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Statutes Limiting Mental Health Professionals' Liability For The Violent Acts Of Their Patients

In a landmark case, *Tarasoff v. Regents of the University of California,*[1] the California Supreme Court held that in some circumstances psychotherapists can be liable for failing to warn or protect third parties from the violent acts of the therapists' patients.[2] The liability and affirmative duty which the court imposed are expansive and have ramifications for professional relationships and circumstances other than those encountered in *Tarasoff.*[3] Some state legislatures have responded by enacting statutes which codify and limit the liability of mental health professionals for the violent acts of their patients.[4] Like *Tarasoff,* these statutes embody the general principle that "in some situations, the person most likely to foresee an

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1. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

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

3. *See, e.g.,* Melella, Travin & Cullen, *The Psychotherapist's Third-Party Liability for Sexual Assaults Committed by His Patients,* 15 J. OF PSYCHIATRY AND L. 83, 110 (1987) [hereinafter Melella] (stating that "[i]f courts are willing to find a broadly defined third-party liability for sexual assaults, the risks to psychotherapists of treating sex offenders on an outpatient basis . . . may be so great as to preclude such treatment"); Sands, *The Attorney's Affirmative Duty to Warn Foreseeable Victims of a Client's Intended Violent Assault,* 21 TORT & INS. L.J. 355 (1986); Student Article, *"Bless Me Father, for I am about to Sin . . .": Should Clergy Counselors Have a Duty to Protect Third Parties?,* 22 TULSA L.J. 139 (1986) [hereinafter *Clergy Counselors*]. The Michigan Court of Appeals has held that a requisite special relationship exists between a physician and patient to support a physician's duty to third parties to warn or take precautions "where the physician determines or, pursuant to the standard of care, should determine that his patient poses a serious threat of danger to a third person." Welke v. Kuzilla, 144 Mich. App. 245, 253-54, 375 N.W.2d 403, 406 (1985).

4. *See* CAL. CIV. CODE § 43.92 (West Supp. 1988); COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. §§ 34-4-12.4-1 to -4 (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.400, 645.270 (Michie/Bobbs-Merrill Supp. 1988); LA. REV. STAT. ANN. § 9:2800.2 (West Supp. 1988); MINN. STAT. ANN. §§ 148.975-.976 (West Supp. 1988); MONT. CODE ANN. §§ 27-1-1101 to -1103 (Supp. 1987); N.H. REV. STAT. ANN. §§ 329:31, 330-A:22 (Supp. 1987); UTAH CODE ANN. §§ 78-14a-101 to -102 (Supp. 1988); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988). Montana's statute is representative:

> Duty to Warn of Violent Behavior. A mental health professional has a duty to warn of or take reasonable precautions to provide protection from violent behavior only if the patient has communicated to the mental health professional an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim. The duty is discharged by a mental health professional if he has:
>
> (1) made reasonable efforts to communicate the threat to the victim and notify the law enforcement agency closest to the patient's or the victim's residence of the threat of violence; and
>
> (2) supplied a requesting law enforcement agency with any information he has concerning the threat of violence.
>
> Immunity from Liability.
>
> (1) No monetary liability and no cause of action may arise against any mental health professional for failing to predict, warn of, or take precautions to

injury should bear the risk of its occurrence and the burden of taking steps to prevent it."[5] However, by limiting the circumstances under which the duty to warn or take precautions will be imposed, these statutes also restrict the *Tarasoff* rule's potential for expanding the scope of liability for mental health professionals.[6]

This Note will survey the history of mental health professionals' duty to warn or take precautions as it developed in *Tarasoff* and later cases, and the factors which condition this duty under the new statutes. Second, it will examine potential differences between application of the statutory duty and common law *Tarasoff* duty. Third, it will argue that the statutes should be construed as limiting the circumstances in which mental health professionals may be liable for the violent acts of their patients. Fourth, it will argue that the statutes do away with the reasonableness test governing a therapist's prediction of violence, but they permit using a reasonableness test to determine the adequacy of a therapist's actions to fulfill the duty to warn or take precautions. Finally, it will propose a formulation of a statute which better encompasses the policy judgments which are implicit in these statutes.

As an epilogue, this Note will argue that the history of the *Tarasoff* duty holds some lessons about affirmative duties in general. As shown below, the therapist's duty to warn or take precautions has undergone considerable development and change. The manner and progress of this metamorphosis prompt some insight about whether and how to impose affirmative duties in other situations.

I. The Common Law and the Statutes

The duty imposed by the *Tarasoff* line of cases is a "special relationship" exception to the general rule that one is not liable for the acts of another.[7]

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provide protection from a patient's threatened violent behavior unless he has a duty to warn of violent behavior, as provided [above].

(2) No monetary liability and no cause of action may arise against any mental health professional for disclosing confidential or privileged information in an effort to discharge a duty arising under [the above section].

Mont. Code Ann. §§ 27-1-1101 to -1103 (Supp. 1987).

5. Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers,* 31 Emory L.J. 263, 293 (1982).

6. *See infra* notes 94-103 and accompanying text.

7. *See* Restatement (Second) of Torts §§ 314, 315 (1965). *See also* Annotation, *Comment Note—Private Person's Duty and Liability for Failure to Protect Another Against Criminal Attack by Third Person,* 10 A.L.R. 3d 619, 626 (1966) (stating that "[a]s a general principle, and in the absence of special relationships or circumstances, a private person has no duty to protect another from a criminal attack by a third person"). Prior to *Tarasoff,* the only two exceptions to this rule were where a special relationship, "usually custodial, but always controlling," existed between the actor and the dangerous person, and where the actor had made an express undertaking to help the victim. Merton, *supra* note 5, at 291. *See also* Restatement (Second) of Torts §§ 315-20 (1965). *Compare* Prosser and Keeton on the

Imposing this duty on various mental health service professionals,[8] the statutes also stand within this exception. In *Tarasoff,* the Supreme Court of California held that a psychologist may be liable for failing to take steps to protect a patient's intended victim after the psychologist has predicted, or reasonably should have predicted, that the patient would do violence to identifiable persons.[9] This case and cases following it have been the subject of much scholarly criticism and analysis.[10] One of the frequent criticisms leveled at the case is the difficulty of keeping the duty and liability confined to fact situations similar to that found in *Tarasoff.*[11]

A. Tarasoff *and its Progeny*

In *Tarasoff,* the two defendant psychologists treated a patient who had told them of his intention to kill a former girlfriend. According to the plaintiffs, the psychologists asked the police to detain the patient, but the police released him when he appeared rational. The psychologists took no other action to confine him. Nor did they issue any warning to the woman he had threatened to kill or to her family. Approximately two months later, the patient killed the woman as he had threatened.[12]

Because the psychologists knew their patient was at large and intended to kill the woman, the court held that "their failure to warn [her] or others likely to apprise her of the danger constituted a breach of the therapists' duty to exercise reasonable care to protect [her]."[13] This duty was framed by the court in terms of reasonable care: "[O]nce a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others,

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LAW OF TORTS, § 56, at 383 (W. Page Keeton 5th ed. 1984) [hereinafter PROSSER AND KEETON ON TORTS] (stating that the duty "to take reasonable precautions for the safety of others may include the obligation to exercise control over the conduct of third persons," and may arise in protective and custodial relationships).

8. Categories of professionals covered by these statutes differ from state to state. *See infra* notes 64-73 and accompanying text.

9. Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 431, 551 P.2d 334, 340, 131 Cal. Rptr. 14, 20 (1976).

10. For examples of such scholarly criticism and analysis, see Schopp & Quattrocchi, Tarasoff, *the Doctrine of Special Relationships, and the Psychotherapist's Duty to Warn,* 12 J. PSYCHIATRY & L. 13 (1984) (arguing that the special relationships exception in the Restatement is conceptually unrelated to a psychiatrist's duty to warn); Note, *The Scope of a Psychiatrist's Duty to Third Persons: The Protective Privilege Ends Where the Public Peril Begins,* 59 NOTRE DAME L. REV. 770 (1984); Note, *Discovery of Psychotherapist-Patient Communications after* Tarasoff, 15 SAN DIEGO L. REV. 265, 266 n.8 (1978) (listing many other articles and Notes which discuss and criticize *Tarasoff*).

11. *See* Sands, *supra* note 3; *Clergy Counselors, supra* note 3.

12. *Tarasoff,* 17 Cal. 3d at 430-32, 551 P.2d at 339-41, 131 Cal. Rptr. at 19-21.

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

he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."[14]

The duty which the court thus imposed upon therapists involves two applications of the standard of reasonable care. First, the therapist must use reasonable care in applying professional standards to determine whether there is a "serious danger" that the patient will do violence to others.[15] This opens the possibility of imposing liability on therapists who have not actually predicted that their patient will harm someone. That is, the therapist may be liable for the violence which a patient commits against others when the therapist reasonably *should* have predicted the violent behavior of the patient toward others.[16]

Second, under the *Tarasoff* rule a therapist must also use reasonable care in discharging the duty to warn or protect the potential victim.[17] This may demand "one or more of various steps" to be taken by the therapist, "depending upon the nature of the case."[18] The court enumerated three specific steps as alternatives, as well as a catch-all provision. The therapist may (1) "warn the intended victim;" (2) warn "others likely to apprise the

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14. *Id.* at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25.

15. *Id.* The court cited other cases and treatises to formulate the reasonableness standard to be used in judging a therapist's determination of a patient's dangerousness. "[T]he therapist need exercise only 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.'" *Id.* (citations omitted).

16. "[O]nce a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger." *Id. See also id.* at 450-52, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34 (Mosk, J., concurring and dissenting). *Cf.* Mavroudis v. Superior Court, 102 Cal. App. 3d 594, 599, 162 Cal. Rptr. 724, 729 (1980).

Responding to amici who claimed that "therapists, in the present state of the art, are unable reliably to predict violent acts . . . and [whose predictions] indeed are more often wrong than right," the court stated only that it was not requiring perfect accuracy from therapists. *Tarasoff,* 17 Cal. 3d at 450-52, 551 P.2d at 344-45, 131 Cal. Rptr. at 24-25. According to the court, "proof, aided by hindsight, that [the therapist] judged wrongly is insufficient to establish negligence." *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25. This does not answer the argument that no professional reasonableness standard exists among therapists by which to decide whether an inaccurate prognosis of violent behavior was negligent, or was merely mistaken but nevertheless reasonable. However, this statement by the court at least opens the possibility of shielding therapists from liability in cases where they have made mistakes in a good faith attempt at correct diagnosis. *See* White v. United States, 780 F.2d 97, 102 (D.C. Cir. 1986) (upholding district court finding that psychiatrist was not negligent by not predicting patient's violent attack on wife where patient had not acted violently for a year, had no history of assaults on women, and psychiatrist had considered patient capable of distinguishing fantasy of harming wife from acting out that fantasy).

For a statutory version of a similar defense covering good faith, but mistaken, breaches of confidentiality when a patient has made a violent threat, see *infra* note 97 and accompanying text.

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

18. *Id.*

victim of the danger;" or (3) "notify the police."[19] More generally, the therapist must "take whatever other steps are reasonably necessary under the circumstances."[20] The latter alternative opens the possibility of negligence actions based on a therapist's failure to detain or prevent the release of a potentially dangerous patient.[21]

Justice Mosk, concurring and dissenting, argued that liability should have been imposed only because the therapists "did in fact predict that [their patient] would kill and were therefore negligent in failing to warn of that danger."[22] In Justice Mosk's view, courts cannot use the *Tarasoff* majority's first standard which evaluates therapists' predictions of their patients' violence. Primarily, his objection was that no such professional standard exists because "psychiatric predictions of violence are inherently unreliable."[23]

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19. *Id.*

20. *Id.* It is important to note that *Tarasoff* does not necessarily require a warning to be issued, but only that the therapist use reasonable care to protect the potential victim in whatever manner reasonable care may require. *See* Givelber, Bowers & Blitch, Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action,* 1984 WIS. L. REV. 443 [hereinafter *Empirical Study*]. The authors conducted a survey, receiving a 59.5% response. They studied a sample of 2,875 psychiatrists, psychologists and social workers in eight cities, drawn from lists of professional associations, classifying and stratifying professional groups into "cells" created by cross-tabulating geographic, practice and experience factors. *Id.* at 454-55. According to the authors, this study suggested that the "respondents believe that there are means other than warning the victim for satisfying their ethical obligation to potential victims. Yet [the] respondents misunderstood *Tarasoff* as requiring them to warn." *Id.* at 472. Nonetheless, "many more therapists communicated with public authorities than with potential victims," perhaps reflecting "the relative difficulty of locating warnable victims, or a therapist's preference to discharge his or her obligation for the welfare of others by dealing with public authorities." *Id.* at 469. Also, the study found that "therapists feel they pay a higher clinical price [of compromising their best judgment] by warning than by making other forms of third party disclosures." *Id.* at 472. Interestingly, the study also found that extra-therapeutic communications of patients' threats were not rare even before *Tarasoff. Id.* at 468.

21. *See* Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 193 (D. Neb. 1980). The court "refuse[d] 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." *See infra* notes 45-48 and accompanying text.

22. *Tarasoff,* 17 Cal. 3d at 451, 551 P.2d at 353, 131 Cal. Rptr. at 33. According to the majority, the plaintiffs had alleged that Poddar, the patient, "informed . . . his therapist, that he was going to kill an unnamed girl, readily identifiable as" the victim, Tatiana Tarasoff, and that the "therapists did in fact predict that [the patient] would kill." *Id.* at 432, 438, 551 P.2d at 341, 345, 131 Cal. Rptr. at 21, 25.

23. *Id.* at 451, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting). This remains a point of controversy. The American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual has declared that "[n]either psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.' Neither has any special psychiatric 'expertise' in this area been established." *Clinical Aspects of the Violent Individual,* 8 AM. PSYCHIATRIC A. TASK FORCE 28 (1974) [hereinafter AM. PSYCHIATRIC A. TASK FORCE], *quoted in* Merton, *supra* note 5, at 297. Merton also lists many studies demonstrating psychiatrists' overprediction of violence and concludes that psychiatrists' "predictions may well be no more reliable than those arrived at by the toss of a coin." *Id.* at 298 n.81. Others have argued that psychiatrists may be less accurate than other professionals in predicting violence. *See* Murel v. Baltimore City Criminal Court, 407 U.S. 355, 364-65 n.2

Justice Mosk disagreed that liability should be imposed on therapists who, according to professional standards, "should have" predicted violence by their patient.[24] Because the unreliability of such predictions results in an incoherent or nonexistent standard, Justice Mosk argued that the majority's imposition of such a standard "will take us from the world of reality into the wonderland of clairvoyance."[25]

The majority's reasonableness standard presents a trier of fact with the *post facto* guesswork of determining whether a duty existed to warn or take precautions. It also presents the professional with the current guesswork of determining whether the trier of fact will find that the professional reasonably applied a phantom standard.[26] Justice Mosk offered a much narrower

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(1972) (Douglas, J., dissenting); People v. Burnick, 14 Cal. 3d 306, 326, 535 P.2d 352, 365, 121 Cal. Rptr. 488, 501 (1975). *See also* Estate of Mathes v. Ireland, 419 N.E.2d 782, 785 n.5 (Ind. App. 1981) (recognizing that "those jurisdictions which permit an action [like *Tarasoff*] . . . are careful to define the standard of reasonable care as that due from similar professionals in a field where there remains considerable uncertainty of diagnosis and tentativeness of professional judgment"). *See also* Comment, *Psychotherapists' Duty to Warn: Ten Years after* Tarasoff, 15 GOLDEN GATE U.L. REV. 271, 279-80 (1985) (recognizing that "[t]herapists' confidence may not . . . reflect their abilities" and that "the accuracy of predictions of dangerousness in *Tarasoff* outpatient situations remains uncertain"). The Comment also points out that "the existence of discrepancies in the very definition of dangerousness complicates any attempt to make accurate determinations." *Id.* at 280.

But see Melella, *supra* note 3, at 100 (briefly describing some works discussing the opposite view). *See also Empirical Study, supra* note 20. "Without taking a position" on the issue whether therapists are more often wrong than right in predicting violence, the authors point out that "[s]even out of ten respondents believed that 90-100% of their colleagues would agree with their conclusion that the patient was dangerous." *Id.* at 462, 464. They concluded that "therapists appear to believe that there are objective professional standards for evaluating dangerousness or, at a minimum, that dangerousness is a little like hard core obscenity in that they 'know it when they see it,' even if they can't define it." *Id.* at 464. However, the authors conceded that "[t]his finding does not mean that therapists can predict future violence or that their colleagues are correct in agreeing with them." *Id.* at 486 n.117.

24. *Tarasoff,* 17 Cal. 3d at 450-52, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34 (Mosk, J., concurring and dissenting). Justice Mosk stated that he "would restructure the rule designed by the majority to eliminate all reference to conformity to standards of the profession in predicting violence." *Id.* at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34.

25. *Id.* at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting).

26. *See* Garvey & Krucks, *A Legal Cuckoo's Nest: The Liability of Mental Health Professionals,* COMPLEAT LAWYER, Fall 1986, at 23, 25 (arguing that "[t]he lack of a precise definition of the 'reasonable therapist' standard of conduct means it is impossible to predict when courts will find liability for a patient's behavior"); Comment, *From* Tarasoff *to* Brady: *Courts Struggle to Apply the Duty to Control Mental Patients,* 14 CUMB. L. REV. 165, 180 (1984) (stating that "[f]actors that add to the difficulty of trying to determine if a duty to control is warranted [under *Tarasoff* and subsequent cases] include the lack of standards by which to predict dangerousness").

The uncertainty of the *Tarasoff* rule and the responsibility it places upon medical practitioners was expressed by one author considering the potential liability of informing a patient's wife that the patient had gonorrhea. Under *Tarasoff,* "there is increasing judicial recognition that there are times when overriding societal concerns, such as public safety or education," may require the physician to break confidentiality. Britton, *Confidentiality in Family Practice,* MEDICAL ASPECTS OF HUM. SEXUALITY, May 1987, at 59, 60. "To date these concerns have

alternative rule: "If a psychiatrist does in fact predict violence, then a duty to warn arises."[27] This rule, however, provides practitioners with an easy escape hatch.[28] Fearing violent actions by a patient, the professional need only avoid making an explicit prediction of violence to escape liability for a failure to warn or take precautions. Thus, professionals themselves would control the imposition of the duty to warn or take precautions and could avoid triggering the duty even in those cases where victims could be saved by reasonable steps.

Justice Clark dissented for two reasons. First, in Justice Clark's view, the majority's rule would result in a net increase in violence and a loss of patients' liberty rights.[29] Second, Justice Clark argued that "[t]he issue whether effective treatment for the mentally ill should be sacrificed to a system of warnings is . . . properly one for the Legislature."[30] According to Justice Clark, the California legislature had already balanced the competing interests involved in the issue of overriding confidentiality to enhance public safety.[31] In doing so, the legislature had weighed patients' rights, public safety and the harmful effects which disclosure has on effective treatment.[32] At least as to persons committed to institutions, the legislature had bound psychotherapists not to disclose any information about their patients, except within narrowly defined circumstances.[33] Since none of these limited situations applied in *Tarasoff,* the therapists were in a dilemma: They must violate either the statute or the new duty imposed by the *Tarasoff*

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been determined on a case-by-case basis, with each court drawing individual conclusions based on the specific scenario presented." *Id.* The conclusion was startling: "[B]ear in mind that *you* [the practitioner] must achieve a balance between individual and social welfare by weighing the need for preserving patient confidentiality against the overriding duty to uphold the public interest in matters of safety and health." *Id.* (emphasis added).

27. *Tarasoff,* 17 Cal. 3d at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting). *Compare Estate of Mathes,* 419 N.E.2d at 785 (a "negligent release" case holding that if either of two defendant-psychiatric centers had taken charge of the patient "and additionally had *actual knowledge* that [the patient] was extremely dangerous, . . . they were bound to exercise reasonable care under the circumstances") (emphasis added).

28. For evidence that Justice Mosk's application of this rule prevents its use as an escape hatch, see *infra* note 54.

29. *Tarasoff,* 17 Cal. 3d at 458, 463, 551 P.2d at 358, 362, 131 Cal. Rptr. at 38, 42 (Clark, J., dissenting).

30. *Id.* at 452, 551 P.2d at 355, 131 Cal. Rptr. at 35 (Clark, J., dissenting).

31. *Id.* at 457, 551 P.2d at 358, 131 Cal. Rptr. at 38 (Clark, J., dissenting).

32. *Id.* at 454-55, 463-64, 551 P.2d at 355-56, 362, 131 Cal. Rptr. at 35-36, 42 (Clark, J., dissenting).

33. *Id.* at 454, 551 P.2d at 355, 131 Cal. Rptr. at 35 (Clark, J., dissenting). According to Justice Clark, a therapist could first disclose the fact of treatment to a family member if the therapist had determined that this would be in the patient's best interest. Second, a therapist was also permitted to disclose a patient's threats to police if such action was necessary to protect elected officials and their families. Finally, a therapist could disclose the fact of a patient's disappearance from an institution to police or the patient's family if this was necessary to protect the patient or others. *Id.* at 455, 551 P.2d at 356, 131 Cal. Rptr. at 36-37 (Clark, J., dissenting).

majority.[34] In Justice Clark's view, the majority had "an obligation to specifically enumerate the circumstances under which the [legislative act] applies as opposed to the circumstances when 'general tort principles' will govern."[35]

Intermediate appellate courts in California began to fine tune the *Tarasoff* rule and to expand its applicability.[36] In *Mavroudis v. Superior Court*,[37] the California Court of Appeal held that *Tarasoff* did not require a prediction of violence toward a *particular* person before the duty to warn or take precautions would arise.[38] According to the court, "the intended victim need not be specifically named by the patient," but need only be "readily identifiable."[39] No independent interrogation of the patient or investigation about the possible victim's identity is required before the duty will arise to protect that victim. Rather, under *Mavroudis,* the duty arises in cases where "a 'moment's reflection' will reveal the victim's identity."[40]

The issue of the required specificity of the victim's identity was again considered in *Thompson v. County of Alameda*.[41] In that case the California Supreme Court held that "the duty to warn depends upon and arises from the existence of a prior threat to a specific identifiable victim."[42] The court found "no affirmative duty to warn of the release of an inmate with a violent history who has made *nonspecific threats of harm directed at nonspecific persons*."[43] The court found too many troubles and too little effectiveness in imposing a duty to warn police, neighborhood parents or the patient's parents when the patient's intended victims were merely "mem-

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34. *Id.* at 457, 551 P.2d at 358, 131 Cal. Rptr. at 38 (Clark, J., dissenting).

35. *Id.* (Clark, J., dissenting).

36. *See, e.g., Mavroudis,* 102 Cal. App. 3d 594, 62 Cal. Rptr. 724; Thompson v. County of Alameda, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

37. 102 Cal. App. 3d 594, 162 Cal. Rptr. 724. In *Mavroudis,* the plaintiffs successfully compelled discovery of the psychiatric records of their son who had attacked them with a hammer while being treated by the defendant-psychiatrists.

38. *Id.* at 599, 162 Cal. Rptr. at 729.

39. *Id. See also* Leedy v. Hartnett, 510 F. Supp. 1125, 1130 (M.D. Pa. 1981) (holding that a readily identifiable victim or group is not defined "solely on a statistical probability that the more one [is with a patient] the more likely it is that one would be a victim of any violent outbreak by [the patient]"), *aff'd,* 676 F.2d 686 (3d Cir. 1982).

40. 102 Cal. App. 3d at 600, 162 Cal. Rptr. at 729 (quoting *Tarasoff,* 17 Cal. 3d at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11).

41. 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70. In *Thompson,* plaintiffs' son was murdered by a juvenile who had been released from a county institution after having "indicated that he would, if released, take the life of a young child residing in the neighborhood." However, the patient had not indicated any specific child as an intended victim. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72.

42. *Id.* at 758, 614 P. 2d at 738, 167 Cal. Rptr. at 80. *See also* Cairl v. State, 323 N.W.2d 20 (Minn. 1982). In that case, the Supreme Court of Minnesota did not decide the question whether a duty to warn exists, but stated that "if a duty to warn exists, it does so only when specific threats are made against specific victims." *Id.* at 26.

43. *Thompson,* 27 Cal. 3d at 753, 614 P.2d at 735, 167 Cal. Rptr. at 77 (emphasis in original).

ber[s] of [a] large amorphous public group of potential targets" and not "precise" or "specifically known and designated individuals."[44]

In other cases involving premature release or failure to detain a patient, courts have imposed liability on psychotherapists even when there was no victim specified by the patient. In *Lipari v. Sears, Roebuck & Co.*,[45] the plaintiff sued doctors who had released a patient who killed her husband and wounded her.[46] The federal district court held that the doctors could be liable because their duty was not limited to warning, but included whatever precautions were reasonably necessary, including commitment or detention of the patient.[47] Acknowledging that a therapist's duty runs to those persons foreseeably endangered, the court also held that the category of persons who may need to be warned includes potential victims not specified by the patient.[48]

The application of the *Tarasoff* rule reached its nadir in *Hedlund v. Superior Court.*[49] In that case, the California Supreme Court held that the duty of psychotherapists is broad enough to include warning or protecting members of a victim's family or others who foreseeably are in close proximity to the victim.[50] In *Hedlund,* the victim was shot by a man who had previously been in therapy with her. During the attack, the victim threw herself over her three-year-old son, seated next to her, saving his life. The son alleged that "because it was foreseeable that [the patient's] threats, if carried out, posed a risk of harm to bystanders and particularly to those in close relationship to [the victim]," the duty of the psychotherapists to warn or take precaution extended to him.[51] The California Supreme Court held that these allegations stated a cause of action against the psychotherapists.[52]

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44. *Id.* at 755, 758, 614 P.2d at 736, 738, 167 Cal. Rptr. at 78, 80. Governmental immunity was a separate basis for finding no liability. *Id.* at 748, 614 P.2d at 731, 167 Cal. Rptr. at 73. "Thus a state may be willing to impose liability upon a private psychologist who fails to warn others that he has a potentially violent patient, but may interpose the protection of the basic policy immunity when the state gives a furlough to a known violent criminal who has every prospect of raping and murdering a child and who in fact does so." PROSSER AND KEETON ON TORTS, *supra* note 7, § 131, at 1046 (footnotes omitted).

45. 497 F. Supp. 185.

46. The patient was an outpatient who stopped his treatment despite the advice of his doctors. The plaintiff claimed that the doctors should have detained or committed the patient. *Id.* at 187.

47. *Id.* The court "refuse[d] 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." *Id.*

48. The court held that the defendants could be held liable if the plaintiffs proved that the defendants reasonably could have foreseen that there was risk to the plaintiffs or "a class of persons of which the [plaintiffs] were members." *Id.* at 195. Furthermore, the plaintiffs did not need to prove that the defendants knew the intended victim's identity. *Id.*

49. 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983).

50. *Id.* at 705, 669 P.2d at 47, 194 Cal. Rptr. at 811.

51. *Id.* at 705, 669 P.2d at 46, 194 Cal. Rptr. at 810.

52. *Id.* at 707, 669 P.2d at 47, 194 Cal. Rptr. at 811.

Justice Mosk dissented, again arguing that psychotherapists have no reliable predictive capabilities, and that no professional standard exists whereby to decide whether a psychotherapist was negligent by not predicting the violent behavior of a patient.[53] Applying his own proposed rule—the actual prediction of violence standard—Justice Mosk argued that the majority's "expansive view of the duty of defendants is probably unnecessary to the result," since the defendant psychologists had actual knowledge of the patient's intent to attack the victim.[54]

Despite vigorous objections and scholarly criticism of the majority's standard, the *Tarasoff* rule was adopted in other jurisdictions in both expanded and limited forms.[55] Not all jurisdictions, however, have adopted the *Tarasoff* duty.[56] Moreover, while therapists are generally aware of the

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53. *Id.* at 707-10, 669 P.2d at 48-50, 194 Cal. Rptr. at 812-14 (Mosk, J., dissenting).

54. *Id.* at 710, 669 P.2d at 49, 194 Cal. Rptr. at 813 (Mosk, J., dissenting). This points out an ambiguity in Justice Mosk's statement of his rule. Although the psychotherapists had knowledge of the patient's threat, there was no evidence that the psychotherapists had used this knowledge to predict violence by the patient. Justice Mosk's argument here implies that where psychotherapists know of threats by their patients, they will be deemed to have made the required prediction and the duty to warn or take precautions will arise.

55. For examples of cases adopting the *Tarasoff* rule, see Durflinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979). For examples of cases adopting a modified version of *Tarasoff,* see Jablonski v. United States, 712 F.2d 391, 398 (9th Cir. 1983) (holding that a "psychological profile indicat[ing] that [the patient's] violence was likely to be directed against women very close to him" can be a sufficiently specific identification of a victim to support imposing a duty to warn on the therapists); Brady v. Hopper, 570 F. Supp. 1333, 1338 (D. Colo. 1983) (stating that it is only "once the patient verbalizes his intentions and directs his threats to identifiable victims, [that] . . . the therapist has a duty to protect those third parties from the threatened harm"), *aff'd,* 751 F.2d 329 (10th Cir. 1984); *Lipari,* 497 F. Supp. at 194-95 (holding that under Nebraska law the *Tarasoff* duty would be limited to reasonably foreseeable victims or "a class of persons of which the [plaintiffs] were members").

Because of the rapid expansion of therapists' duties, these cases and others have been taken by some courts as placing a duty on therapists to protect society in general. *See, e.g.,* Leverett v. Ohio, 61 Ohio App. 2d 35, 40-41, 399 N.E.2d 106, 110 (1978) (holding that a mental hospital has a duty to the public when considering a patient's release and may be held liable for negligent discharge if it knew or reasonably should have known the patient could do harm when released). *See also* Melella, *supra* note 3, at 93. *But see* Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983) (en banc) (holding that physicians owe no duty to the general public when deciding whether to release involuntarily committed patients). The court in *Sherrill* did not want physicians to

> have to function under the threat of civil liability to members of the general public when making decisions about passes and releases . . . . The effect would be [that] treating physicians would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest.

Id.

56. The Iowa Supreme Court has discussed the *Tarasoff* duty to warn or take precautions but has not yet explicitly adopted it. *See* Anthony v. State, 374 N.W.2d 662, 668 (Iowa 1985) (not recognizing the *Tarasoff* duty in this case because "[s]uch far-reaching and sensitive issues will be better decided in a case in which they are dispositive"); *In re* Estate of Votteler, 327 N.W.2d 759, 760-62 (Iowa 1982); Cole v. Taylor, 301 N.W.2d 766, 768 (Iowa 1981). Neither have the Maryland courts accepted or rejected a duty of psychiatrists to warn specifically

Tarasoff rule, there is confusion among them about what it requires and in what jurisdictions it is applicable.[57] As one commentator puts it, "The result is that there is a great deal of confusion among psychotherapists about what their duty is to potential third-party victims."[58] Moreover, the potentially broad liability which therapists face under *Tarasoff* and its progeny may contribute to the growing expense and difficulty of obtaining professional malpractice insurance.[59]

B. *The Statutes*

Responding to the confusion and increased liability for therapists caused by the expanding *Tarasoff* duty,[60] ten states have enacted statutes codifying

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identifiable victims. *See* Furr v. Spring Grove State Hospital, 53 Md. App. 474, 487, 454 A.2d 414, 420 (1983); Shaw v. Glickman, 45 Md. App. 718, 725, 415 A.2d 625, 630 (1980). More speculatively, the Texas Court of Appeals declined to find a breach of such a duty in one case, but based its decision on the "logic" of *Tarasoff* and *Thompson* without explicitly adopting the rule in those cases. Williams v. Sun Valley Hospital, 723 S.W.2d 783, 787 (Tex. Ct. App. 1987).

57. Melella, *supra* note 3, at 99. *See also Empirical Study, supra* note 20. In a formal, jurisdictional sense, *Tarasoff* does not apply to all psychotherapists everywhere, and outside of those jurisdictions explicitly recognizing or rejecting that duty, the best description is that *Tarasoff* "is potentially the law everywhere." *Id.* at 474. The study, however, showed that "[m]ost respondents seem to have a fairly good understanding of the jurisdictional issue, but a majority of them nonetheless believed themselves bound by *Tarasoff,* with therapists outside of California "evenly divided on the question." *Id.* Many therapists also mistakenly believe that *Tarasoff* requires a warning, as opposed to other means of precaution. *See supra* note 20.

58. Melella, *supra* note 3, at 89. *See also* George, Korin, Quattrone & Mandel, *The Therapist's Duty to Protect Third Parties: A Guide for the Perplexed,* 14 RUTGERS L.J. 637, 651 (1983) (concluding, after reviewing contemporaneous cases, that "until further cases refine the factual circumstances under which a therapist will be held liable for failure to warn others, there can be no complete guide for the perplexed").

59. King, *Are Therapists Liable for Their Patients' Violence?,* STATE LEGISLATURES, Feb. 1988, at 19, 19. There has also been speculation that students avoid entering the practice of psychiatry because of apprehension "based upon the perception that the respective rights and responsibilities of both the psychiatrist and the patient have been made so ambiguous by the legal system that the practitioner is left without meaningful guidance concerning the legally permitted boundaries of clinical conduct." Kapp, *Editor's Page,* 10 J. OF PSYCH. AND L. 131, 131 (1982). Admitting that no empirical studies yet supported this speculation, Kapp argues that even superficial contact with the profession reveals its high level of anxiety over uncertain legal liability, and this "supports reference to this anxiety as one potential explanation of the current psychiatric shortage." *Id.* at 132. Kapp suggests a number of actions which could counteract this anxiety, including authoring "objective and even-handed articles" about mental health professionals' liability. *Id.*

60. In Colorado, at least, the legislative action was prompted by associations of mental health professionals because malpractice insurance for mental health professionals was becoming more expensive and difficult to find. The associations believed that legislation could be used more precisely to delineate under what circumstances therapists would be responsible for actions by their patients. Another concern of the legislators was the uncertainty of holding therapists liable for malpractice when engaging in an inexact science. King, *supra* note 59, at 19-21.

Compare Act approved Feb. 8, 1988, ch. 88-1, § 10, 1988 FLA. SESS. LAW SERV. 1, 12

the duty of mental health professionals to protect against violent acts by their patients. The statutes address the issues through a variety of approaches. Statutes have been enacted in California, Colorado, Indiana, Kentucky, Louisiana, Minnesota, Montana, New Hampshire, Utah and Washington.[61]

(West) (to be codified at FLA. STAT. § 455.2415). This recently enacted Florida statute creates an exception to patient-psychiatrist confidentiality when the patient makes a threat of violence to others. *Id.* In part, the Florida legislature was prompted to pass this statute by finding "a financial crisis in the medical liability insurance industry" in which "the cost of medical liability insurance is excessive and injurious to the people of Florida and must be reduced." *Id.* at 3. *See also infra* note 94.

61. *See supra* note 4.

Indiana's statute is the most comprehensive. IND. CODE ANN. §§ 34-4-12.4-1 to -4 (West Supp. 1988) reads in full:

> Chapter 12.4. Immunity and Privileged Communications: Mental Health Service Providers.
>
> Sec. 1. As used in this chapter, "mental health service provider" means any of the following:
>
> (1) A physician licensed under IC 25-22.5.
> (2) A hospital licensed under IC 16-10-1.
> (3) A private institution licensed under IC 16-13-2.
> (4) A psychologist licensed under IC 25-33.
> (5) A school psychologist licensed by the state board of education.
> (6) A university or college counseling center under the direction of a licensed psychologist, physician or mental health professional.
> (7) A registered nurse or licensed practical nurse licensed under IC 25-23.
> (8) A social worker who meets the criteria for membership in the Academy of Certified Social Workers.
> (9) A partnership, a corporation, or a professional corporation, as defined in IC 23-1.5-1-10, whose partners or shareholders are mental health service providers described in subdivisions (1) through (6).
> (10) A community mental health center, as defined in IC 16-16-1-1.
> (11) A program for the treatment, care, or rehabilitation of alcohol abusers or drug abusers that is:
> (A) certified under IC 16-13-6.1-4; or
> (B) created and funded under IC 16-13-6.1-30 or IC 16-13-6.1-31.
> (12) A state mental health institution described in IC 16-13-1-9(a).
>
> Sec. 2. A mental health service provider is immune from civil liability to persons other than the patient for failing to:
>
> (1) predict; or
> (2) warn or take precautions to protect from;
> a patient's violent behavior unless the patient has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others.
>
> Sec. 3. The duty to warn of or to take precautions to provide protection from violent behavior or other serious harm arises only under the limited circumstances specified in section 2 of this chapter. The duty is discharged by a mental health service provider who takes one (1) or more of the following actions:
>
> (1) Makes reasonable attempts to communicate the threat to the victim or

The new statutes limit the civil liability of mental health care providers for failing to predict violence by their patients and for failing to warn or take precautions to protect other people from this violence. Generally, a duty arises upon the mental health professional to warn or take precautions against violence by a patient only when a patient has communicated a threat to the professional.[62] Under most of the statutes, if a mental health service professional is forced to disclose confidential information in order to discharge this duty, the professional is immune from liability under other statutes which protect patient confidentiality.[63]

The ten statutes are distinguished from the *Tarasoff* line of cases and from one another by four factors: (1) who is subject to the duty to warn or take precautions, (2) the type of threats which will activate the duty, (3) the required identifiability of the victim, and (4) the proper means of discharging the duty.

1. Who is Subject to the Duty

The first difference is upon whom the duty is placed and to whom the immunity is given. All of the statutes cover psychologists, and all but one cover psychiatrists.[64] In addition, five—Colorado, Indiana, Kentucky, Mon-

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victims.

(2) Makes reasonable efforts to notify a police department or other law enforcement agency having jurisdiction in the patient's or victim's place of residence.

(3) Seeks civil commitment of the patient under IC 16-14-9.1.

(4) Takes steps reasonably available to such provider to prevent the patient from using physical violence or other means of harm to others until the appropriate law enforcement agency can be summoned and takes custody of the patient.

(5) Reports the threat of physical violence or other means of harm, within a reasonable period of time after receiving knowledge of the threat, to a physician or psychologist who is designated by the employer of a mental health service provider as an individual who has the responsibility to warn under this chapter.

Sec. 4. A mental health service provider who discloses information that must be disclosed to comply with sections 2 through 3 of this chapter is immune from civil and criminal liability under Indiana statutes that protect patient privacy and confidentiality.

62. *See, e.g.,* COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. §§ 34-4-12.4-2, -3 (West Supp. 1988).

63. COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. § 34-4-12.4-4 (West Supp. 1988); LA. REV. STAT. ANN. § 9:2800.2(A), (C) (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.400(3), 645.270(3) (Michie/Bobbs-Merrill Supp. 1988); MINN. STAT. ANN. § 148.975(4) (West Supp. 1988); MONT. CODE ANN. § 27-1-1103 (1987); N.H. REV. STAT. ANN. §§ 329:31(III), 330-A:22(III) (Supp. 1987); UTAH CODE ANN. § 78-14a-102(2) (Supp. 1988).

64. CAL. CIV. CODE § 43.92 (West Supp. 1988) (imposing duty on psychotherapists) (CAL. EVID. CODE § 1010 (West Supp. 1988) defines psychotherapist as psychiatrists; psychologists; social workers; school psychologists; marriage, family and child counselors and counseling

tana and New Hampshire—also place the duty upon physicians.[65] Some states also cover interns and assistants working under the supervision of psychologists, psychiatrists and physicians.[66] Social workers[67] and registered

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interns; psychological assistants and apprentice social workers); COLO. REV. STAT. § 13-21-117 (1987) (imposing duty on physicians, social workers, psychiatric nurses, psychologists, mental health professionals, mental health hospitals, community mental health clinics, institutions and their staffs); KY. REV. STAT. ANN. §§ 202A.400(1), 645.270 (Michie/Bobbs-Merrill Supp. 1988) (imposing duty on "qualified mental health professionals" and on any "person serving in a counselor role" when the patient is a "child") (*Id.* §§ 202A.011(11), 645.020(38) defines "qualified mental health professional" as including physicians, psychiatrists, psychologists, psychiatric nurses and social workers) (*Id.* § 645.020(5) defines "child" for purposes of § 645.270 as one under 18 years of age who is covered by the Mental Health Act of the Unified Juvenile Code); LA. REV. STAT. ANN. § 9:2800.2(A) (West Supp. 1988) (imposing duty on psychologists and psychiatrists); MINN. STAT. ANN. § 148.975 (West Supp. 1988) (imposing duty on psychologists, school psychologists, nurses, chemical dependency counselors and social workers); MONT. CODE ANN. § 27-1-1101 to -1103 (1987) (imposing duty on physicians, professional counselors, psychologists, social workers and "certified professional[s]") (*Id.* § 53-21-106(1), -101(1) defines "certified professional" as one certified to care for those who are "seriously mentally ill or suffering from a mental disorder"); N.H. REV. STAT. ANN. § 329:31 (Supp. 1987) (imposing duty on physicians and persons treating patients under a physician's supervision); *Id.* § 330-A:22 (imposing duty on psychologists or "certified" persons [including psychiatrists] and persons treating patients under their supervision); UTAH CODE ANN. § 78-14a-102 (Supp. 1988) (imposing the duty on therapists) (*Id.* § 78-14a-101(1)-(4) defines "therapist" as psychiatrists, psychologists, marriage and family therapists, social workers, and psychiatric and mental health nurses licensed to practice advanced psychiatric nursing); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988) (affirming the existence of the duty to warn or take precautions). The Washington statute declares that it "does not relieve a person from . . . the duty to warn or take precautions." *Id.* It is unclear to whom "person" refers, but § 71.05.120(1) applies to officers of public and private hospitals or treatment facilities for the mentally ill, the facilities themselves, their attending staff or persons in charge, officials administering mental illness laws, designated mental health professionals, the state or its subdivisions. *See id.* § 71.05.020 (defining the applicable persons and situations).

The Indiana statute covers psychologists and other professionals and professional groups, but not psychiatrists explicitly. IND. CODE ANN. § 34-4-12.4-1(1) to (12) (West Supp. 1988). In the chapters governing state psychiatric hospitals, the Indiana Code separately defines a psychiatrist as a person licensed to practice medicine and "certified by the American Board of Psychiatry and Neurology, Incorporated, or who is eligible for such certification." IND. CODE ANN. § 16-14-1-1(8) (West 1984).

65. COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. § 34-4-12.4-1(1) (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.011(11)(a), 202A.400, 645.270 (Michie/Bobbs-Merrill Supp. 1988); MONT. CODE ANN. § 27-1-1101(2) (1987); N.H. REV. STAT. ANN. § 329:31 (Supp. 1987). The courts in at least one jurisdiction have recently held that physicians owe a duty of reasonable care to protect third parties potentially harmed by their patients. Welke v. Kuzilla, 144 Mich. App. 245, 253-54, 375 N.W.2d 403, 406 (1985).

66. CAL. EVID. CODE § 1010(f), (g) (West Supp. 1988); N.H. REV. STAT. ANN. §§ 329:31(IV), 330-A:22(IV) (Supp. 1987). Washington and Colorado also cover staff members of certain mental health care facilities, and thus may also impose the duty on interns or assistants who are often considered staff of such institutions. *See* COLO. REV. STAT. § 13-21-117 (1987); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988).

67. CAL. EVID. CODE § 1010(c) (West Supp. 1988); COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. § 34-4-12.4-1(8) (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.400(11), 600.020(38) (Michie/Bobbs-Merrill Supp. 1988); MINN. STAT. ANN. § 148.975(c) (West Supp. 1988); MONT. CODE ANN. § 27-1-1101(5) (1987); UTAH CODE ANN. § 78-14a-101(4) (Supp. 1988).

nurses or psychiatric nurses[68] also are covered by a majority of the states. Professional counselors are covered in four states[69] and school psychologists in three.[70]

Two of the statutes cover a very broad category of professionals. Indiana covers all of the professionals listed above and adds licensed practical nurses.[71] In addition, Indiana places the duty upon a number of legal entities, including university and college counseling centers, community mental health centers, addiction rehabilitation programs, all of the state's mental hospitals, and partnerships, corporations and professional corporations whose members are any of the professionals covered by the statute.[72] Colorado's law covers mental health hospitals, centers, clinics, institutions, and their staffs.[73]

2. The Type of Threats Which Activate the Duty

A second feature of the statutes is the conditioning of the duty to warn or take precautions upon the patient's expression of a violent threat. All of the states require a threat by the patient of "physical violence" to another person.[74] More importantly, in all of the states except Indiana, it is only when a threat of physical violence against some other person is "communicated" to the professional that the duty will arise.[75] "Commu-

68. COLO. REV. STAT. § 13-21-117 (1987); IND. CODE ANN. § 34-4-12.4-1(7) (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.400, 645.020(38) (Michie/Bobbs-Merrill Supp. 1988); MINN. STAT. ANN. § 148.975(c) (West Supp. 1988); N.H. REV. STAT. ANN. §§ 329:31(IV), 330-A:22(IV) (Supp. 1987); UTAH CODE ANN. § 78-14a-101(5) (Supp. 1988); WASH. REV. CODE ANN. § 71.05.020(8) (Supp. 1988).

69. CAL. EVID. CODE § 1010(e) (West Supp. 1988); KY. REV. STAT. ANN. § 645.270 (Michie/Bobbs-Merrill Supp. 1988); MINN. STAT. ANN. § 148.975(c) (West Supp. 1988); MONT. CODE ANN. § 27-1-1103(3) (West Supp. 1988).

70. CAL. EVID. CODE § 1010(d) (West Supp. 1988); IND. CODE ANN. § 34-4-12.4-1(5) (West Supp. 1988); MINN. STAT. ANN. § 148.975(c) (West Supp. 1988).

71. IND. CODE ANN. § 34-4-12.4-1(7) (West Supp. 1988).

72. *Id.* § 34-4-12.4-1(6), (9)-(12). Such institutions may be held liable through *respondeat superior. See, e.g., Tarasoff,* 17 Cal. 3d at 442, 551 P.2d at 348, 131 Cal. Rptr. at 28; *Estate of Mathes,* 419 N.E.2d at 786.

73. COLO. REV. STAT. § 13-21-117 (1987). Washington's statute may also impose the duty on some institutions since the section as a whole also deals with institutions, but the subsection which affirms the duty mentions only "persons." *See* WASH. REV. CODE ANN. § 71.05.120 (Supp. 1988).

74. *See supra* note 4. New Hampshire also includes "a serious threat of substantial damage to real property." N.H. REV. STAT. ANN. §§ 329:31(I), 330-A:22(I) (Supp. 1987). This differs from the *Tarasoff* line of cases which limited the duty to warn about physical harm to persons and excluded property damage. *See* Bellah v. Greenson, 73 Cal. App. 3d 911, 141 Cal. Rptr. 92 (1977), *aff'd on rehearing,* 81 Cal. App. 3d 614, 146 Cal. Rptr. 535 (1978).

75. *See supra* note 4. Under the broadly-worded Indiana statute, the duty arises if the patient "evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others." IND. CODE ANN. § 34-4-12.4-2 (West Supp. 1988). Under this clause the duty could

nicated" seems to imply some assertive verbal or written conduct. Some states require this to be an "actual" threat, which also connotes assertive conduct.[76] Other states require a "serious" threat.[77] Some statutes are also triggered by threats of "imminent" violence,[78] or physical violence "by specific means,"[79] or a "serious, specific threat."[80]

Louisiana's statute is the most detailed. It requires "an immediate threat of physical violence . . . coupled with the apparent intent and ability to carry out that threat."[81] This formula provides a means to filter out mechanical responses to the statute. It prevents unnecessary breaches of confidentiality in cases of specifically expressed threats which a therapist knows the patient cannot carry out.

3. The Identifiability of the Victim

A third distinguishing characteristic of these statutes is the requisite identifiability of the potential victim. Most of the statutes incorporate a

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arise even in the event of non-assertive statements or conduct by the patient which would indicate a danger to third parties. This addition to the statute covers instances when a patient may pose a danger to others, but has not assertively verbalized a threat. In these cases, threatening activity, though non-assertive, will still trigger the duty to warn or take precautions and the immunity from liability for breaking confidentiality. Thus, the possible circumstances of liability are broader under the Indiana statute than under the other statutes.

For example, consider a patient with Acquired Immune Deficiency Syndrome (AIDS) who has a spouse or has made statements indicating that the patient is having regular sexual relations with someone. Even without actually threatening to infect them with the AIDS virus, the patient may be exhibiting sufficient "conduct" or making "statements" indicating that the patient will use sexual intercourse as "other [nonviolent] means" to harm another person. *Id.* A physician who has a patient with AIDS, therefore, may have a duty under the Indiana statute to inform the patient's partner of the presence of the disease. Some commentators beleive that this may also be the result under *Tarasoff.* Annas & Davison, *The HIV-Positive Patient Who Won't Tell the Spouse,* MEDICAL ASPECTS OF HUMAN SEXUALITY, March 1987, at 16, 16 (relying on *Tarasoff* and the common law regarding a physician's duty to inform family members and others likely to be exposed about a patient's contagious or infectious disease). Under the other, more restrictive statutes physicians would not be exposed to liability unless the patient makes an "actual" or "serious" threat to infect the partner, and unless the threat of being infected with AIDS is interpreted as "physical violence." *See infra* text accompanying notes 76-81. Liability could still be the result under general rules about physicians' responsibilities when a patient has an infectious or contagious disease. *See* 70 C.J.S. *Physicians and Surgeons* § 88 (1987); 61 AM. JUR. 2d *Physicians, Surgeons* § 245 (1981).

76. IND. CODE ANN. § 34-4-12.4-2 (West Supp. 1988); KY. REV. STAT. ANN. §§ 202A.400(1), 645.270(1) (Michie/Bobbs-Merrill Supp. 1988); MONT. CODE ANN. § 27-1-1102 (1987); UTAH CODE ANN. § 78-14a-102(1) (1988); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988).

77. CAL. CIV. CODE § 43.92(a) (West Supp. 1988); COLO. REV. STAT. § 13-21-117 (1987); MINN. STAT. ANN. § 148.975 (West Supp. 1987); N.H. REV. STAT. ANN. §§ 329:31(I), 330-A:22(I) (Supp. 1987). It is unclear whether "serious" refers to the harm to be done (serious bodily injury) or to the threat itself (a threat which is to be taken seriously), or both. Since the statutes require a serious threat of violence, the latter reading is the most plausible interpretation. The former reading would be more readily acceptable if the statutes instead required "threats of serious violence."

78. COLO. REV. STAT. § 13-21-117 (1987).

79. MONT. CODE ANN. § 27-1-1102 (1987).

80. MINN. STAT. ANN. § 148.975(2) (West Supp. 1988).

81. LA. REV. STAT. ANN. § 9:2800.2 (West 1987).

standard that the victim be reasonably identifiable, similar to the *Tarasoff/ Mavroudis* requirement of a readily identifiable victim.[82] Some of the statutes explicitly include threats made about "clearly identified"[83] or "specific, clearly identified or identifiable" victims.[84] However, Colorado and Louisiana limit their statutes' coverage to include only threats made about "specific" or "clearly" identified victims, respectively.[85] Kentucky, on the other hand, requires no identifiable potential victim.[86]

4. Discharging the Duty

Finally, on the issue of discharging the duty, the statutes fall into two classes: (1) statutes which mandate specific action by the professional, and (2) statutes which allow the professional to choose between specified alternatives.[87] California, Louisiana, Montana, Utah and Washington require the professional to make efforts to inform both the potential victim and law enforcement persons.[88] In Colorado the professional must inform both

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82. CAL. CIV. CODE § 43.92(a) (West Supp. 1988) (requiring a reasonably identifiable victim); IND. CODE ANN. § 34-4-12.4-2 (West Supp. 1988) (including a reasonably identifiable victim); N.H. REV. STAT. ANN. §§ 329:31(I), 330-A:22(I) (Supp. 1987) (requiring a clearly identified or reasonably identifiable victim); MONT. CODE ANN. § 27-1-1102 (1987) (requiring a clearly identified or reasonably identifiable victim); UTAH CODE ANN. § 78-14a-102(1) (Supp. 1988) (requiring a clearly identified or reasonably identifiable victim); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988) (requiring a reasonably identifiable victim). However, the *Tarasoff* and *Mavroudis* courts interpreted "readily identifiable" to include "cases in which a 'moment's reflection' will reveal the victim's identity." *See Mavroudis,* 102 Cal. App. 3d at 600, 162 Cal. Rptr. at 729 (quoting *Tarasoff,* 17 Cal. 3d at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11). This judicial standard may be narrower than the statutory standard of "reasonably" identifiable.

83. LA. REV. STAT. ANN. § 2800.2(A) (West Supp. 1988) (requiring a clearly identified victim); N.H. REV. STAT. ANN. §§ 329:31(I); 330-A:22(I) (Supp. 1987) (requiring a clearly identified or reasonably identifiable victim); MONT. CODE ANN. § 27-1-1102 (1987) (requiring a clearly identified or reasonably identifiable victim); UTAH CODE ANN. § 78-14a-102(1) (Supp. 1988) (requiring a clearly identified or reasonably identifiable victim).

84. MINN. STAT. ANN. § 148.975(2) (West Supp. 1988).

85. COLO. REV. STAT. § 13-21-117 (1987); LA. REV. STAT. ANN. § 9:2800.2 (West Supp. 1988). These formulations seem to reject the *Mavroudis/Hedlund* rule that the duty may arise when the victim is only reasonably identifiable whether or not specifically or clearly identified by the patient.

86. Kentucky's statutes are an exception and do not require an identifiable victim for the duty to warn or take precautions to arise. The duty to warn or take precautions arises when the patient makes a threat against a "clearly identified or reasonably identifiable" victim, or when the patient threatens "some specific violent act." KY. REV. STAT. ANN. §§ 202(A).400(1), 645.270(1) (Michie/Bobbs-Merrill Supp. 1988). Also, in an amending provision, the statutes later state that the duty to warn may be discharged by informing the police when the patient has made "an actual threat of some specific violent act and no particular victim is identifiable." *Id.* §§ 202A.400(2), 645.270(2). This latter provision also implies that the duty to warn may arise even when there is no identifiable victim.

87. All of the statutes require "reasonable efforts" to carry out the activities needed to discharge the duty. *See supra* note 4. Colorado requires "reasonable and timely" efforts. COLO. REV. STAT. § 13-21-117 (1987).

88. CAL. CIV. CODE § 43.92(b) (West Supp. 1988); LA. REV. STAT. ANN. § 9:2800.2 (West Supp. 1988); MONT. CODE ANN. § 27-1-1102 (1987); UTAH CODE ANN. § 78-14a-102(1) (Supp. 1988); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988).

the potential victim and the police, or take other "appropriate action, including but not limited to, hospitalizing the patient."[89] Similarly, under the Kentucky statute the professional may notify the potential victim and the police or commit the patient.[90] New Hampshire and Minnesota, on the other hand, require a professional who has received a threat to inform *either* the victim *or* the police nearest the patient or the victim.[91]

In Indiana a professional may take any one of five possible actions to discharge the duty: (1) inform the victim; (2) inform the police who have jurisdiction over the patient or the victim; (3) seek to have the patient committed; (4) use "steps reasonably available to such provider to prevent the patient from using physical violence or other means of harm to others" until the police can take custody of the patient; or (5) report the threat to a physician or psychologist designated by the professional's employer as the person who has the responsibility to warn.[92] Thus, while the Indiana statute is the broadest statute in the options it gives the care provider, its language fits the narrower paradigm which requires the provider to do only one act in order to fulfill the duty.

Interestingly, the last option—reporting the threat to a designated physician or psychologist—makes possible an arrangement whereby some of the individuals and institutions covered by the Indiana statute may further limit their chances of being held liable for violent acts by patients. By designating an individual as the channel through which communicated threats are engaged, a mental health service employer can set up a system whereby all communicated threats are passed on to one person. This designee can then develop a proficiency over the legal requirements of a particular jurisdiction about when a duty to warn or take precautions arises and what actions must be taken in response. By a simple rule that all patient threats be communicated to this designee, a mental health service employer is freed of the difficulty, time and expense of educating many employees to master what can be complex, intricate and sometimes confusing rules. This would be especially helpful under a statute such as Indiana's which places the duty to warn or take precautions on health institutions which employ many individual professionals.[93]

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89. COLO. REV. STAT. § 13-21-117 (1987).

90. KY. REV. STAT. ANN. §§ 202A.400(2), 645.270(2) (Michie/Bobbs-Merrill Supp. 1988). Notifying the police is sufficient when the patient has not identified a particular victim. *Id.*

91. N.H. REV. STAT. ANN. §§ 329:31(II), 330-A:22(II) (Supp. 1987) (stating that the professional may discharge the duty by warning the victim, notifying the police, or obtaining the patient's civil commitment); MINN. STAT. ANN. § 148.975(1)(e) (West Supp. 1988) (stating that a professional can discharge the duty by informing the police when a potential victim cannot be reached).

92. IND. CODE ANN. § 34-4-12.4-3 (West Supp. 1988).

93. The Indiana statute requires that the individual to whom threats are channeled be a physician or psychologist. *Id.* § 34-4-12.4-3(5). It is not clear why the designee must be a

C. The Statutes Compared to the Common Law

From this analysis four significant differences appear among all the statutes and the *Tarasoff* line of cases. The statutes provide a solution to the legal dilemma between breaching confidentiality and giving a warning or taking precautions. Moreover, the statutes do not have explicit reasonableness standards regarding when the duty to warn or take precautions arises and what actions the professional should choose to fulfill this duty.

First, most of the statutes grant immunity to therapists who break confidentiality in order to discharge the duty to warn.[94] This prevents the dilemma, recognized by Justice Clark, which confronts psychotherapists under *Tarasoff*.[95] By an explicit grant of immunity, the statutes shield therapists from a draconian choice between fulfilling a statutory duty to preserve confidence or a *Tarasoff*-like duty to reveal. Some statutes go further. In addition to immunity from actions for damages, Colorado grants immunity from "professional discipline" for breaking confidentiality in discharge of the duty to warn or take precautions.[96] Minnesota grants immunity from liability for disclosures made "in a good-faith effort" to discharge the duty to warn or take precautions.[97] This affords mental health professionals some breathing space in which to avoid the disclose-reveal dilemma in close cases.

Second, no professional reasonableness standard determines when the duty arises under the statutes.[98] Under the *Tarasoff* line of cases, the existence of the duty depends upon the operation of a standard of reason-

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member of one of these two professions, especially when any particular employee, such as a social worker, may be adequately qualified for this responsibility in the employer's estimation. *See also Empirical Study, supra* note 20. The study found that "'notifying superiors' rather than exercising reasonable care is the second most frequently identified behavior thought to be required by *Tarasoff.*" *Id.* at 466. The authors also stated that "[t]his is extremely specific behavior which is not required by the *Tarasoff* decision, but it may represent exactly what administrative personnel in a mental health setting would want a therapist to do," and that "[t]herapists who are troubled by how to respond to a particular violent patient may also find notifying a superior to be a congenial response." *Id.* at 466-67.

94. *See supra* note 63 and accompanying text. *Compare* Act approved Feb. 8, 1988, ch. 88-1, § 10, 1988 FLA. SESS. LAW SERV. 1 (West) (to be codified at FLA. STAT. § 455.2415). The Florida statute does not impose a duty to warn or take precautions. Rather, it allows an exception to confidentiality when a patient "engaged in a treatment relationship with a psychiatrist . . . has made an actual threat to physically harm an identifiable victim or victims" and the psychiatrist makes "a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out that threat." *Id.* at 12. In this situation a "psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency." *Id.*

95. *Tarasoff,* 17 Cal. 3d at 457, 551 P.2d at 358, 131 Cal. Rptr. at 38. *See also supra* text accompanying notes 29-35.

96. COLO. REV. STAT. § 13-21-117 (1987).

97. MINN. STAT. ANN. § 148.975(4) (West Supp. 1988).

98. Indiana's statute may be the only exception. *See infra* note 134.

ableness used to judge the professional's determination of the patient's dangerous disposition. If a professional applying the standard of the profession with reasonable care would find that the patient poses a serious danger of violence to others, the duty to protect third party potential victims arises.[99] The statutes, on the other hand, determine when the duty arises by looking to the actions of the patient, not the reasonableness of the professional. The patient must communicate a threat before a professional has any duty to take precautions to protect a third party. Under the statutory scheme, therefore, it is no longer an issue whether a professional *should* have predicted violence by the patient. Rather, if the patient makes a threat, the duty arises independently of the operation of a legal standard of professional reasonableness.

Third, the language of the statutes apparently does away with the reasonableness test used in *Tarasoff* to evaluate the professional's choice of the type of action necessary to discharge the duty.[100] The statutes specifically prescribe alternative actions which may discharge the duty, including warning the victim or the police, or both.[101] In Indiana the professional may discharge the duty by performing *one* or more of five actions. This is significant. Under the statutes which give a choice to the professional, the choice of which action to take appears to be within the discretion of the professional. Unlike *Tarasoff*, the statutes have no explicit provision for reviewing whether the professional made a negligent choice between types of actions to discharge the duty under the circumstances.[102]

Reviewing the facts of *Tarasoff* will clarify the importance of this difference. In *Tarasoff*, the defendants originally called the police to have their patient detained. The police did not detain him because he appeared rational and promised to stay away from the woman he had threatened to kill. According to the court, the psychotherapists' actions were nonetheless subject to review to determine whether they had done all that was reasonably

99. *See supra* text accompanying notes 15-16.

100. All of the statutes still require "reasonable efforts" to fulfill the statutory requirements of warning or informing the police. *See supra* note 4. However, this list of choices is still much clearer and more specific about what *type* of actions are required to discharge the duty. The apparent statutory inquiry into the sufficiency of the professional's action is much narrower than under the *Tarasoff* line of cases, which requires any type of action which is "reasonably necessary under the circumstances" without differentiating or specifying types of actions to guide the professional. *But see* Colo. Rev. Stat. § 13-21-117 (1987) (requiring "other appropriate action" when necessary); *infra* text accompanying notes 136-38.

101. *See supra* notes 88-91 and accompanying text.

102. This is not to say that the statutes do not require reasonable efforts in carrying out the types of actions enumerated by the statutes. *See supra* notes 87, 100. Moreover, although the statutes have no *explicit* standard regarding the professional's choice of actions to discharge the duty, see *infra* note 138 and accompanying text for an argument that they are open to an interpretation requiring a reasonableness test governing this choice.

necessary to protect the woman from the threat.[103] On the other hand, under some of the current statutes a notification to either the police or the potential victim would discharge the duty. Under such a statute, the defendants in *Tarasoff* might have prevailed. Having notified the police, they would not have been liable for not taking other action to protect the woman as needed under the circumstances. Moreover, under any of the other statutes which require notification of both the police and the victim, the therapists would have known beforehand that a call to the victim or her family was also required. Presuming that they had followed such a clear command, their action might not have been subject to a further test of reasonableness and may have protected them from liability. Thus, regarding the sufficiency of warnings and precautions, the statutes act as a limitation of mental health professionals' liability for the violent acts of their patients.

Finally, most of the statutes retain something like the reasonably or readily identifiable victim standard to determine whether the duty to warn or take precautions arises.[104] In these states, a reasonableness rule must still be used to determine if the duty arises. Even in the face of threats by the patient, the statutory duty will not arise unless the potential victim is reasonably or readily identifiable.

II. The Reasons for Codification

Codification of the *Tarasoff* duty to warn or take precautions shows a recognition of the concerns voiced by Justice Clark in his *Tarasoff* dissent. "The issue whether effective treatment for the mentally ill should be sacrificed to a system of warnings is . . . properly one for the Legislature," according to Justice Clark.[105] As a response to *Tarasoff* and the common law development of its rule,[106] the statutes imply a number of legislative decisions.

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103. The court reached this result despite the fact that the therapists' action was sufficient under statutes in effect at that time. *Tarasoff,* 17 Cal. 3d at 457, 551 P.2d at 358, 131 Cal. Rptr. at 38 (Clark, J., dissenting).

104. *See supra* notes 82-86 and accompanying text.

105. Tarasoff v. Regents of the Univ. of California, 17 Cal. 3d 425, 452, 551 P.2d 334, 355, 131 Cal. Rptr. 14, 35 (1976) (Clark, J., dissenting).

106. Statutes are often read as legislative responses to the common law. *See, e.g.,* Ashlock v. Norris, 475 N.E.2d 1167, 1169 (Ind. App. 1985). Legislative correction is one undertaking called for by critics of the *Tarasoff* decision. *See* Meyers, *The Legal Perils of Psychotherapeutic Practice (Part II): Coping with* Hedlund *and* Jablonski, 12 J. of Psychiatry and L. 39, 46 (1984). Much of the tort reform undertaken in the late 1970s was by legislation. *See generally Tort Reform and Related Proposals: Annotated Bibliographies on Product Liability and Medical Malpractice,* 1979 A.B.A. Sec. Ins., Negl. & Compensation L. Special Committee to Study the Tort Sys. (B. Levin & R. Coyne eds.) [hereinafter ABA Bibliographies].

A. *Policy Implications of Codification*

First, the immunity provisions of the statutes are a means of solving the "manifestly unfair" position which Justice Clark argued that professionals face under the *Tarasoff* rule.[107] The immunity provisions provide a legal defense for professionals who reveal confidential information in order to fulfill their duty to protect persons other than their patients. By providing a legislative response, the statutes also prevent a conflict between the judicial and legislative branches as to the proper weights to be accorded the competing interests of confidentiality, public safety and professional liability. Thus, professionals faced with violent threats by their patients need no longer fear that they will have to defend in court their choice between a *Tarasoff* duty to disclose and a statutory duty to keep confidentiality. Through immunity clauses, these statutes explicitly reconcile the duty to keep confidentiality and the duty to warn or take precautions.[108]

Second, the statutes reflect no common legislative judgment about what actions should fulfill the duty to warn or take precautions. Some statutes require specific actions or a combination of actions, while others leave to the professional an apparent choice among enumerated options. In addition, some statutes require any other action appropriate to the circumstances.[109]

Third, the statutes implicitly address the spectre of a "net increase in violence" under the *Tarasoff* rule. Although Justice Clark suggested that this would result from patients being reluctant to talk freely with mental health professionals who may have a legal duty to reveal their confidence,[110] it may also result from a fear of liability on the part of the mental health professional. Healing mental illness is unlike healing physical disease. Once treatment is undertaken, physical healing may take place with or without revelation of confidences. In psychiatric care, on the contrary, revelation of a patient's violent thoughts may undo all of the healing which has taken

107. *Tarasoff*, 17 Cal. 3d at 457, 551 P.2d at 359, 131 Cal. Rptr. at 38 (Clark, J., dissenting). For a discussion of the immunity clauses of these statutes, see *supra* text accompanying notes 94-97.

108. The California and Washington statutes are exceptions. *See supra* note 63 and accompanying text.

109. *See supra* notes 87-91 and accompanying text.

110. *Tarasoff*, 17 Cal. 3d at 459, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting). *See also* Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976). Stone argues that patients who are perceived as dangerous already receive good treatment only rarely, and after *Tarasoff* will get even less because of the vagueness of the duty and psychotherapists' fear of liability. *See also* Melella, *supra* note 3, at 111 (arguing that placing broad liability on psychotherapists for the sexual assaults of their patients could ultimately "defeat the rationale for which the courts had originally created third-party liability, namely, the protection of potential victims from harm").

place up to that point.[111] As one commentator puts it, "The extent of the protection of confidentiality in any jurisdiction may, to a large extent, determine who can be treated."[112] Patients who are warned that there are substantial limits to confidentiality may not be sufficiently confident to release hostility in the form of verbal threats and may miss an opportunity to prevent violent acts by verbal release of this hostility.[113] In any event, studies have suggested that some patients have ceased psychiatric care when informed of the potential limits of confidentiality after *Tarasoff*,[114] and the uncertainty of the *Tarasoff* rule has tempted some psychiatrists to avoid delving into areas of potential violence with their patients.[115] In any case, the statutes reflect a legislative judgment that the indirect cost of a potential increase in violence by breaching confidentiality is outweighed by the benefit of requiring protective action when threats are communicated to therapists.

More generally, the statutes reflect a legislative balance of the interests of professionals, patients and victims. The statutes stand as a codification of when and upon whom a duty to warn should be imposed and how that duty should be discharged. The variations among the statutes reveal different priorities among the legislatures regarding who should be subject to a duty to warn, the type of threats which will activate the duty, the required identifiability of the potential victims, and the actions which will discharge the duty.[116] Notwithstanding these differences, the statutes reveal similar judgments among these legislatures about the relative costs and benefits of

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111. *See* Merton, *supra* note 5, at 305. There is also a sense in which breaches of confidentiality may threaten the healing of physical illness as well, especially where stigma attaches to the illness, as in the case of AIDS or genetic maladies, as well as mental illness. However, this threat blocks physical healing by preventing treatment from ever beginning, and not by physiologically blocking the action of medications or other treatments. Mental illness, on the other hand, not only may never be treated if confidentiality is not ensured and well protected, but may also worsen if revelations are made and the resultant shame or fear of exposure prevents further releases of hostility or itself causes a regression.

112. *See* Melella, *supra* note 3, at 95.

113. "The potential for third-party liability for the psychotherapist, and criminal liability on the part of the patient, may be so great as to preclude some offenders from obtaining treatment." *Id.* at 95.

114. *See* Merton, *supra* note 5, at 313. *Compare* Melella, *supra* note 3, at 95. The authors stated that while some consider absolute confidentiality critical to successful therapy, they found in an outpatient clinical research program that informing patients of the limitations of confidentiality had "not prevented most offenders from reporting . . . their deviant sexual behavior." *Id.* However, the authors admitted that "there is no sure way of determining whether these offenders would have been more candid had we been able to guarantee complete confidentiality." *Id.*

115. Melella argues that if broad liability is found by courts, "many psychotherapists, upon realizing that they were treating inherently dangerous patients, might act defensively to avoid assuming the risk for such patient liability either by attempting to discourage treatment or by referring the patients to less legally sophisticated colleagues." *Id.* at 110. *But see Empirical Study, supra* note 20 (arguing that their survey shows that *Tarasoff* has not discouraged therapists from treating dangerous patients).

116. *See supra* notes 64-93 and accompanying text.

public safety and confidentiality, the effects of mandatory disclosure and the exposure of mental health professionals to liability based on their patients' actions. These statutes define limits to the circumstances of liability which are both more specific and more narrow than the circumstances of liability under the *Tarasoff* line of cases.[117] They reflect a legislative decision to limit the liability of mental health professionals to the more clearly enumerated and specified conditions of the statutes.[118]

Much has been written about the ill effects of the potentially vast liability under the rationale of *Tarasoff.*[119] The amount of liability is made more troublesome by the confusion about what circumstances trigger the duty under the common law progeny of *Tarasoff.*[120] Moreover, although the *Tarasoff* line of cases claims to impose a standard of professional reasonableness by which to measure a psychotherapist's prognosis of violence, there is much dispute over whether anyone can predict violence by a mentally ill person.[121] This places not only triers of fact, but also the professionals themselves, in the position of guessing about what reasonably should be foreseen.[122]

This guesswork is particularly onerous in the case of violence by mental health patients because an essential element of the negligence calculus is missing, or at least hotly contested. Negligence is typically found where the cost of precautions to prevent a loss is less than the loss discounted by the probability of that loss.[123] In the case of violence by mental health patients, a viable method of determining the probability of loss, *i.e.*, the predictability of an attack by the patient, has not yet been accepted, even by the professionals themselves.[124]

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117. *See supra* text accompanying notes 98-99.

118. Frequently, the imposition of a legal duty is regarded as a decision about public policy. *See* Annotation, *supra* note 7, at 624. Public policy and legislative intent, as found in a statute's plain language, are sometimes used as factors to decide the extent of a statutory duty. *See, e.g.,* Rose v. Lundy, 455 U.S. 509, 517 (1982).

119. *See supra* notes 3, 10 and accompanying text. *See* Melella, *supra* note 3. Melella argues that broad liability for psychotherapists may require that they commit or confine patients with a history or tendency of sexual assault in order to avoid liability for their patients' violent acts. "This action would preclude preventive remedial treatment, while overburdening institutions with already scarce resources." *Id.*

120. *See* Melella, *supra* note 3. *See also supra* notes 55-59 and accompanying text.

121. *See supra* note 23 and accompanying text.

122. *See supra* notes 26-28 and accompanying text. The uncertainty and unpredictability have also been blamed for forcing professional liability insurance rates higher. *See supra* note 60.

123. United States v. Carroll Towing, 159 F.2d 169, 173 (2d Cir. 1947) (stating that a "duty . . . to provide against resulting injuries is a function of three variables: (1) The probability [of loss]; (2) the gravity of the resulting injury . . . ; (3) the burden of adequate precautions"). *See also* PROSSER AND KEETON ON TORTS, *supra* note 7, § 43, at 296 (stating that "the American formula . . . balanc[es] magnitude of risk and gravity of harm against utility of conduct").

124. *See supra* note 23 and accompanying text.

The statutes attempt to remedy this problem of uncertainty by removing the doubtful legal standard—what a reasonable professional would have predicted in this situation—and specifying what actions by the patient will cause the duty to arise. Thus, the statutes address the concerns voiced by Justice Mosk[125] and by psychiatrists about the absence of a professional standard of prediction.[126] The statutes present a specific guide to determine whether the professional must take precautionary action. If a threat has been communicated, the professional must take the statutorily prescribed action. Through this specificity, the statutes raise the predictability of the law and may relieve upward pressure on insurance rates for professionals. Moreover, the simplicity of the statutes goes beyond the rule proposed by Justice Mosk. His rule depends upon the professional's action: The psychiatrist must actually make a prediction of dangerousness.[127] The statutory rule, however, depends solely on affirmative action by the patient: The patient must communicate a threat to the mental health service professional.[128]

B. Preemption by the Statutes

A myriad of interests must inform a professional's decision to break confidentiality in order to warn or protect a person other than a patient. A professional must consider the patient's interest in confidentiality and reputation, the safety of the public and the potential victims, and the professional's own exposure to liability. As discussed above, the statutes reveal a legislative balance of these interests and imply legislative decisions about public policy, social experience, predictability and fairness.

Although the statutes have preemptory language, the extent to which they preempt the common law *Tarasoff* line of cases is unclear. And although neither of the two reasonableness tests mandated by the *Tarasoff* line of cases is explicitly present in the statutes,[129] it is not clear that both must be

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125. *Tarasoff,* 17 Cal. 3d at 450-52, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34 (Mosk, J., concurring and dissenting); Hedlund v. Superior Court, 34 Cal. 3d 695, 707-10, 669 P.2d 41, 48-50, 194 Cal. Rptr. 805, 812-14 (1983) (Mosk, J., dissenting). *See also supra* notes 22-28, 53-54 and accompanying text.

126. *See* AM. PSYCHIATRIC A. TASK FORCE, *supra* note 23; Merton, *supra* note 5.

127. *See supra* note 54 (discussing a possible ambiguity in Justice Mosk's statement of his own rule).

128. Justice Mosk's proposed rule—an actual prediction of violence—leaves open the possibility that a professional may avoid liability merely by refusing to make a prediction of violence in the face of a patient's threats. In contrast, this loophole is not available under the statutes. When a patient manifests certain behavior, the professional must respond regardless of whether the professional makes a prognosis of violent behavior in response. *See supra* notes 98-99 and accompanying text. However, the statutes still leave a practical gap in that psychotherapists may attempt to avoid their potential liability by engaging in therapy which is calculated to avoid occasions in which the patient may communicate a threat.

129. *See supra* text accompanying notes 98-102.

preempted by the statutes. The statutes modify the common law approach of the *Tarasoff* line of cases, and therefore are in derogation of the common law. Typically, statutes in derogation of the common law are strictly construed so that there is a limited preemption of the common law.[130] Moreover, questions about the statutes' preemptive reach should be resolved in light of the implied legislative balance struck between the competing interests.

1. The Prediction Test

The first of the *Tarasoff* reasonableness tests—the reasonableness of the mental health professional's prediction of a patient's violent behavior—is the more controversial.[131] The test is difficult to apply, and the difficulty stems in part from the logically prior controversy over whether a standard exists by which to judge a professional's prediction of violent behavior.[132] In its place, the statutes prescribe a test for liability for a failure to warn or take precautions based on statutorily enumerated circumstances. These circumstances have to do with actions by the patient, not the reasonableness of the professional's predictive response.[133] The switch from one kind of test (professional reasonableness) to a wholly different kind of test which is easier to apply (specifically enumerated actions by a patient) suggests an intent to replace completely the *Tarasoff* prediction test with the statutory conditions. Moreover, the statutory language also supports a reading which completely preempts the reasonableness test from a determination of liability under the statutes. According to the statutes, liability arises *only* in the enumerated circumstances, without regard to the reasonableness of the professional's response.[134]

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130. 15A C.J.S. *Common Law* § 12 (1967) (stating that statutory "alteration or repeal will not be considered effected to a greater extent than the unmistakable import of the language used").

131. As discussed above, many psychiatrists dispute whether the profession can predict a patient's behavior. *See supra* note 23. Moreover, most professionals have little control over their patients, lacking any legal ability to confine them. Although the element of psychiatrists' control over their patients played a part in the *Tarasoff* decision, *see* 17 Cal. 3d at 435-36, 551 P.2d at 343, 131 Cal. Rptr. at 23, some suggest that even psychiatrists lack any effective custody or control over outpatients who are the subject of the vast majority of these cases. *See* Melella, *supra* note 3, at 97; Schopp & Quattrocchi, *supra* note 10, at 27. There have also been questions about why the psychiatrists were held liable in *Tarasoff* but not the police when law enforcement agents have a "power to restrain the liberty of the 'dangerous' person [which] exceeds that of any therapist." Merton, *supra* note 5, at 296.

132. *See supra* notes 22-28 and accompanying text.

133. *See supra* text accompanying notes 98-99.

134. *See supra* note 4. The Indiana formula does not clearly preempt the reasonableness test of a professional's prediction. In Indiana, the statute contains a clause creating the duty even when the patient "evidences conduct or makes statements indicating an imminent danger" of harm to others. The statute does not specify to whom the conduct or statements must

Doing away with this first reasonableness test has the further advantage of avoiding the necessity of different standards for each type of professional covered by the same statute. It would also end the creation of nonexistent standards to which Justice Mosk objected[135] by limiting the duty to more clearly identifiable occasions. This is especially important for professions covered by these statutes, such as nursing, which do not have even a reputation of predictive capability.

Thus, the statutory language and the underlying legislative balance of the competing interests favor restricting the potential liability under the common law approach of *Tarasoff* and finding liability only under the more clear and predictable statutory terms.

2. The Reaction and Identifiability Tests

On the other hand, the second *Tarasoff* reasonableness test—governing the professional's choice of action in the face of a violent threat—does not present the controversy of the test of a professional's predictive response. The task of warning or taking precautions against a person's violent behavior presupposes no particular professional skill or training. The same is true for the reasonably identifiable victim test. Neither standard is fraught with the conceptual and application disputes to which Justice Mosk and psychotherapists object.[136] Any person faced with a threat which triggers the statutory duty could be expected to choose a reasonable response to the threat to protect an identifiable person.

The absence of a specified test in those statutes which leave a choice to the professional among actions to discharge the duty does not necessarily preempt the use of a reasonableness test to judge whether the professional's warning or precaution was adequate. The language of the statutes is not clearly preemptive. All of the statutes require reasonable efforts to carry out the specified action, but some require appropriate action not limited to the statutory list. The language of some of the statutes requires the professional to take all of the enumerated actions. Other statutes give a choice to the professionals without specifying a test by which to judge this choice. Within this category are statutes which require the professional to take any

"indicate" an imminent danger that the patient will do violence to others. Presumably, the mental health service provider must witness the conduct or statements. But conduct may indicate violent propensities to a psychiatrist and not to a health professional trained in another specialty. Moreover, the clause does not supply a standard to apply to this issue. *See supra* note 61; IND. CODE ANN. § 34-4-12.4-2 (West Supp. 1988).

135. *See supra* text accompanying notes 22-25.

136. "Reasonably identifiable" or "readily identifiable" can simply be taken as a person who is identifiable after a "moment's reflection" as determined in Mavroudis v. Superior Court, 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980). *See supra* text accompanying notes 37-40.

one of the enumerated options in order to fulfill the duty. This raises the possibility of avoiding liability merely through a *pro forma* performance of the alternative most easily fulfilled by the professional, but not reasonably suited to the circumstances.[137]

Requiring a professional to choose reasonably among alternative warnings or precautions to protect reasonably identifiable persons depending on the circumstances demands no more from the professional than the reasonable care required of all persons in carrying out their legal duties.[138] And since these legislatures have decided that confidentiality must be broken in some circumstances, the breach should be reasonably calculated at least to provide protection in the circumstances. Moreover, although a reasonable reaction test would demand no more from the professional, it would frustrate an escape from liability through a *pro forma* response to a patient's threat. This, in turn, would help assure the best choice among the safeguards minimally required by the legislatures.

Thus, effective and efficient use of the statutory alternatives requires, and the language of the statutes permits, that a reasonableness test be maintained by which to determine the sufficiency of the professional's discharge of the duty and whether the victim was sufficiently identifiable for the duty to arise.

III. A PROPOSAL

Since these statutes are intended to displace the common law *Tarasoff* line of cases, a formulation should be used which better encompasses the policy terms discussed above. A suggested formulation is set out below. It incorporates terms of various statutes already enacted which help to delineate clearly what circumstances will trigger the duty.

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137. *See supra* notes 87-92 and accompanying text.

138. *See Hedlund,* 34 Cal. 3d at 708-10, 669 P.2d at 49, 194 Cal. Rptr. at 813-14 (Mosk, J., dissenting) ("Since it is not the medical care or treatment of a patient that is involved [in warning another], but a species of civilian duty that has arisen to a third party, the acts or omissions of the doctors are not malpractice, but simple negligence."). *See also* PROSSER AND KEETON ON TORTS, *supra* note 7, § 56 (stating that where the duty to protect others from third persons does exist, the obligation is not an absolute one to insure the plaintiff's safety, but requires only that the defendant exercise reasonable care). *But see Hedlund,* 34 Cal. 3d at 703, 669 P.2d at 45, 194 Cal. Rptr. at 809 (the majority holding that "the manner in which the warning is given may also involve professional judgment").

Mental Health Professionals' Liability for the Violent Acts of Patients

Section 1. A mental health professional is immune from liability to persons other than a patient for failing to predict or warn or take precautions to protect from a patient's violent behavior, unless

A) the patient communicates a threat to the mental health professional, and

B) the threat is coupled with the apparent intent and ability to carry out the threat

that the patient will use physical violence or other means of harm to cause serious personal injury or death to reasonably identifiable persons.

Section 2. Regardless of any other provision of law, a mental health professional's duty to warn or take precautions arises only under the limited circumstances described in section 1.

Section 3. A mental health professional's duty to warn of or take precautions to protect another from the threatened violence of a patient is discharged by the mental health professional giving a warning or taking precautionary actions such as

A) communicating the threat to the potential victim or victims,

B) informing a law enforcement agency having jurisdiction in the patient's or victim's place of residence,

C) seeking civil commitment of the patient,or

D) any other actions,

provided that the action which the professional takes is reasonably suited to the circumstances. The professional to whom a threat is communicated may also discharge the duty under section 1 by informing a person designated by the professional's employer as the individual who has the responsibility to warn or take precautions.

Section 4. A mental health professional is immune from liability under state statutes which protect patient privacy and confidentiality for actions taken in good faith to discharge the duty which has arisen or may have arisen under section 1.

Because of the controversy over the existence of a standard to judge the prediction of violence by mental health professionals, the proposed statute limits the circumstances of liability to specific, clearly recognizable situations based on patient actions. By including the Louisiana clause requiring an apparent intent and ability to carry out the violent threat,[139] it also seeks to ensure that as few breaches of confidence are made as possible. The proposed statute retains two reasonableness tests. It requires that a potential victim be reasonably identifiable before a duty to warn or take precautions arises. It also places the choice of which type of action to take to discharge the duty within a reasonable person's experience by requiring the professional to choose a reasonably suited action. Following the Indiana statute, the model includes a provision whereby an employer of mental health professionals may designate one person as the individual responsible for

139. *See supra* note 81 and accompanying text.

determining whether a duty has arisen under the statute and what actions are required to discharge that duty.[140] The proposed statute makes clear that reasonable care is required in response to a communicated threat, not necessarily a warning.[141] Like the Minnesota statute, the proposal grants immunity from liability for disclosures made in good faith when there is a close question about whether the statutory duty has arisen.[142] Finally, the suggested formulation includes in section 2 a clause clearly manifesting the statute's preemptory intent.

CONCLUSION

Considerations of public policy, predictability and legislative reform mandate that the statutes discussed in this Note be interpreted as limiting the extensive potential liability which professionals face under the *Tarasoff* line of cases. By determining whether there is a duty to warn or take precautions based on patient actions rather than under a doubtful and ambiguous standard, the statutes provide a scheme by which courts and, more importantly, professionals can more readily determine when there is a duty to warn or take precautions to safeguard identifiable victims. Nonetheless, the statutes should be interpreted to retain a reasonableness standard by which to determine the adequacy of the professional's response to a threat. Whether the courts will so read the statutes and public policy is yet to be seen.

EPILOGUE

The question whether the judicial expansion and subsequent legislative limitation of the *Tarasoff* rules yield any insight about handling affirmative duties in the future will now be addressed. The difficulties of dealing with affirmative duties are recurring because "as our ideas of human relations change the law as to duties changes with them."[143] Therefore, if a lesson is present and discernible in the history of the *Tarasoff* duty, learning that lesson may save society the trouble of repeating *Tarasoff's* meandering course.

AIDS and genetics are two areas in which "our ideas of human relations" are currently being reevaluated. Both present conflicts of rights and interests

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140. For a discussion of the Indiana provision, see *supra* notes 92-93 and accompanying text.

141. See *supra* note 20 for a discussion of what may be a prevailing confusion among mental health practitioners over whether a warning, as opposed to other types of action, is required by the *Tarasoff* duty.

142. *See supra* note 97 and accompanying text.

143. PROSSER AND KEETON ON TORTS, *supra* note 7, § 53.

much like the controversy presented in the *Tarasoff* line of cases. Given its fatality rate, contagiousness, and associated stigma, AIDS presents a myriad of situations in which conflicts arise among confidentiality, protection of third parties from harm, and standards of professional conduct. An immediate issue is whether one with knowledge of another's exposure ought to have a duty to inform third parties at risk.[144] Similarly, advancing capabilties of genetic diagnosis present genetic counselors and patients with new knowledge about genetic risks.[145] This knowledge implicates stigma, confidentiality concerns and potential third-party victims. Here also is the issue of whether one with knowledge ought to have a duty to inform others at risk, such as spouses outside of the counseling relationship who could legally be obligated to care for offspring. It is clear that both AIDS and genetics will involve more and more people in conflicts about third-party risk.[146]

What is new in the cases of AIDS and genetic counseling is that society already knows, though controversies are as yet infrequent, some of the issues which will be encountered. Moreover, unlike predicting violence by mentally ill patients, there is no phantom standard of prognosis with which to contend in the cases of AIDS and genetics. Geneticists often deal with known probabilities of the potential genetic makeup of offspring.[147] Similarly, AIDS is commonly known to have a very high, if not total, fatality rate. And although rates of transmission are less well known, they are generally accepted to be high among risk groups.[148]

As shown above, however, there is no generally accepted standard among mental health professionals by which to judge a professional's prognosis of violent activity.[149] Thus, an essential factor of the negligence calculus is missing, and this prevents professionals from accurately evaluating alternative courses of action.[150] In response to this absence of an acknowledged standard, ten legislatures have imposed a blanket duty to warn or take precautions which is triggered by specific patient actions. This reflects an implicit judgment that, in the absence of a recognized standard by which to predict violence, the costs and benefits of a rule requiring protective action in the face of communicated threats are more favorable to society

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144. For an example of such a conflict, see *supra* note 75.

145. *See generally* J. FLETCHER, COPING WITH GENETIC DISORDERS: A GUIDE FOR CLERGY AND PARENTS (1982) (outlining capabilities of modern genetics and potential responses by counselors).

146. *See* M. BAYLES, REPRODUCTIVE ETHICS 42 (1984); Fineberg, *The Social Dimensions of AIDS,* SCI. AM., Oct. 1988, at 128, 131.

147. *See* J. FLETCHER, *supra* note 145, at 4-32.

148. Heyward & Curran, *The Epidemiology of AIDS in the U.S.,* SCI. AM., Oct. 1988, at 72, 75, 79-80.

149. *See supra* note 23 and accompanying text.

150. *See supra* text accompanying notes 123-24.

than operating under a standard which is not widely recognized, if it exists at all.

Reviewing the history of the *Tarasoff* duty, it may be tempting to argue that an initial legislative decision is needed to prevent society from retracing this wandering path in the cases of AIDS and genetics. Prospective legislative decisions may help persons plan their actions so as to avoid liability.[151] This course may be especially tempting given the prevalence of legislative attempts at tort reform since the late 1970s.[152] However, because of the differences between current ability to predict violence by the mentally ill, on the one hand, and current knowledge about AIDS and genetics, on the other, such a route is not required and would be ill-advised.

The prognostic capabilities of health professionals regarding AIDS and genetic maladies are much better and more widely recognized than the abilities of mental health professionals to predict violent behavior by their patients. Unlike the case of predicting violence by mental health patients, there are much clearer standards of predictability in the fields of AIDS and genetics by which professionals can judge the risk of danger which their patients may pose to third parties. Thus, professionals dealing with AIDS and genetics are more capable of determining the requirements of reasonable care in their respective fields. Consequently, a coherent professional standard like that on which courts traditionally rely is available to help discern in what circumstances, if any, affirmative duties to third parties ought to be found for health professionals in the fields of AIDS and genetics. Given the presence of clear standards by which to judge a professional prognosis in the cases of AIDS and genetics, much of the justification for legislative intrusion like the *Tarasoff* statutes is gone. Rather, courts should be left unimpeded in their case by case exploration of what reasonable care requires of professionals working in the fields of AIDS and genetics.

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151. For an example of how previously legislated duties may have prevented the dispute in *Tarasoff*, see *supra* note 103 and accompanying text.

152. *See* ABA BIBLIOGRAPHIES, *supra* note 106.