364 S.E.2d at 145. Thus, the commission found "no showing of negligence upon the part of defendant which proximately caused injury to plaintiff." *Id.* at 523, 364 S.E.2d at 146. Because the plaintiff did not challenge these facts on appeal, the appeals court held that unchallenged facts existed that supported and justified the legal conclusion of the commission; therefore, the commission's decision was affirmed. *Id.*

Paschall is a puzzling case that appears to turn on the Industrial Commission's uncontested finding that the patient-arrestee was not dangerous at the time of release. Given such a fact, obviously, no negligence could ever have occurred; "plaintiff simply failed to prove any negligence by the defendant." *Id.* The court, however, felt obliged to go further and it stressed that the doctor, by reporting to the judge, had done all he was legally required to do, and that the decision to release was one made by the district court. Therefore, the doctor had fulfilled his duty. *Id.* at 524-25, 364 S.E.2d at 146-47.

The court never explained exactly what the doctor's duty was with respect to his patient beyond evaluating her and reporting to the judge on her fitness for trial. The court seemed to suggest that if the doctor had any duty to seek further detention of the patient, that duty required only recommending detention to the district judge that had placed the patient in the department's care in the first place. *Id.* at 524-25, 364 S.E.2d at 146. The district court's decision not to act on what may have been a suggestion by the doctor for further detention then appears to have been the equivalent of a legal finding that the patient did not meet the criteria for further commitment.

Because the court was most unclear about the nature of the duty owed by the DHR doctor, it seems best to view the case as involving a patient who was found by the trier of fact to have posed no danger to others. Thus, any claims of negligence with respect to third parties would be necessarily precluded regardless of any duty that might be owed.

115. 250 Ga. 199, 296 S.E.2d 693 (1982). *Bradley* involved a patient who had been voluntarily admitted to a psychiatric hospital and revealed while there that he would likely cause harm to his wife. When he was permitted to leave the hospital on a weekend pass, he murdered her. A wrongful death claim was brought against the hospital. *Id.* at 199-200, 296 S.E.2d at 694.

> of "control" over [the patient] by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient.[116]

The North Carolina court found that Dr. Saad breached this duty to plaintiff and that her injury was a reasonably foreseeable result.[117]

Pangburn acknowledges a cause of action that traditionally has been recognized by the courts,[118] and the Court of Appeals chose not to elaborate on the rationale behind it. It contented itself simply with citing the Georgia Supreme Court decision. A closer look at *Bradley* reveals that although the Georgia court framed its holding in terms of the "control" that a hospital exercises over a dangerous patient, it emphasized that the doctor-patient special relationship creates the duty.[119] "Control" in *Bradley* is not the product of forced custody, but rather a characteristic of the relationship between a hospital and a voluntary inpatient.[120] The supreme court noted that the duty it had recognized was consistent with the duty found in cases that involved dangerous outpatients, including *Tarasoff* and *Lipari*.[121] An examination of the appellate decision affirmed by the Georgia Supreme Court confirms that Georgia law envisioned the duty imposed on the hospital as arising out of the relationship between doctor and patient.[122] The lower court quoted liberally from *Tarasoff* to explain the nature of the duty owed.[123]

In addition to the cases discussed above, North Carolina statutes outline the rights of doctors and their role in the involuntary commitment process.[124] Statutory law also shields psychotherapists and hospitals to a limited degree from liability arising out of the "examination, management, supervision, treatment or release" of mental patients.[125] This immunity is conditioned on the doctor following "accepted professional judgment, practice and standards" and it absolves the doctor of liability for his own acts as well as "for actions of the client."[126]

116. *Pangburn*, 73 N.C. App. at 338, 326 S.E.2d at 367 (quoting *Bradley*, 250 Ga. at 201, 296 S.E.2d at 695-96).

117. *Id.* at 338, 326 S.E.2d at 367.

118. *See supra* notes 49-50 and accompanying text.

119. *Bradley*, 250 Ga. at 201-02, 296 S.E.2d at 695-96.

120. This distinction was discussed at length in the lower court's decision. *See* Bradley Center, Inc. v. Wessner, 161 Ga. App. 576, 580-82, 287 S.E.2d 716, 721-22 (1982).

121. *Bradley*, 250 Ga. at 202, 296 S.E.2d at 696.

122. "The patient-physician relationship is thus important in the instant case only because the independent duty to control, which was alleged as having been breached, arose from that underlying relationship." *Bradley*, 161 Ga. App. at 581, 287 S.E.2d at 721. This finding was essential in this case because there was no forced custody relationship present in typical negligent release cases, such as those cited *supra* note 50.

123. *Id. passim*, 287 S.E.2d *passim*. *But see* Note, *Tort Liability in Georgia for the Criminal Acts of Another*, 18 GA. L. REV. 361, 376-83 (1984) (arguing that the *Bradley* court's citations to *Tarasoff* and *Lipari* were improvident and that the Georgia courts probably intended to create a duty to control only in the traditional context of negligent release).

124. *See* N.C. GEN. STAT. §§ 122C-261 to -277 (1986 & Supp. 1987).

125. N.C. GEN. STAT. § 122C-210.1 (1986); *see supra* note 40.

126. *Id.* This statute, as written, has not been construed by the North Carolina courts, but one

Given the fragmented state of North Carolina law governing the duties owed by psychotherapists to third parties, the two federal courts that considered *Currie* were quite justified in turning to the law of other jurisdictions to resolve the legal issues posed in the complaint. The approach chosen by the Fourth Circuit to analyze the duty of psychotherapists, however, is poorly supported by logic and precedent. It implicitly rejected the rationale underlying *Tarasoff* and misperceived the whole nature of the affirmative duty to protect third parties from the conduct of others.

The Fourth Circuit reached its conclusion by determining that no right of control exists in a psychotherapist-outpatient relationship. That right, the court claimed, is the key to an individual's duty to protect third parties.[127] The court noted that mental hospitals traditionally have been held liable for injuries caused by their negligent release of dangerous patients and that the control element of the forced custody relationship gave rise to the duty.[128]

By seeming to limit a "right of control" to forced custody situations, however, the Fourth Circuit dodged the inquiry essential to determining whether a duty to protect third parties exists. What the court failed to acknowledge is that a duty to control another's conduct arises out of a relationship. As Harper and Kime stressed in 1934, certain "social relationships . . . are of such a character that the law imposes the affirmative duty upon one person to attempt to control another's conduct."[129] The relevant inquiry when searching for such an affirmative duty is whether the relationship between the parties is sufficiently important to society as to impose a duty on one party to protect third persons from a danger posed by the other. The "right of control" touted by the Fourth Circuit in *Currie* arises from the significant nature of the relationship, not somehow independent of it. Certainly rights of control exist in the relationships cited in Restatement sections 316 through 319—parent-child,[130] master-servant,[131] and custodian-charge[132]—but they exist because these relationships are "of sufficient importance to require for a sound and stable social order certain assurances of safety to person and property on the part of the parties thereto."[133] As Harper

commentator has concluded that it establishes a negligence standard to be applied in a manner not unlike that demonstrated by the court in *Currie I.* Note, *supra* note 28, at 1540 ("Although phrased in terms of providing 'immunity' . . . the statutory language clearly provides that state psychiatrists will now be liable for ordinary negligence in cases of wrongful release").

127. The Fourth Circuit cited *Semler*, 538 F.2d 121, and *Abernathy*, 773 F.2d 184, as support for a control based duty. Both cases did discuss liability in terms of whether a defendant had taken control of a patient. *Semler*, however, was a forced custody case decided before *Tarasoff* and involved a court order requiring a hospital to control a patient. *Abernathy* addressed the issue of whether a duty exists to seek an outpatient's commitment in much the same manner as did the Fourth Circuit in *Currie*. See *supra* text accompanying notes 98-106 and *infra* text accompanying note 156 for a discussion of the *Abernathy* holding.

128. *See supra* text accompanying notes 49-50.

129. Harper & Kime, *supra* note 43, at 887.

130. RESTATEMENT, *supra* note 45, § 316.

131. RESTATEMENT, *supra* note 45, § 317.

132. RESTATEMENT, *supra* note 45, § 319. Section 318 addresses liability in negligent entrustment situations. *Id.* § 318.

133. Harper & Kime, *supra* note 43, at 904. This concept is reflected in general principle of § 315 of the Restatement. *See supra* note 47.

and Kime explained:

> The social policies which determine what relationships require such special assurance and what ones are sufficiently unimportant not to require them are so incredibly complicated as to almost defy analysis . . . They represent for the most part the popular notions of what constitutes proper assumptions on the part of one person when dealing with another. The common law attempts to interpret these communal reactions and to crystallize them into rules of law. As business and social relations become more and more complicated, these reactions are modified on the one hand and extended on the other. This requires modification and extension of the common law.[134]

Tarasoff marked just such a "modification and extension of the common law" when it held that the special psychotherapist-patient relationship could give rise to an affirmative duty to protect third parties from mental patients who threaten violence.[135]

Furthermore, a consideration of the "contagious disease" and "duty to provide proper treatment" cases that provided the groundwork for *Tarasoff*[136] reveals that a right of control does exist in the doctor-patient relationship independent of any forced custody. The doctor who enters into a professional relationship with a patient "takes charge" of that patient for the purpose of treating him.[137] In situations where the patient's condition poses a risk to society, the control inherent in this voluntarily assumed relationship may give rise to

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134. Harper & Kime, *supra* note 43, at 904-05. The relational nature of the duty to control the conduct of others, as described by Harper and Kime, is critically important. Harper and Kime never claimed that an individual must have actual physical control over one who poses a risk of harm to third parties before a duty to protect could arise. The parent-child relationship, for example, reveals nothing of the complete control found in the jailor-inmate relationship. The common thread running through these relationships is that society has determined them significant enough to confer rights of control concomitant with a duty to protect.

135. *See supra* text accompanying notes 51-57. If one attempts to pigeonhole *Tarasoff* into one of the four examples listed in the Restatement, one has no choice but to look to § 319. Section 319, however, suggests a custodial relationship which, as explained *supra* note 57, denotes a situation in which one actor has taken charge over another. In a psychotherapist-outpatient relationship, however, the doctor does not appear to have taken charge of a patient to the same degree as a hospital. For this reason, some commentators have argued that *Tarasoff* was wrongly decided. *See* Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 365-66 (1976).

If, however, one focuses on the reasoning behind Harper and Kime's argument and overlooks the artificial distinctions made by § 319, the special relationship between psychotherapist and dangerous outpatient clearly seems one of such social significance that it would support a "right of control" in the doctor and a duty to protect others from harm. Moreover, one might well conclude that the psychotherapist-patient relationship does involve a significant element of "taking charge." Certainly, the doctor takes charge of the patient for purposes of treating him. *See supra* text accompanying notes 136-38. One could argue then that the doctor also takes on duties to the public with respect to providing non-negligent treatment. *See supra* note 58.

Once a right of control is recognized in the therapist-patient relationship, the question of what steps must be taken to protect others simply becomes a policy decision, and the doctor's use of his statutorily granted power to seize control over a dangerous patient by seeking his commitment should not automatically be dismissed as an inappropriate step without weighing competing policies. *See infra* note 154.

136. *See supra* note 58.

137. *See* Note, *Affirmative Duties in Tort Following* Tarasoff, 58 ST. JOHN'S L. REV. 492, 511-14 (1984) (describing a doctor's power to control a patient as fundamental; "the nature of the control practiced by a physician is in many respects similar to that asserted by a parent").

a duty on the part of the doctor to protect third parties from the risk posed by the patient.[138] This aspect of the physician-patient relationship appears to have been at the heart of the *Tarasoff* result.

Implicit then in the Fourth Circuit's *Currie* argument is that *Tarasoff* was wrongly decided. The Fourth Circuit attempted to distinguish that landmark case by describing it as recognizing "a duty to warn" that is an "expression of humanitarianism and the spirit of the good Samaritan."[139] *Tarasoff*, however, did not recognize a duty to warn. It recognized a duty to protect that could be discharged in most instances by a warning. The California Supreme Court clearly anticipated that in some situations a psychotherapist might have to go further and take "whatever other steps are reasonably necessary" to meet his duty to protect.[140] Furthermore, the basis of the protective duty, according to the *Tarasoff* court, was the established tort doctrine of affirmative obligation and special relationships.[141] It was most certainly not "the spirit of the good Samaritan."[142] By attempting to redefine *Tarasoff* in such peculiar terms and by ignoring the special relationship and right of control that arises when a psychotherapist "takes charge" of a patient for treatment purposes, the Fourth Circuit managed to distinguish *Tarasoff* virtually out of existence.

The essence of the *Tarasoff* court's holding was that a psychotherapist's relationship with a patient who has threatened a third party involves sufficient elements of control and social significance to support a duty to protect others—a point not lost on the lower court in *Currie*.[143] This duty is not boundless, however, and is constrained by traditional policy considerations.[144] The *Tarasoff* court considered the policy aspects of imposing liability and, on the facts of that case, concluded that the peril that could be avoided by warning the victim

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138. *Tarasoff I* elaborated on this idea, explaining the doctor's relationship with a patient in terms of an undertaking that produces a duty to perform with due care towards all concerned, the patient or any foreseeable third parties with whom he will come in contact. *Tarasoff I*, 529 P.2d at 559, 118 Cal. Rptr. at 135. Arguably, the duty of care would run then to third parties even after the doctor-patient relationship has terminated, for although the source of duty lies in the relationship, the doctor's obligation continues on because of his initial undertaking.

139. *Currie II*, 836 F.2d at 213.

140. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

141. *See supra* text accompanying notes 51-57.

142. One can scarcely imagine all of the hydra-headed duties that might arise from such a bizarre basis for tort liability.

143. *Currie I*, 644 F. Supp. at 1080. "Plaintiff is correct that *Tarasoff*'s finding of a special relationship between therapist and patient allows an affirmative duty to be placed on a party 'to control' another." *Id.*

144. *See Currie I*, 644 F. Supp. at 1079-83; *Tarasoff II*, 17 Cal. 3d at 434-35, 437-43, 551 P.2d at 342-43, 344-48, 131 Cal. Rptr. at 22-23, 24-28. The general rule that one is liable to another for injury caused by want of ordinary care or skill is departed from after weighing a number of policy considerations. These include:

> the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved.

Id. at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22 (quoting Rowland v. Christian, 69 Cal. 2d 108, 113, 443 P.2d 561, 564, 70 Cal. Rptr. 97, 100 (1968)).

greatly outweighed any damage to the doctor-patient relationship that might be caused by breaching the confidentiality privilege. A warning to a foreseeable victim in these circumstances, it held, was the proper means for discharging the duty to protect.[145]

An argument can be fashioned to support the Fourth Circuit's conclusion that liability should not exist for failure to commit without misinterpreting the *Tarasoff* holding. In *Thompson*[146] the California Supreme Court held that a duty to warn could extend only to readily identifiable victims, explaining its holding in the traditional tort language of "foreseeability." The court in *Brady* used this same argument to find that John Hinckley's psychotherapist did not owe unidentifiable plaintiffs duty to confine his patient.[147]

The *Lipari* court, however, produced a compelling argument that in some circumstances—as when a patient exhibits clear violent tendencies that cannot be controlled or predicted—a doctor's duty to protect should not be eliminated simply because a warning is impractical. The duty to protect, it explained, may be interpreted fairly to include a duty to "attempt to detain a patient."[148] The court further held that the *Tarasoff* duty to protect should be limited not to identifiable victims alone, but should be owed to any person "foreseeably endangered."[149]

Lipari may have painted the duty to protect with too broad a brush.[150] The *Currie* district court, however, refined the notion of duty suggested in that case by explaining that "foreseeability," as it was discussed in *Thompson*, was really nothing more than a policy judgment.[151] The imposition of "readily identifiable victim" limits in that case, it argued, was policy based—a fact borne out by the California court's emphasis on the enormous burden that would accompany a duty to warn a class of unidentifiable people.[152] In situations where a patient is dangerous not just to one individual but to others generally, the *Currie* district court argued that a *Lipari*-type duty to seek commitment can arise and any policy considerations that restricted the duty to warn in *Thompson* would van-

145. *Tarasoff II*, 17 Cal. 3d at 441, 551 P.2d at 346-47, 131 Cal. Rptr. at 27. *Tarasoff* has been criticized for placing too much emphasis on steps such as giving warnings that are apparently unrelated to the actual treatment of the patient. *See* Mills, *supra* note 84, 249-51, 257. A warning, however, is a perfectly justified means of dispatching the doctor's duty to protect. The duty of protection is owed to third parties, not to the patient. Although proper treatment of the patient is one means of meeting the duty, other steps that go beyond the treatment of a patient, e.g., warning third parties of the contagious or dangerous nature of patient, can be required. The idea that dispatching the duty of protection can never require a doctor to attempt to restrain a dangerous patient should be quickly rejected because involuntary commitment is not punishment, but a means of treatment. "In a real sense the [involuntary commitment proceeding] is an important step in [the patient's] medical and psychiatric treatment." *Farrow*, 41 N.C. App. at 683, 255 S.E.2d at 780.

146. *See supra* text accompanying notes 64-68.

147. *See supra* text accompanying notes 93-97.

148. *Lipari*, 497 F. Supp. at 193.

149. *Id.* at 194.

150. *Lipari* discussed the entire *Tarasoff* duty to protect as one owed to foreseeable persons. It did not acknowledge that practicalities may necessarily narrow the scope of a duty to warn to readily identifiable victims; however, that particular issue was not before the court.

151. *Currie I*, 644 F. Supp. at 1079.

152. *Id.*; *see Thompson*, 27 Cal. 3d at 754-58, 614 P.2d at 735-38, 167 Cal. Rptr. at 77-80.

ish.[153] The *Currie* district court then considered other policy considerations that might weigh against a duty to commit, but ultimately found them unpersuasive.[154]

Needless to say, the Fourth Circuit engaged in very little analysis of this sort. Instead, it grounded its conclusion that an affirmative duty to commit can never exist in the flawed assumption that some "right to control" analogous to forced custody must exist before a duty to protect others can arise.[155] In addition to this misperception of what constitutes "taking charge," the one relevant opinion that the court appeared to cite for its proposition provides weak support at best. *Abernathy* employed the same "control based" theory similar to that relied on by the Fourth Circuit in *Currie*, but, significantly, defendants in that case were not psychotherapists and the court relied heavily on a finding of statutory immunity.[156]

Even if one were to conclude, in the fashion of the *Brady* court, that liability for failure to confine should not exist in cases like *Lipari* and *Abernathy* because plaintiffs were not sufficiently identifiable,[157] *Currie* presents a much more compelling case for a duty to seek commitment.[158] The VA psychotherapists knew the nature of Avery's threats and the likely victim was a clearly identified

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153. *Currie I*, 644 F. Supp. at 1079.

154. Some of these considerations are discussed *supra* note 22. Chief among them is the loss of a patient's liberty that accompanies commitment and the high price that would be paid for a wrong decision.

Other policy considerations include the lack of expertise of jurors and judges in making predictions of dangerousness and in evaluating the need for commitment, as well as the relatively pressing circumstances under which these decisions often must be made. Considerations of this sort typically are those used to justify immunity statutes in this area.

The *Currie* district court, having found North Carolina's immunity statute to be limited to those situations where a doctor's best professional judgment was employed, made a strong argument that some liability should exist for those decisions that might fall below the standard of immunity. *See Currie I*, 644 F. Supp. at 1080-83. "[T]he court believes that therapists have some duty not to let known dangerous mental patients whom they treat run around in public." *Id.* at 1082. The creation of the "psychotherapist judgment rule" to protect psychotherapists from liability in most cases seems quite consistent with the immunity concept. *Currie I* has been described by a professor of psychiatry at Harvard Medical School as "a clear thoughtful, balanced opinion." Beck, *The Psychotherapist's Duty to Protect Third Parties From Harm*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 141, 142 (1987).

The policy arguments made by the Fourth Circuit simply are not persuasive. *See supra* text accompanying notes 36-39. Affirmative steps to secure involuntary commitment are not necessarily destructive to the doctor-patient relationship and indeed are considered part of a patient's treatment. Although a patient's liberty interest is at risk in commitment, the complex judicial process required for commitment is designed to protect a patient's right to liberty. Finally, the presence of North Carolina's immunity statute for commitment decisions actually seems to anticipate the possibility of liability in this area. *See infra* notes 163-64 and accompanying text. To the degree that these policy considerations have validity, there seems no reason to believe that the "psychotherapist judgment rule" proposed by *Currie I* would not resolve them.

155. *See supra* text accompanying notes 24-35.

156. *See supra* notes 98-105 and accompanying text.

157. The rationale behind this view, as suggested in *Brady*, seems to be that if a doctor cannot tell exactly to whom a patient is dangerous, he cannot predict the patient's dangerousness in a manner sufficient to justify any affirmative steps to protect others and control the patient's conduct. *Brady*, 570 F. Supp. at 1338. This argument is simply hard to swallow. *See Currie I*, 644 F. Supp. at 1079 ("Arguably, the patient who will kill wildly (rather than specifically identifiable victims) is the one most in need of confinement.").

158. See facts stated *supra* at text accompanying notes 12-18.

class—the employees at the IBM medical clinic.[159] The VA doctors apparently were convinced that the threat posed by Avery was serious enough to merit three warnings to the victim and calls to a variety of law enforcement agencies. The only avenue left to protect the victim was to petition for Avery's involuntary commitment, a measure the doctors declined only because they misunderstood the state standards and thought that Avery, whom they recognized as both mentally ill and dangerous, was not a proper candidate.[160]

Not only was the reasoning employed by the Fourth Circuit at odds with the law of affirmative obligation and poorly supported by precedent, North Carolina law, vague as it may be, should not have been distorted to support the court's argument and conclusion. At the very least, North Carolina law provides no clues as to how the state supreme court would rule on the question. At best, it indicates a contrary result. If one delves into the Georgia cases cited in *Pangburn* and if one ascribes significance to the mention of *Tarasoff* in *Farrow*, one could argue that North Carolina was poised to accept *Tarasoff*[161] and, consequently, the reasoning advanced in the *Currie* district court opinion.

Viewed from all angles, the treatment of the issues in *Currie* by the Fourth Circuit was less than satisfactory. The federal district court seems to have advanced the much sounder argument from the standpoint of both general tort doctrine and specific case precedent from North Carolina and other jurisdictions. Given the radically conflicting rationales behind the *Currie* holdings, one comment shared by the two opinions stands out: a North Carolina statute allowing federal courts to certify cases that involve state law issues of first impression to the North Carolina Supreme Court would have provided a much more reasonable means of resolving this case.[162]

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159. On the facts of *Currie*, the court might have found Ralph Glenn, the victim, to have been "readily identifiable" due to the nature of the threat against IBM. Avery had threatened a bombing at the company's medical facility. Such a destructive act could easily affect everyone in the building, making them all "readily identifiable victims." Such an argument was not addressed by the court.

160. The doctors' erroneous decision is discussed *supra* note 17.

161. *See supra* notes 107-26 and accompanying text.

162. The State-Federal Judicial Council has thoroughly considered whether a certification statute should be enacted in North Carolina. Such statutes typically allow federal courts to certify to state supreme courts novel state law issues that arise for the first time in the federal system. Although several federal judges have expressed a desire to see North Carolina adopt such legislation, *see, e.g.*, St. Paul Mercury Ins. Co. v. Duke Univ., 670 F. Supp. 630, 635 n.13 (M.D.N.C. 1987), the council has yet to make any recommendations to the North Carolina General Assembly.

The North Carolina Supreme Court has indicated that it does not wish to address questions of law on an advisory basis only. Therefore, it would approve only a certification procedure that enables it to render opinions that have the binding force of law. North Carolina's Constitution, however, strictly confines the court's jurisdiction, and no clause exists granting the general assembly the power to expand it. *See* N.C. CONST. art. IV, § 12(1); *see also* North Carolina *ex rel.* Utils. Comm'n v. Old Fort Finishing Plant, 289 N.C. 416, 142 S.E.2d 8 (1965) (legislature may not expand state supreme court's jurisdiction beyond limits set in state constitution). Establishing a certification procedure that would satisfy the supreme court would therefore require a constitutional amendment—a measure that, to this date, the council has not proposed.

Other considerations that may make a certification procedure less attractive to state courts include concern about increased workloads and the possibility that federal courts might play a role in setting a state court's agenda. Proponents of the procedure point out, however, that state statutes frequently place the certification of particular cases purely within the discretion of the state supreme court. Interview with Chief Justice James G. Exum, Jr., North Carolina Supreme Court, May 12, 1988; Interview with J. Rich Leonard, Clerk of Court, United States District Court for the Eastern

The confusion reflected in the *Currie* opinions over the duties owed by psychotherapists to third parties is typical of tort doctrine in the whole area of affirmative obligation. The question of when a person owes a duty to control the conduct of others for the protection of third parties has always been approached gingerly by the law. As a general principle, an individual may incur such a duty when he enters into a special relationship that involves some element of control over another who threatens harm to third parties. The key to finding such a duty and the requisite element of control lies in the degree of importance society attaches to the relationship. *Tarasoff* stands as a landmark decision because it first recognized that the psychotherapist-outpatient relationship was of such a character as to impose a duty on the part of the doctor to protect intended victims of his dangerous patients. That duty may often be discharged with a warning.

Linda Currie's complaint differed from the standard *Tarasoff* dilemma. Warnings from the VA psychotherapists could not have effectively protected IBM from Leonard Avery's threat of violence, and the psychotherapists apparently knew it. The *Currie* facts cried out for other "reasonably necessary" measures of protection. The issue therefore arose as to whether the doctors had a further duty to seek Avery's commitment. The Fourth Circuit ruled that they did not, but relied on a legal rationale that misinterpreted the nature of affirmative obligation and, accordingly, discredited existing North Carolina law in the area.

The proper place of the *Tarasoff* doctrine in North Carolina law remains unanswered. The state supreme court has not spoken on the issue and the Fourth Circuit's rather garbled holding in *Currie* offers no real guidance. After studying *Pangburn*, *Farrow* and the state statutes governing procedures for involuntary commitment, one is left with the impression that North Carolina law could expand to accommodate comfortably a duty on doctors to protect foreseeable victims from an outpatient's violence. In that regard, the district court in *Currie* did no violence to existing state law. The Fourth Circuit's assertion that North Carolina's immunity statute effectively forecloses any expansion of this area of tort law beyond *Pangburn*'s liability for negligent release simply is not persuasive.[163] Rather than seeming inconsistent with the recognition of a *Tarasoff* legal duty, it seems to anticipate it.[164] Given that North Carolina law could accommodate a *Tarasoff* duty on psychotherapists, the district court's

District of North Carolina (April 4, 1988); Interview with Professor Jim Drennan, Institute of Government (March 23, 1988).

For an example of the havoc that can be wrought in federal courts by unresolved issues of state law, compare Martin v. Volkswagen of America, Inc., 707 F.2d 823 (4th Cir. 1983) (finding North Carolina would not adopt crashworthiness doctrine) with Seese v. Volkswagenwerk A.G., 648 F.2d 833 (3rd Cir.) (finding North Carolina would recognize crashworthiness doctrine), *cert. denied*, 454 U.S. 1031 (1981).

163. *See supra* note 40 and accompanying text.

164. The statute declares that so long as accepted professional judgment is followed, no doctor or facility will be liable "for actions of the client." N.C. GEN. STAT. § 122C-210.1 (1986). The obvious implication is that doctors will be liable for the actions of a client when they fail to use professional judgment. *See supra* note 40; *Cantrell* Plaintiff's Memorandum, *supra* note 4, at 20-22, 22 n.3.

conclusion that a duty to protect can at times require a doctor to seek commitment of a dangerous patient seems a logical extension with respectable support in the existing law. One can only hope that if the issue finally does come before the North Carolina Supreme Court, it will enjoy more enlightened treatment than it received at the hands of the Fourth Circuit Court of Appeals.

J. DONALD HOBART, JR.