The Psychiatrist's Dilemma: Protect the Public Or Safeguard Individual Liberty?

*Fay Anne Freedman**

More than a decade has passed since the landmark case of *Tarasoff v. Regents of the University of California*.[1] In *Tarasoff*, the California Supreme Court ruled that a psychiatrist is under a duty to use reasonable care to warn an intended victim of a patient's dangerous condition if the psychiatrist knows or should have known that the patient presents a serious danger of violence to that particular individual.[2] Throughout the years, courts have increasingly relied on *Tarasoff* as support for imposing a duty on mental health professionals to protect third parties. Washington law,[3] however, takes *Tarasoff* an unreasonable step further, requiring a psychiatrist to take precautions to protect *anyone* who might foreseeably be endangered by his patient's mental problems. This duty includes the duty to protect the public at large from an individual's dangerous propensities, including those that are drug-related.[4]

In *Petersen v. State*,[5] the Washington Supreme Court, while reaffirming the current law which requires those with special powers, skills, and knowledge gained through the doctor-patient relationship to discharge a legal duty to protect, dramatically widened the scope of a psychiatrist's responsibility to include a duty to protect unintended or unidentifiable victims. By expanding this duty, the court recognized that it confronted difficult issues of first impression for the state. These issues included the nature of the psychiatrist-patient

* J.D., 1985, University of Puget Sound School of Law; M.P.A., 1981, The Georgetown University; B.A., 1973, University of California at Berkeley. Ms. Freedman is a practicing attorney in Seattle, Washington and a member of the Washington, Seattle-King County, and Federal Bar Associations.

1. 17 Cal. 3d 425, 551 P.2d 344, 131 Cal. Rptr. 14 (1976).

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

3. WASH. REV. CODE § 71.05.120 (1987); Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983).

4. *Petersen*, 100 Wash. 2d 421, 671 P.2d 230 (1983).

5. *Id.*

relationship, the effect of a psychiatrist's decision to release his patient from involuntary civil commitment, and the duty a psychiatrist owes to third parties for the behavior of his patient.

This Article argues that the psychiatrist's[6] dual duty of protecting others, while effectively treating patients, places the psychiatrist in a dilemma.[7] *Petersen*'s expansion of the law exacerbates this dilemma by extending the duty of a psychiatrist to protect identifiable victims to include a duty to protect the public at large. Ultimately, this dilemma exposes the disparity between the goals of the mental health and legal communities: fostering of individual freedom[8] by safeguarding against unfounded use of the civil commitment process, and protecting the public. Unless the law of *Petersen* and social policy are reconciled, legislative mandate[9] underlying the State's civil commitment process will be rendered impotent. This is in spite of the Washington legislature's recent attempt to limit *Petersen* by amending the relevant mental health laws.[10] There is reason to believe, however, that this new legis-

---

6. For the purpose of this paper, "psychiatrist" refers to those professionals who can initiate involuntary civil commitment proceedings, or who are responsible for the treatment, care, release, or other disposition of an individual who has entered a state's involuntary civil commitment system. *See* WASH. REV. CODE § 71.05.020(13) (1987).

7. *See infra* text accompanying notes 43-48 & 65-68.

8. Although *Petersen* does not explicitly focus on fostering individual freedom, it implicitly does so by discussing Washington's Involuntary Treatment Act (ITA) throughout the case. *Petersen*, 100 Wash. 2d at 429, 430, 441, 671 P.2d at 238, 239, 244. Thus, in analyzing any part of the ITA, as well as *Petersen*, one must keep in mind the prefatory intent to "safeguard individual rights." *See* WASH. REV. CODE §§ 71.05.360, .370, .380 (1987).

9. The intent of the ITA was specifically enunciated by the legislature as follows:

1) To end inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;
2) To provide prompt evaluation and short-term treatment of persons with serious mental disorders;
3) To safeguard individual rights;
4) To provide continuity of care for persons with serious mental disorders;
5) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures;
6) To encourage, whenever appropriate, that services be provided within the community.

WASH. REV. CODE § 71.05.010 (1987).

10. WASH. REV. CODE § 71.05.120(2) (1987) (amending WASH. REV. CODE § 71.05.120 (1985)). Following substantial changes in 1986 to Washington tort law, a variety of constituencies perceived that the result of *Petersen* required further adjustments to the law. The chief concern of mental health professionals was that the duties imposed by *Petersen* left them vulnerable to greater liability and that the effect of this would lead to the dismantling of the mental health community. The primary groups involved

lation will do nothing to cure the effect of *Petersen*, or to resolve the psychiatrists' conflict of duties. Thus, the result will be unnecessarily increased use by psychiatrists of their authority to involuntarily commit, a lessening of personal liberty rights, and a growing and overburdened civil commitment system.[11]

This Article argues that the duty of psychiatrists to protect, as articulated by the *Petersen* court and left unchanged by the Washington legislature, should be imposed only in specified circumstances. Such circumstances include situations where the psychiatrist has actual knowledge[12] of a patient's dangerousness, or where a notice or warning can be made to an identifiable victim. When those circumstances are not present, however, there is no justification for placing a psychiatrist in the dilemma of having to choose confinement over risk.[13]

Part I of this Article traces the development and expansion of tort rules governing psychiatric liability and the mental health field. Part II briefly examines the concept of involuntary civil commitment, generally, and in Washington. Part III presents a factual overview and analysis of *Petersen v. State*, followed by a criticism of the court's decision and legislative response.

I. DEVELOPMENT AND EXPANSION OF TORT RULES

A. Common Law Origins of the Duty to Protect

At common law, there was no duty to control the conduct of another or to protect those who were endangered by

---

with amending the law were the Washington State Trial Lawyers and the Liability Reform Coalition. Telephone conversations with Dick Armstrong, Staff Counsel, Senate Judiciary Committee; Clifford Webster, lobbyist for the Washington State Medical Association, and a member of the Liability Reform Coalition (January 1988). *See infra* notes 132-33 and accompanying text.

11. For an excellent review on the impact resulting from the expanding civil commitment power of the state on a state's mental health policy, see Durham and LaFond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395 (1985) [hereinafter Durham and La Fond].

12. *See infra* notes 131 & 147 and accompanying text.

13. *See generally* Stone, *The Tarasoff Decisions: Suing the Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976); Special Project, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165 (1978); Mills, *The So-Called Duty to Warn: The Psychotherapeutic Duty to Protect Third Parties From Patients' Violent Acts*, 2 BEHAV. SCI. & LAW 237 (1984).

another's conduct.[14] This rule of no duty to control or protect originated in the common law distinction between action and inaction, or "misfeasance" and "nonfeasance."[15] The common law provided that one who injured another by a positive, affirmative act was held liable, while one who did nothing escaped liability, despite the harm resulting from inaction.[16]

Exceptions to this rule were made, however, when some type of special relationship existed between the person whose conduct posed the harm and the person threatened.[17] Thus innkeepers were held to have an obligation toward their guests,[18] employers toward their employees,[19] schools toward their pupils,[20] and businesses toward their customers.[21] The duty imposed was one of reasonable care under the circumstances; it did not require a party to take action until the party knew, or had reason to know a person was threatened.[22]

---

14. The Restatement of Torts reflects the general rule of nonliability: "The fact that the actor realizes or should realize that the action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action." RESTATEMENT (SECOND) OF TORTS §§ 314, 315 (1965).

15. *Id.* § 314 comment c (1965).

16. The rule owes its survival to "the difficulties of setting any standards of unselfish service to fellow men, and of making any workable rule to cover possible situations where fifty people might fail to rescue. . . ." W. PROSSER & W. KEETON, THE LAW OF TORTS 376 (5th ed. 1984) [hereinafter PROSSER & KEETON].

17. Because practical difficulties exist in distinguishing the actor and non-actor, the courts have increased the number of instances in which an affirmative duty is imposed. They have done this, not by the direct rejection of the common law rule, but by expanding the list of special relationships which justify departure from the common law rule. *See, e.g.*, PROSSER & KEETON, *supra* note 16, at 356-85. *See also* RESTATEMENT (SECOND) OF TORTS § 315(a), (b) (1965).

18. Fortney v. Hotel Rancroft, 5 Ill. App. 2d 327, 125 N.E.2d 544 (1955) (action by guest against hotel for injuries resulting from assault by intruder in guest's room).

19. Taylor v. Slaughter, 171 Okl. 152, 42 P.2d 235 (1935) (duty of sheriff to prisoner for injuries sustained if sheriff and his deputies, or jailer in sheriff's employment, were aware of contemplated assault on prisoner and did not use reasonable means to prevent it).

20. Shultz v. Gould Academy, 332 A.2d 368 (Me. 1975) (negligence action against boarding school for failure to protect student from intruder into his dormitory room).

21. Winn-Dixie Stores, Inc. v. Johnstoneaux, 395 So.2d 599 (Fla. App. 1981) (action against supermarket for injuries sustained by customer robbed by unknown assailant in common parking lot of shopping center; extensive evidence indicated many attacks in this high crime district).

22. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 314A:

(1) A common carrier is under a duty to its passengers to take reasonable action
   (a) To protect them against unreasonable risks, physical harm, and
   (b) To give them first-aid after it knows or has reason to know that they are ill or injured, and to care for them until they can be cared for by others.
(2) An innkeeper is under a similar duty to his guests.

Case law and statutes gradually extended the special relationship exception to include the duty to control the conduct of third persons when a special relationship existed between the actor and the third person. The duty arose when an individual had control or custody of another, and knew, or had reason to know of the possibility of harm to other parties.[23] For example, courts imposed upon parents a duty to protect a babysitter by warning of their child's violent propensities; likewise, the state, to discharge its duty to protect, must warn guardians of a ward's dangerous tendencies.[24] The courts have extended this duty and imposed liability even where there was no relationship between the actor and the person threatened.[25]

The physician-patient relationship was a natural area for extending the duty to protect. Thus, a physician has an affirmative duty to protect third parties from dangers created by their patient.[26] The basis for this duty is the special relationship between the physician and patient which consists of the doctor's right of custody over the patient,[27] and of the professional knowledge gained in treating or evaluating a patient.[28]

---

(3) A possessor of land who holds it open to the public is under a similar duty to members of the public who enter in response to the invitation.

(4) One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection is under a similar duty to the other.

23. *Id.* § 315 comment a (1965).

24. Other duties traditionally include the duty of a parent to control a child's conduct, the duty of a master to control a servant's conduct, a landholder's duty to control the conduct of a licensee, the duty of those charged with the custody of persons with dangerous propensities, and the duty of a custodian to control the conduct of another. *See id.* §§ 316, 317, 318, 319, and 320; Ellis v. D'Angelo, 116 Cal. App. 2d 310, 253 P.2d 675 (1953). *See also* Eldredge v. Kamp Kachess, 90 Wash. 2d 402, 583 P.2d 626 (1978) (parents liable for the tortious conduct of their children if parents know of the child's dangerous proclivity and fail to take reasonable measures to control those proclivities; state agency designated to care for children held to same standard.).

25. Johnson v. State, 69 Cal. 2d 782, 447 P.2d 352, 73 Cal. Rptr. 240 (1968) (state liable for parole officer's negligence in failing to warn foster parent of child's dangerousness). *See* Christensen v. Murphy, 296 Or. 610, 678 P.2d 1210 (1984) (public safety officer can recover damages for personal injuries sustained in course of employment as result of defendant's negligence).

26. *See, e.g.*, Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

27. Section 319 of the RESTATEMENT (SECOND) OF TORTS reflects the general rule of liability for physicians and hospitals: "One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."

28. *See* Harper and Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 897 (1934).

Ample precedent now exists in which the special relationship has been used to impose liability on doctors and health-care institutions.[29]

In light of the relationship that develops between doctor and patient, and the status society attributes to health care professionals,[30] it is no surprise that most courts have extended the duty to protect to psychiatrists. With their superior knowledge, psychiatrists are expected to identify individuals who are dangerous to themselves or others and to recommend preventive action.[31] This occurs both in the mental health context and within the judicial system where psychiatrists are called upon to assist in making decisions about culpability, competence, incarceration, or rehabilitation.[32]

B. Development of the Psychiatrist's Duty to Protect

The duty of a psychiatrist to protect others from a patient's dangerousness was first articulated in *Tarasoff v. Regents of California*.[33] The parents of a woman brought suit against the University of California when their daughter was killed by a patient under the care of a psychologist employed by the University. The patient had told the psychologist that he was going to kill a girl.[34] Although she was unnamed, the Tarasoffs' daughter was readily identifiable as the victim.[35] The psychologist gave no warning to the victim or her family.[36]

---

29. *See, e.g.*, Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976); Bradley Center, Inc. v. Wessner, 250 Ga. 199, 296 S.E.2d 693 (1982); Gooden v. Tips, 651 S.W.2d 364 (Tex. App. 1983). This duty is most apparent when the doctor treats a patient with a contagious disease. Liability can be imposed due to a failure to diagnose or warn of the disease. RESTATEMENT (SECOND) OF TORTS § 319 comment a, illustrations 1, 2 (1965).

30. *See generally* 61 AM. JUR. 2D, *Physicians and Surgeons*, § 246 (1981).

31. Persons within the profession have long recognized that psychiatrists occupy a privileged position within society. For a discussion of the power and status afforded psychiatrists, see T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 79-80 (1980); S. HALLECK, THE POLITICS OF THERAPY 99-117 (1971).

32. *See* Fleming and Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1031 (1974) [hereinafter Fleming and Maximov] ("[H]ospitals and medical sciences are charged with a public interest. Their image of responsibility in our society makes them prime candidates for converting their moral duties into legal ones.").

33. 17 Cal. 3d 425, 551 P.2d 324, 131 Cal. Rptr. 14 (1976).

34. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

35. *Id.*

36. *Id.* at 433, 551 P.2d at 341, 131 Cal. Rptr. at 21. The psychologist conferred with two University psychiatrists, and all three concurred in the need to commit the patient. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21. This need was communicated to the University police orally and in writing. *Id.* However, the director of the

The victim's parents sued the psychologist and the University alleging the failure to exercise reasonable care in protecting their daughter.[37] This alleged breach of the psychiatrist's duty to protect resulted from both the University's failure to commit the patient and the failure to provide any warning to the victim.[38]

In holding that a duty to protect existed under the circumstances, the court applied an exception to the common law rule that one person owed no duty to control the conduct of another.[39] The court found that an exception to the common law rule exists in cases when the defendant stands in some special relationship to either the person whose conduct needs to be controlled, or in a relationship to the foreseeable victim[40] of that conduct.[41] Thus, it was the nature of the relationship between the physician and patient that created the duty owed by the therapist to a third party.[42]

In enunciating this duty to protect, the *Tarasoff* court recognized the existence of a conflict in public policy. First, there was an important public interest in supporting effective treatment of mental illness, protecting the rights of patients' privacy, and safeguarding the confidential character of the psychotherapists' communications.[43] Second, there was an

---

psychology department countermanded the order to seek confinement and directed that copies of the letter to the police and the psychologist's notes be destroyed. *Id.*

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

38. *Id.*

39. *Id.* at 435, 551 P.2d at 343, 131 Cal. Rptr. at 23. *See supra* notes 14-16 and accompanying text.

40. *Tarasoff*, 17 Cal. 3d at 435, 551 P.2d at 343, 131 Cal. Rptr. at 23. The foreseeability of harm in *Tarasoff* was apparent from the directive of the chief psychiatrist to destroy all records of the therapist. The court ruled that records were not privileged because the interest of the protection of the victim outweighed the interest of the confidentiality of the patient. *Id.* at 439 n.12, 551 P.2d at 346, 131 Cal. Rptr. at 26.

41. Thus, a relationship of a therapist to either the victim or the perpetrator will suffice to establish a duty of care. *Id.* at 435, 551 P.2d at 343, 131 Cal. Rptr. at 23.

42. *Id.* at 439, 551 P.2d at 346, 131 Cal. Rptr. at 26. One commentator asserts that the *Tarasoff* court, originally asked to choose between a duty to warn and a duty to confine, in reality, opted for a third and more ambiguous choice, a duty to protect. A. STONE, *The Tarasoff Case and Some of Its Progeny*, in LAW, PSYCHIATRY AND MORALITY 161 (1984) [hereinafter STONE]. Avoiding a position which would favor civil commitment, *Tarasoff* tells the psychiatrist that he must protect third parties, but does not specify what steps are legally necessary and sufficient to meet this obligation. *Id.* Stone notes that subsequent judicial decisions have failed to recognize this distinction and the law, as interpreted, stands for the broad duty to protect, rather than the narrow duty to warn, and creates a greater risk of psychiatric liability. *Id.*

43. *Tarasoff*, 17 Cal. 3d at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

important public interest in protecting society by warning of impending violence.[44] The court balanced these countervailing concerns by relying on the state's evidence code,[45] which provides a limited exception to the psychotherapist-patient privilege, allowing disclosure of communication necessary to protect third parties from a patient's dangerousness.[46] Thus, the court found that the need to protect the public from dangerous behavior far outweighed the psychotherapist-patient privilege or confidentiality.[47] The court finally concluded that "the public policy favoring protection of the confidential character of the patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."[48]

In *Mavroudis v. Superior Court*,[49] another California case, the court attempted to clarify when one public policy concern outweighed the other. In *Mavroudis*, the plaintiffs' son, while receiving psychiatric treatment, attacked his parents and caused them personal injuries. The lower court had denied the parents' motion to compel production of their son's psychiatric records because of its interpretation of *Tarasoff* as limiting a therapist's duty to protect by warning when he has actual knowledge of the danger, or where the danger is present toward particular individuals.[50]

The appellate court stated that actual knowledge of a patient's dangerousness and knowledge of the identity of the intended victim were not prerequisites to imposing liability on a therapist for a failure to warn.[51] The court held that

---

44. *Id.*

45. *Id.* at 440-41, 551 P.2d at 346-47, 131 Cal. Rptr. at 26-27.

46. CAL. EVID. CODE § 1024 (West 1966) provides in part: "There is no privilege . . . if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to . . . another and that disclosure . . . is necessary to prevent the threatened danger."

47. *Tarasoff*, 17 Cal. 3d at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

48. *Id.*

49. 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980).

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

51. The *Mavroudis* court makes clear that the intended victim need not be specifically named by the patient, but must be "readily identifiable." *Id.* at 600, 162 Cal. Rptr. at 729. The *Tarasoff* court indicated what it meant by "readily identifiable" in a footnote in which it recognized that it would be unreasonable to require the therapist to interrogate the patient or to conduct an independent investigation to discover identity of the patient's intended victim. On the other hand, the *Tarasoff* court stated that there are cases in which a "moment's reflection" will reveal the victim's identity. In such cases, the *Tarasoff* court indicated that the therapist had a

Tarasoff imposes a duty to protect whenever a therapist determines, or pursuant to the standards of the profession *should have* determined, that the patient presents a serious threat of violence to others.[52] Thus, where the victim's identity will be revealed in a "moment's reflection," the duty to protect exists.[53]

In recent years courts have subjected psychiatrists and other mental health professionals to increased judicial scrutiny, fostering the social policy of protecting public safety.[54] The rationale for imposing this duty to protect is based in tort law and on the notion that those with special powers and skills are obligated to act in the community's best interests.

II. INVOLUNTARY CIVIL COMMITMENT

As noted in the previous discussion, the psychiatrist's position of knowledge, power, and control has been the underlying rationale for imposing a duty to protect society from dangerous individuals. That duty can be discharged in a variety of ways, and will often take the form of warning potential victims or detaining a patient for a period of care or treatment. The most

---

duty to protect that person from the danger presented by his patient. *Id.* (citing *Tarasoff*, 17 Cal. 3d at 439 n.11, 551 P.2d at 345, 131 Cal. Rptr. at 25.).

52. *Mavroudis*, 102 Cal. App. 3d at 599-600, 162 Cal. Rptr. at 729.

53. The *Tarasoff* court recognized the difficulty encountered by therapists in attempting to forecast whether a patient presents a serious danger of violence: "Obviously we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances." 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (citations omitted). For a review of other jurisdictions following the California rule, see McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979) (psychiatrist has a duty to "protect an intended victim or potential victim when he determines, or should determine, . . . that the patient is or may present a probability of danger to that person."); Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983) (United States held liable for failing to warn victim of dangerous propensities of Veterans Administration Hospital patient). *See also* Underwood v. United States, 356 F.2d 92 (5th cir. 1966) (liability imposed upon a psychiatrist for the harm to a third party caused by the negligent release of a patient from psychiatric custody).

54. This is obvious in view of the ever-expanding imposition of liability. *See* Semler v. Psychiatric Institute of Washington, D.C., 538 F.2d 121 (4th Cir. 1976), *cert. denied*, 429 U.S. 827 (1976) (institution failed to contact the court about a patient-probationer's change in treatment plan); Pangburn v. Saad, 73 N.C. App. 336, 326 S.E.2d 365 (1985) (claim of negligence sustained even when the intended victim had knowledge of the patient's dangerous propensities because a psychiatrist released his patient in spite of objections made by the patient's family); *see also* Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975) (hospital negligent in failing to inform court of necessary details of patient's mental condition that resulted in patient's wife's death).

effective mechanism afforded the psychiatrist to discharge this duty, however, is to recommend involuntary civil commitment.[55]

Underlying civil commitment of the mentally ill are the theories of the state's police power and *parens patriae*.[56] Under its police power,[57] the state may exercise its authority to enact laws to protect the health, welfare, and safety of the community at large. Similarly, under the protective authority of *parens patriae*,[58] a state is empowered to act on behalf of others who lack the capacity to act in their own best interests.

In all 50 states and the District of Columbia, an individual may be civilly committed, against his will, to a mental institution.[59] To justify involuntary hospitalization, some showing of the existence of a mental disorder is universally required.[60] Both emergency and non-emergency state commitment statutes contain the standards governing involuntary civil commitment.[61] Although a review of states' standards for commitment suggests different thresholds for hospitalization, commitment is generally restricted to mentally ill persons who appear dangerous to themselves or others, or to those to whom a threat of harm is immediate.[62]

---

55. In this article, "involuntary civil commitment" or "civil commitment" refers to any state-imposed, compulsory hospitalization, confinement, or other restriction of personal liberty premised on an individual's mental illness. *See* WASH. REV. CODE §§ 71.05.030, .040 (1987).

56. For a thorough discussion of these theories, see La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFFALO L. REV. 499 (1981) [hereinafter La Fond].

57. The state's police power to commit persons who may be of danger to themselves or to others has its roots in common law. *See* La Fond, *supra* note 56, at 501. Theoretically, a person committed pursuant to the police power of the state can remain in confinement until he is no longer dangerous to himself or others. *Id.*

58. This power, recognized in English Common Law, is used to exercise commitment authority over persons with a variety of mental disabilities. Most *parens patriae* schemes authorize involuntary commitment of mentally ill persons who cannot care for themselves, are unable to seek appropriate treatment, or are gravely disabled. *Id.* at 504-06.

59. *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1202, 1202 n.3 (1974) [hereinafter *Developments - Civil Commitment*].

60. *Id.* at 1202 n.4.

61. For an overview of civil commitment statutes, see *id.* at 1202 & n.2; *see also* Beis, *State Involuntary Commitment Statutes*, 7 MENTAL DISABILITY L. REP. 358-69 No. 4 (1983).

62. *Developments - Civil Commitment*, *supra* note 59, at 1203-05. *See, e.g.*, WASH. REV. CODE §§ 71.05.150 (1)(b), 71.05.020(1), (2), (3) (1987), which provide that a person may be involuntarily committed, if as a result of mental disorder, the person presents a likelihood of serious harm to others or himself, or is gravely disabled. *See infra* note 70. *See also* ALASKA STAT. § 47.30.700 (1984); ARIZ. REV. STAT. ANN. § 36-526 (1986);

Current procedural provisions for commitment vary from state to state and range from judicial hearings to discretionary administrative proceedings.[63] Generally, involuntary commitment is initiated in an emergency by a police officer or by a mental health professional.[64]

A psychiatrist's use of involuntary civil commitment of a dangerous person may ensure public safety and obviate the necessity of warning. However, this type of detainment threatens important liberty interests of the patient such as privacy, violation of due process, and loss to the patient of expected treatment.[65] State legislatures have responded to this clash of interests by limiting involuntary civil commitment to specified circumstances.[66] For example, state intervention is generally

---

ARK. STAT. ANN. § 59-1406 (Supp. 1985); CAL. WELF. & INST. CODE § 5150 (West. 1984); COLO. REV. STAT. §§ 27-10-105 (Supp. 1987); CONN. GEN. STAT. ANN. § 17-183 (West Supp. 1988); DEL. CODE ANN. tit. 16 § 5122 (Supp. 1983); FLA. STAT. ANN. § 394.463 (West 1986); HAW. REV. STAT. § 334-59 (1985 & Supp. 1987); IDAHO CODE § 66-326 (Supp. 1987); ILL. REV. STATE. ch. 91 1/2, § 3-601 (1987); IND. CODE ANN. § 16-14-9.1-3 (Burns Supp. 1987); IOWA CODE ANN. § 229.22 (West 1985); KAN. STAT. ANN. § 59-2908 (1983); KY. REV. STAT. ANN. § 202A.026 (Bobbs-Merrill 1982); LA. REV. STAT. ANN. § 28:53 (West Supp. 1988); MD. HEALTH-GEN. ANN. CODE § 10-622 (Michie 1982 & Supp. 1987); MASS. GEN. LAWS ANN. ch. 123, § 12 (West Supp. 1987); MICH. COMP. LAWS ANN. § 330.1427 (West Supp. 1980); MINN. STAT. ANN. § 253.05 (West Supp. 1988); MISS. CODE ANN. § 41-21-71 (1972 & Supp. 1987); MONT. CODE ANN. § 53-21-129 (1987); NEB. REV. STAT. §§ 83-1020, 1021 (1981); NEV. REV. STAT. § 433A.160 (1985); N.H. REV. STAT. ANN. § 135-C: 27 (Supp. 1987); N.J. STAT. ANN. § 30:4-26.3 (West 1981); N.M. STAT. ANN. § 43-1-10 (Supp. 1984); N.Y. MENTAL HYG. LAW § 9.39 (McKinney Supp. 1988); N.C. GEN. STAT. § 122C-261 (Michie 1986); N.D. CENT. CODE § 25-03.1-25 (Smith Supp. 1987); OHIO REV. CODE ANN. § 5122.10 (Anderson 1981 & Supp. 1986); OR. REV. STAT. §§ 426.175, .215 (Butterworth 1987); PA. STAT. ANN. tit. 50, §§ 7301, 7302 (Purdon Supp. 1987); S.C. CODE ANN. § 44-17-410 (Law. Co-op 1976 & Supp. 1987)); S.D. CODIFIED LAWS ANN. § 27A-10-3 (Smith 1984); TENN. CODE ANN. § 33-6-103, 104 (Michie Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 5547-28 (Vernon Supp. 1988); UTAH CODE ANN. § 64-7-34 (Michie 1986); VT. STAT. ANN. tit. 18, §§ 7504, 7505 (Equity Supp. 1986); WIS. STAT. ANN. § 51.15 (West 1987); WYO. STAT. § 25-10-109 (Michie Supp. 1987).

63. *Developments - Civil Commitment*, *supra* note 59, at 1265.

64. For example, see WASH. REV. CODE § 71.05.150 (1)(a) (1987), which provides for the initiation of the process when a county mental health professional, after interviewing an individual, determines that the individual is in need of treatment or evaluation at a mental health facility.

65. *See* Fleming and Maximov, *supra* note 32, at 1049, 1051. This conflict of interest, or "dilemma," could be resolved by improving diagnostic methods and therapeutic skills, guarding the timing of disclosure, selecting a form of intervention with the least harmful impact upon the patient's interest, and utilizing the procedures of informed consent. *Id.* at 1065-66.

66. ALA. CODE § 22-5291, 10 (Supp. 1982); ARIZ. REV. STAT. ANN. §§ 36-501-520 (West 1986); CAL. WELF. & INST. CODE § 5150 (West 1984); CONN. GEN. STAT. ANN. §§ 17-176, 183 (West Supp. 1988); GA. CODE ANN. § 88-501-504.2 (Harrison 1986 & Supp. 1987); HAW. REV. STAT. §§ 334-59, 60 (1985 & Supp. 1987); IDAHO CODE ANN. §§ 66-317, 329 (Supp. 1987); ILL. REV. STAT. ch. 91 1/2, § 1-119, 3-700, -706 (Smith-Hurd 1987); IND.

limited to committing only those patients who are dangerous to themselves, or others, as manifested by recent conduct. And although the use of a "dangerousness" standard has generated great debate by courts and commentators alike,[67] recent reform in civil commitment laws has signaled to psychiatrists that commitment may not occur without a sufficiently strong governmental interest.[68]

In Washington, for example, the Involuntary Treatment Act[69] (ITA) allows commitment of people who are either "gravely disabled" or present a "likelihood of serious harm."[70]

CODE ANN. § 16-14-9.1-1 (Michie/Bobbs-Merrill 1983 & Supp. 1987); IOWA CODE ANN. § 229.11 (West 1985); KAN. STAT. ANN. §§ 59-2908, -2909 (Supp. 1987); KY. REV. STAT. ANN. § 202A.026, (Michie 1982); ME. REV. STAT. ANN. tit. 34-B, § 386 2-3863 (West Supp. 1986); MD. HEALTH GEN. CODE ANN. §§ 10-6 20 to 632 (Michie 1982 & Supp. 1987); MASS. GEN LAWS ANN. ch. 123, § 12 (West Supp. 1987); MICH. COMP. LAWS ANN. § 330.1401 (West 1980); MINN. STAT. ANN. § 253B.05 (West Supp. 1988); MONT. CODE ANN. §§ 53-21-102, -129 (1987); NEB. REV. STAT. §§ 83-1009, -1020, -1037 (1981); NEV. REV. STAT. §§ 433A.160, .170-.310, (1985); N.H. REV. STAT. ANN. §§ 135-C: 27 to 33 (Supp. 1987); N.J. STAT. ANN. §§ 30: 4-23, -25, -26.3 (West 1981); N.M. STAT. ANN. § 43-1-10 (Supp. 1984); N.Y. MENTAL HYG. LAW §§ 9.37, 9.39, 9.41, 9.43 (McKinney 1978 & Supp. 1988); N.C. GEN. STAT. §§ 122C-262 to 293 (Michie 1986); N.D. CENT. CODE §§ 25-03.1-02, 09 (Smith Supp. 1987); OKLA. STAT. ANN. tit. 43A, § 5 (West Supp. 1988); OR. REV. STAT. § 426.175 (Butterworth 1987); PA. STAT. ANN. tit. 50, §§ 7301, 7302, 7303 (Purdon Supp. 1987); S.D. CODIFIED LAWS ANN. §§ 27A-10-1 to 27A-10-9 (Smith 1984); TENN. CODE ANN. § 33-6-103 (Michie Supp. 1987); UTAH CODE ANN. § 64-7-36 (Michie 1986 & Supp. 1987); VT. STAT. ANN. tit. 18, §§ 7101, 7504 (Equity Supp. 1986); W. VA. CODE § 27-5-2 (Michie 1986); WIS. STAT. ANN. §§ 51.15, 51.20 (West 1987); WYO. STAT. § 25-10-110 (Michie 1982). For a discussion of the limitation of coercive interaction by the state, see La Fond, *supra* note 56.

67. *See, e.g.*, Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); *In re* Harris, 98 Wash. 2d 276, 654 P.2d 109 (1982); Groethe, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977) [hereinafter Groethe, *Overt Dangerous Behavior*].

68. In O'Connor v. Donaldson, 422 U.S. 563 (1975), the Supreme Court specifically addressed the constitutionality of involuntary civil commitment outside of the criminal context. In its decision, it articulated a state interest standard, holding the involuntary civil commitment of the mentally ill impermissible when insufficient state interest is present. *See also* Groethe, *Overt Dangerous Behavior*, *supra* note 67, at 563-69.

69. WASH. REV. CODE § 71.05.015 (1987).

70. "Gravely disabled" means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essentially human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his actions and is not receiving such care as is needed for his or her health or safety.

Id. § 71.05.020(1).

"Likelihood of serious harm" means either: (a) A substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual

The involuntary commitment process is initiated when a mental health professional[71] receives information alleging that a person presents an imminent likelihood of serious danger to himself or others, or is in imminent danger because of being gravely disabled.[72] The mental health professional must thoroughly evaluate information received and assess the "reliability and credibility" of the person providing the information.[73] The initial detention of an individual may not exceed a 72-hour evaluation period.[74]

Once admitted to an evaluation and treatment facility,[75] an individual must be examined within 24 hours by a licensed physician and mental health professional.[76] Following the examination, an individual receives the treatment and care required by his condition, and beginning 24 hours prior to a court proceeding, the individual may refuse all but emergency life-saving treatment.[77]

Persons who meet the criteria for further commitment during this period can be held for not more than 14 additional days.[78] Washington law also provides that prior to each involuntary civil commitment order, other less restrictive alterna-

---

upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others . . . .

Id. § 71.05.020(3).

71. Mental health professional means "a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules and regulations. . . ." *Id.* § 71.05.020(11).

72. *See, e.g., In re* Harris, 98 Wash. 2d 276, 284-85, 654 P.2d 109, 112-13 (1982) (WASH. REV. CODE ch. "71.05's standard of dangerousness provides a valid basis for the involuntary commitment of an individual. The risk of danger must be substantial and the harm must be serious before detention is justified.").

73. WASH. REV. CODE § 71.05.150(1) (1987).

74. *Id.* § 71.05.180. At this time, an individual is released or provided a probable cause hearing. *Id.* §§ 71.05.180, .240.

75. An "evaluation and treatment facility" is a mental health facility which provides directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and short-term inpatient care to persons suffering from a mental disorder, and which is certified by the State Department of Social and Health Services. *Id.* § 71.05.020 (16).

76. *Id.* § 71.05.210.

77. *Id.* The law requires that an individual must also be informed of his right to refuse such treatment. *Id.*

78. *Id.* § 71.05.230. Requirements for further detention are that the individual's condition is caused by a mental disorder and results either in a likelihood of serious harm to others, or in an individual being gravely disabled *and* that the individual has not in good faith volunteered for additional treatment.

tives to voluntary or involuntary detention must be examined.[79] If commitment is ordered, each individual is afforded the "right to adequate care and individualized treatment."[80]

Additional confinements for up to 90 days[81] can be imposed if an individual threatens, attempts, or inflicts harm upon another or himself and thus presents a likelihood of serious harm to himself or others.[82] At the end of this period, an individual is released unless he meets criteria for further confinement for up to 180 days.[83] The 180-day periods of detention can be renewed indefinitely provided a full hearing[84] is held prior to each renewal.[85]

The objectives[86] of Washington law are progressive and safeguard the liberty interests of mental patients.[87] As is clear from its prefatory language, the ITA addresses the protection of a patient's rights against wrongful or indefinite commitment. To this end, the law articulates standards to end inappropriate commitment, to hasten patient evaluation, to shorten, when appropriate, treatment and hospitalization, and to encourage the use of community services.

These and other safeguards present in the ITA, dedicated to protecting individual rights, conflict with society's expectation of protection by psychiatrists from patient dangerousness. And the continual debate in medical and legal literature

---

79. *Id.* § 71.05.230(4).

80. *Id.* § 71.05.360.

81. *Id.* § 71.05.320.

82. *Id.* § 71.05.280(1).

83. *Id.* § 71.05.320(2)(d).

84. *Id.* Procedural due process rights include written and oral notice of the nature of the hearing, as well as the right to (1) communicate with counsel immediately upon detention, (2) remain silent, (3) be represented by counsel at the hearing, (4) present evidence and cross-examine witnesses, (5) have the hearing governed by evidence rules, (6) view and copy contents of the court file. *See id.* §§ 71.05.150, .230, .240, .250, .310.

85. *Id.* §§ 71.05.180, .240.

86. The Washington legislature has clearly set out the objectives of its involuntary civil commitment law, which are carefully designed to ensure the protection of a mental patient's rights against wrongful or indefinite commitment. *Id.* § 71.05.010. *See supra* note 9.

87. One of the most important decisions which has influenced protection of patients' rights is Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *order on remand*, 379 F. Supp. 1376 (1974), *vacated and remanded*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (1976). In this case, the court articulated standards for procedural due process which have been followed by many courts and legislatures throughout the country.

regarding the duty of a psychiatrist to third parties virtually assures that this conflict of interest is far from resolved.

This conflict is especially stark in situations where there is no victim to be warned and where a patient's behavior does not warrant confinement under the restrictive standards of the law. Such a situation came before the Washington Supreme Court in *Petersen v. State*.[88]

III. *PETERSEN V. STATE*

A. Facts

In May 1977, Larry Knox injured Cynthia Petersen in an automobile collision when Knox, under the influence of drugs, struck her car.[89] At the time of the accident, Knox was on probation for a burglary conviction, which required his participation in mental health counseling and required that he not use controlled substances.[90]

In April 1977, a month before the automobile collision, Knox removed his left testicle and was subsequently hospitalized.[91] Dr. Alva Miller, Knox's physician at the hospital,[92] learned that Knox took angel dust[93] prior to emasculating himself. Dr. Miller diagnosed Knox as having a schizophrenic reaction primarily due to the use of angel dust.[94] Dr. Miller prescribed Navane, an antipsychotic medication.[95]

On April 22, 1977, Dr. Miller and a psychiatric nurse filed

---

88. 100 Wash. 2d 421, 671 P.2d 230 (1983).

89. *Id.* at 422-23, 671 P.2d at 234.

90. *Id.* at 423, 671 P.2d at 234.

91. *Id.*; Knox was involuntarily detained at Western State Hospital pursuant to WASH. REV. CODE §§ 71.050.150, .180 (1987).

92. Dr. Miller was Clinical Director of Western State Hospital. *Petersen*, 100 Wash. 2d at 423, 671 P.2d at 235. *See* WASH. REV. CODE § 71.05.020 (1987), which provides in part:

> (11) "Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules and regulations adopted by the secretary pursuant to the provisions of this chapter;
>
> (12) "Professional person" shall mean a mental health professional, as above defined, and shall also mean a physician, registered nurse, and such others as may be defined by rules and regulations adopted by the secretary pursuant to the provisions of this chapter. . . .

93. Angel dust is the street name for phencyclidine hydrochloride, or "PCP." PCP is used in veterinary medicine as a horse tranquilizer. SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 545 (1987). "Abuse of [PCP] may lead to serious psychological disturbances." *Id.*

94. *Petersen*, 100 Wash. 2d at 423, 671 P.2d at 235.

95. *Id.*

a petition requesting authority to further detain Knox.[96] They maintained that Knox was gravely disabled[97] because of his drug abuse, that Knox presented a likelihood of harm to himself,[98] and that he was not ready for less restrictive care.[99] The court found that Knox was gravely disabled and ordered that Knox be detained for another 14 days.[100]

By the first week of May 1977, Knox showed no further signs of drug-related problems.[101] On May 8, 1977, Knox was allowed to go home on a day pass. That evening he returned to the hospital driving his car "in a reckless fashion that involved spinning his car in circles."[102] The next day, Dr. Miller discharged Knox from the hospital. Dr. Miller believed Knox had recovered from the drug reaction and was fully in "contact with reality."[103]

On May 14, 1977, the automobile accident involving Cynthia Petersen occurred. Knox was under the influence of illegal drugs at the time and had not taken the medication prescribed for him at the hospital.[104]

Cynthia Petersen alleged in her claim against the State that it failed to protect her against Knox's dangerous propensities.[105] She claimed that Dr. Miller's failure to seek additional confinement was a proximate cause of her injuries.[106] The case was allowed to go to the jury on this theory, and the jury agreed. On appeal, the Washington Supreme Court found that the lower court's decision that Dr. Miller's conduct constituted gross negligence was not reversible error.[107] The court found that Dr. Miller had a duty to protect the plaintiff from the

---

96. *Id.* at 424, 671 P.2d at 235.

97. *See* WASH. REV. CODE § 71.05.210 (1987); *see supra* note 70.

98. 100 Wash. 2d at 424, 671 P.2d at 235; *see supra* note 70.

99. 100 Wash. 2d at 424, 67 P.2d at 235. *See supra* notes 78-80 and accompanying text.

100. 100 Wash. 2d at 424, 671 P.2d at 235.

101. *Id.*

102. Brief for Appellant at 15, Petersen v. State, 100 Wash. 2d 421, 671 P.2d 330 (1983) (No. 06021 3-II).

103. 100 Wash. 2d at 424, 671 P.2d at 235.

104. *Id.*

105. *Id.*

106. *Id.* Apparently, Petersen believed that Knox's driving on hospital grounds as he did demonstrated his dangerousness. This writer believes, however, that driving in circles does not constitute dangerous conduct under Washington law.

107. *Id.* at 438, 671 P.2d at 242. Petersen additionally claimed that Dr. Miller's failure to disclose information about Knox's parole violation caused her injury. The court, however, found that Dr. Miller could not lawfully disclose such information. This issue is not addressed in this article.

dangerous propensities of his patient and that sufficient evidence had been presented to the jury to find that the doctor's action was a proximate cause of the injuries.[108]

B. The Petersen *Court's Decision*

In *Petersen*, the court confronted the dilemma between the affirmative duty of a psychiatrist to protect others from his patient's dangerousness and the statutory duty of protecting a patient's civil liberty under Washington's ITA. In balancing these competing interests, the court, without dissent, tipped in favor of public protection, and thus expanded psychiatric liability in a new direction.

A close reading of *Petersen*, however, reveals that it lacks adequate legal authority for the public policy it creates. In addition, contrary to the legislature's intent to limit commitment to those who are gravely disabled or dangerous, the law as articulated by the court now places psychiatrists in the untenable position of seeking confinement whether or not the prerequisites to detainment have been met.

Specifically, the *Petersen* court held that there is a duty to protect unidentifiable third-party victims of psychiatric patients. This duty exists because of the "special relationship"[109] between the psychiatrist and the patient, in which the psychiatrist can foresee possible harm to a victim. The court acknowledged that the question of whether such a duty exists was an issue of first impression in Washington.[110]

The court recognized *Tarasoff*, holding that the psychiatrist has a duty "to take reasonable precautions to protect anyone who might foreseeably be endangered" by the patient's actions.[111] The court further relied upon *Kaiser v. Suburban Transp. System*,[112] and upon *Lipari v. Sears, Roebuck & Co.*,[113] for the exception to the general rule of nonliability.[114]

The *Petersen* court, however, found it unnecessary to discuss any of the distinguishing issues present in these other

---

108. *Id.* at 436, 671 P.2d at 241.

109. *Id.* at 426, 671 P.2d at 236. *See supra* notes 23-29 and accompanying text.

110. *Petersen*, 100 Wash. 2d at 426, 671 P.2d at 236.

111. *Id.* at 427, 671 P.2d at 236-37.

112. 65 Wash. 2d 461, 398 P.2d 14, *corrected in* 401 P.2d 350 (1965).

113. 497 F. Supp. 185 (D. Neb. 1980).

114. Under the common law, a person had no duty to prevent a third party from causing physical injury to another. *Petersen*, 100 Wash. 2d at 426, 671 P.2d at 236 (citing *Lipari*, 497 F. Supp. 185). *See supra* notes 14-16 and accompanying text.

cases before affirming the finding that the defendant breached the duty to the plaintiff. The court's failure to address these issues is fatal to its analysis and provides little guidance for future decisions. The *Petersen* decision forces professionals to abide by its precedent rather than to depend on their expertise, skill, and knowledge, and unfortunately, the recent legislative attempts to ameliorate this result will prove ineffective.[115] Thus, society is faced with still unanswered public policy questions: Should it advocate the psychiatrist's increased use of the commitment process so that the public may enjoy greater protection, or should it insist that the stated purposes of Washington's civil commitment law be the guideline for protecting individual freedom and limiting circumstances for involuntary confinement?

C. Critique of the Court's Decision

As decided, *Petersen* emphasizes and contributes to the dilemma faced by psychiatrists in the treatment of their patients. This is due, in part, to the limited consideration the *Petersen* court gave to the legislative restrictions contained in Washington ITA that preclude detainment solely by reason of drug impairment.[116] The exacerbation of the conflict can also be attributed to the court's reliance on cases which, with one exception, contain sound legal propositions, but are factually distinguishable from *Petersen*.

While the cases relied upon by the *Petersen* court may provide the necessary foundation for imposing the duty to protect on the psychiatrist, they do not support the expansion of this duty to protect the public at large. Current Washington law is therefore without adequate support for imposing a duty to protect society en masse. The court's analysis is further weakened because the only facts shared by *Petersen* and cases relied upon by the court are that the defendant was a treating physician and the harm caused by the patient resulted from his mental condition.

First, in *Kaiser v. Suburban Transp. Sys.*,[117] unlike *Peter-*

115. *See* text accompanying notes 10 & 132-33.

116. *See* WASH. REV. CODE § 71.05.040 (1987), which provides that persons impaired by drug abuse shall not be detained or committed solely by reason of that condition unless it causes grave disability or harm to self or others. When Knox was discharged, Dr. Miller believed that he had recovered from his drug reaction and that he was back to his usual behavior. *Petersen*, 100 Wash. 2d at 424, 671 P.2d at 235.

117. 65 Wash. 2d 461, 401 P.2d 350 (1965).

sen, the patient whose act harmed another had neither a history of dangerousness to himself or others nor any type of mental condition for which he was being treated. In *Kaiser*, no question arose of predicting the patient's dangerousness based upon his past behavior or mental condition.[118] Further, unlike *Petersen*, the physician's liability in *Kaiser* was predicated, not upon his duty to protect the public, but upon his duty to inform his patient, whom he knew to be a bus driver, of the foreseeable side effects of the medication prescribed. This, of course, was a simple application of precedent requiring full disclosure of the risks and consequences of medical treatment. All that *Kaiser* added was a view that this duty extended also to third parties who might foreseeably be injured by a doctor's breach of his duty.[119]

What is important to stress about *Kaiser* is that the duty to the plaintiff was a duty that undeniably existed in the first place.[120] The duty was established by the doctor's superior knowledge of his patient's occupation and his medical condition, as well as the knowledge of the potential dangers of the prescribed medication. If the doctor had fully informed his patient of the probable consequences of the medication, the doctor would have had no liability to any third party. This specific duty of full disclosure stands in contrast to the generalized duty created in *Petersen* to protect third parties who suffer injury as a result of a patient's medical condition. The generalized duty created in *Petersen* is a duty independent and beyond that of the physician's responsibility to inform his patient of known medical risks or consequences of treatment.

Tarasoff also stands in sharp contrast to *Petersen* because in *Tarasoff* it was possible to identify and warn the victim and her parents. *Tarasoff* carefully narrowed the duty to protect third parties to cases where the patient's victim was identifiable or could be identified in a "moment's reflection."[121] The

118. The *Kaiser* plaintiff was injured while a passenger on a bus when the bus driver lost consciousness and the bus struck a telephone pole. The driver's lapse of consciousness was attributed to the side effects of a drug prescribed for the treatment of a nasal condition. *Id.* at 462, 463, 401 P.2d at 352.

119. There was no contention that the passenger-plaintiff was not the foreseeable victim of the bus driver's accident.

120. The doctor's duty to affirmatively act in *Kaiser*, established by his superior knowledge of his patient's occupation and his medical condition, is in concert with the RESTATEMENT (SECOND) OF TORTS §§ 315, 319 (1965); *see supra* note 27.

121. *Tarasoff*, 17 Cal. 3d at 439 n.11, 551 P.2d at 345, 131 Cal. Rptr. at 25. The court acknowledged the unreasonableness of requiring a doctor to "interrogate" a

Tarasoff court did not create a generalized duty on the part of the psychiatrist to protect unidentifiable victims or the public at large. Instead, the court imposed a rather minimal burden on the doctor to contact the victim through parents, friends, or mental health authorities.[122] The carefully limited duty in *Tarasoff* is markedly dissimilar to the broad duty of the care created in *Petersen*. In *Petersen*, any kind of notification would have been impractical and ineffective. Dr. Miller had neither the ability nor the knowledge to protect Cynthia Petersen from Knox's dangerous propensities.

Finally, in relying on *Lipari v. Sears, Roebuck & Co.*,[123] the *Petersen* court fails to distinguish between the failure to detain when a patient's dangerousness satisfies the requirement for further confinement, and the release of a patient when the patient no longer fits the criteria for further commitment.[124] In doing so, the *Petersen* court ignored established precedent of other jurisdictions where courts have refused to impose liability because of statutory limitations in the commitment scheme. Under Washington law, an individual impaired by drugs cannot be detained for evaluation or treatment unless dangerous to

---

patient regarding a victim's identity, or to conduct an independent investigation. *See supra* note 51 and accompanying text.

122. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20. See Thompson v. County of Alemeda, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980), where the California Supreme Court refused to extend the *Tarasoff* duty to include county probation officers. In *Thompson*, a juvenile offender released from confinement into the temporary custody of his mother, killed the plaintiffs' son. Although the county knew that the offender had stated that he would kill some nonidentifiable child in the community, officials released him without warning police, parents, or the offender's mother. The *Thompson* court argued that liability could only be imposed when "the released offender posed a predictable threat of harm to a named or readily identifiable victim. . . ." *Id.* at 759, 614 P.2d at 732, 167 Cal. Rptr. at 80. The offender had made a "generalized threat to a segment of the population," and not to a specific victim. *Id.* at 751, 614 P.2d at 733, 167 Cal. Rptr. at 75.

123. 497 F. Supp. 185 (D. Neb. 1980).

124. At least two jurisdictions have refused to impose liability on psychiatrists because of statutory limitations in the commitment scheme. *See* Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982); Estate of Gilmore v. Buckley, 608 F. Supp. 554 (D. Mass. 1985) *cert. denied*, 107 S.Ct. 270 (1986). In *Hasenei*, the court, applying Pennsylvania law, determined that the mental patient, who was released from an outpatient clinic, could not have been involuntarily committed under the applicable civil commitment statute, which required a "clear and present danger to self or others." *Hasenei*, 541 F. Supp. at 1010. *Gilmore* involved a murder by an inmate on work release. The Massachusetts court held that medical personnel of the state mental institution were not negligent for failing to petition for civil commitment. Citing MASS. GEN. LAWS ANN. ch. 123, § 15 (e) (West Supp. 1985), the court stated that because the statute merely authorized, but did not require the medical director to petition for commitment, negligence was absent. *Gilmore*, 608 F. Supp. at 560.

himself or others.[125] When released from the hospital, Knox exhibited normal behavior and demonstrated no dangerousness toward himself or others.[126]

A review of the facts also reveals that the element of cognitive choice present in *Lipari*, is nonexistent in *Petersen*. In *Lipari*, a previously hospitalized mental patient purchased a shotgun, and shortly thereafter resumed participation in a psychiatric day treatment program. After removing himself from this treatment, against medical advice, the patient shot and injured the plaintiffs.[127] Importantly, in *Lipari* it was the patient's choice to remove himself from a psychiatric day care treatment facility against medical advice.[128] In *Petersen*, Knox neither requested further confinement when his treatment terminated, nor did he remove himself from the treatment program, as he was a full-time institutionalized patient. Further, in *Lipari* the patient intentionally harmed the plaintiffs while acting under a mental defect. Knox's acts, however, were unintentional, notwithstanding the fact that he was under the influence of drugs.[129]

Perhaps the strongest argument for re-evaluating the *Petersen* court's reliance on *Lipari* and for limiting its future application is that the *Lipari* court had no precedent for its generalized duty to protect except for the failure-to-warn cases of *Tarasoff* and its progeny.[130] Although *Lipari* directly held that a psychiatrist owes an affirmative duty to persons other than the patient, it should have followed the *Tarasoff* line of cases in limiting this duty to a duty to protect identifiable victims. *Lipari* and *Petersen* are both wrong in creating a generalized duty to protect in a context of psychotherapy because they fail to limit liability to circumstances when the victim is "identifiable" or there is actual knowledge[131] of the patient's

125. WASH. REV. CODE § 71.05.040 (1987).

126. *Petersen*, 100 Wash. 2d at 424, 671 P.2d at 235. Furthermore, Knox did not fit the criteria as established in *In re* Harris, 98 Wash. 2d 276, 654 P.2d 109 (1982). The *Harris* court interpreted the dangerousness standard of WASH. REV. CODE § 71.05.020 (1987) to require "a showing of a substantial risk of physical harm as evidenced by a recent, overt act." *Id.* at 284, 654 P.2d at 113.

127. *Lipari*, 497 F. Supp. at 187.

128. *Id.*

129. *Petersen*, 100 Wash. 2d at 424, 671 P.2d at 235.

130. *See supra* note 53.

131. Decisions from other jurisdictions support this contention by rejecting *Lipari*. *See* Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981), *aff'd*, 676 F.2d 686 (3d Cir. 1982); Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982). *But see* Sakuda v. Kyodogumi Co., 555 F. Supp. 371 (D. Haw. 1983). *See also* Brady v. Hopper, 570 F.

dangerousness. By extending the duty to circumstances where there is no victim to be warned, *Lipari* and *Petersen* create a new responsibility neither considered nor supported by earlier case law.

Unfortunately, the recent legislative changes in Washington's mental health law enacted in response to *Peterson* surprisingly endorse the court's holding regarding the duty of psychiatrists and the standard of care. Although the law is now broadened to grant limited immunity to the state, local governmental entities, and to evaluation and treatment facilities,[132] it does nothing to protect a mental health professional or entity from liability for gross negligence for failing to detain an individual when the victim, as in *Peterson*, is not identifiable. This is because the law, while codifying the *Tarasoff* rule requiring that notice, warning, or precautions be given where a patient communicates an actual threat of physical violence against a "reasonably identifiable victim,"[133] retains a standard

---

Supp. 1333 (D. Col. 1983), *affd.*, 751 F.2d 329 (10th Cir. 1984). In *Brady*, the Colorado court rejected the argument that the special therapist-patient relationship creates duties which extend to "the world at large." 570 F. Supp. at 1338. In this case, brought by three men seriously injured by John Hinckley in his presidential assassination attempt, the court held that there was no relationship between the defendant psychiatrist and plaintiffs to create a legal obligation from him to them. The decision noted with favor the *Tarasoff* rule, where there are specific threats to specific victims, and implicitly opted for the duty to warn identifiable victims. *Id.* *See* STONE, *supra* note 42, at 172. *See also infra* note 147 and accompanying text.

132. WASH. REV. CODE § 71.05.120(1)(1987) (amending WASH. REV. CODE § 71.05.120 (1985)) provides:

> (1) No officer of a public or private agency, nor the superintendent, professional person in charge, his professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, release, or detain a person for evaluation and treatment: *Provided*, that such duties were performed in good faith and without gross negligence.

133. WASH. REV. CODE § 71.05.120(2) (1987) (amending WASH. REV. CODE § 71.05.120 (1985)) provides:

> (2) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

of gross negligence regarding the psychiatrist's duty to protect where a victim is unidentified.

Thus, even under this new law, *Peterson* would be decided in the same way. The *Peterson* court would never have had to reach the *Tarasoff*-type duties because it found, notwithstanding the fact that Cynthia Peterson was an unidentified victim, the psychiatrist's conduct grossly negligent for failing to detain. Psychiatrists should not be liable to unidentifiable third parties, however, unless there is actual knowledge of a patient's dangerousness. Imposing liability without actual knowledge presupposes that psychiatrists have the ability to predict dangerousness.

In *Petersen*, the court's extension of a duty to protect beyond identifiable victims implicitly assumes that psychiatrists possess the expertise to reliably[134] or validly[135] predict dangerous behavior without knowledge thereof. By extending the law, the court overlooked important countervailing policy reasons for not further extending liability.

First, within the psychiatric field, serious doubt exists concerning the expertise in predicting dangerous behavior.[136] Several studies demonstrate that psychiatric predictions of dangerousness are unreliable and do not accurately identify

---

134. Reliability, as used by Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping the Coin in the Courtroom*, 62 CALIF. L. REV. 693 (1974) [hereinafter Ennis and Litwack, *Presumption of Expertise*], "refers to the probability or frequency of agreement when two or more independent observers answer the same question. . . ." *Id.* at 697. One example they offer is as follows: "If representative pairs of psychiatrists, interviewing a representative sample of prospective patients, usually agree that each individual is or is not 'dangerous,' the judgment of 'dangerousness' is said to be reliable." *Id.*

135. Validity refers to how accurate the judgments of psychiatrists are. *Id.*

136. Even in *Tarasoff*, the court raised concern about the psychotherapist's ability to predict dangerousness. Justice Mosk, in a dissenting opinion, questions what "standards of the profession" will govern the court's evaluation of the therapist's performance of his duty to protect victims. *Tarasoff*, 17 Cal. 3d at 451, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting). Mosk points out in *Tarasoff* that the California court had previously opined that psychiatric predictions about future dangerousness were inherently unreliable. *Id.* at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting) (citing People v. Burnick, 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975)). Mosk concludes in *Tarasoff*:

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

17 Cal. 3d at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk. J., concurring and dissenting). *See also* STONE, *supra* note 42, at 169.

potentially violent individuals.[137] Empirical studies reveal that psychiatrists consistently overpredict dangerous behavior[138] due to a lack of expertise[139] or the fear of responsibility for the negligent release of a violent individual. Second, psychiatric literature generally reveals that most diagnoses do not accurately describe actual symptoms exhibited by a patient, and that little correlation exists between diagnosis and patterns of actual behavior.[140] In sum, largely unchallenged societal expectations about psychiatric expertise are misplaced.

Such findings of unreliability and lack of expertise are echoed by the American Psychiatric Association (APA) in a report on the clinical aspects of violence.[141] The APA's position is that the ability of psychiatrists to predict dangerousness is unsatisfactory and that the "ability of psychiatrists to relia-

---

137. *See* J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 19 (1981) [hereinafter MONAHAN, CLINICAL PREDICTION] (The prediction of dangerousness "is currently used to assist in making a wide variety of legal decisions, from civil commitment to the imposition of the death penalty.").

138. *See* Dix, *Expert Prediction Testimony in Capital Sentencing: Evidentiary and Constitutional Considerations*, 19 AM. CRIM. L. REV. 1 (1981); Dix, *Clinical Evaluation of the "Dangerousness" of "Normal" Criminal Defendants*, 66 VA. L. REV. 523, 532-44, (1980); Groethe, *Overt Dangerous Behavior*, *supra* note 67, at 583; Haddad, *Predicting the Supreme Court's Response to the Criticism of Psychiatric Predictions of Dangerousness in Civil Commitment Proceedings*, 64 NEB. L. REV. 215 (1985) [hereinafter Haddad, *Predictions of Dangerousness*] (the highest rate of accurate predictions of potential dangerousness was about 35 percent); Schwitzgebel, *Prediction of Dangerousness and its Implications for Treatment*, in W. CURRAN, A. MCGARRY, & C. PETTY, MODERN LEGAL MEDICINE PSYCHIATRY AND FORENSIC SCIENCE 783 (1980); Steadman & Cocozza, *Psychiatry, Dangerousness, and the Repetitively Violent Offender*, 69 J. CRIM. L. & CRIMINOLOGY 226, 229-31 (1978); Ennis & Litwack, *Presumption of Expertise*, *supra* note 134; Wenk, Robison & Smith, *Can Violence Be Predicted?* 18 CRIME & DELINQ. 393 (1972).

139. Ennis and Litwack, *Presumption of Expertise*, *supra* note 134.

140. Haddad, *Predictions of Dangerousness*, *supra* note 138, at 222 (citing Ennis and Litwack, *Presumption of Expertise*, *supra* note 134, at 709-10). *See also* Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 10 (1984) ("Even in the best of circumstances—with lengthy multidisciplinary evaluations on patients who had already manifested their violent proclivities on several occasions—psychiatrists and psychologists seemed to be wrong at least twice as often as they were right when they predicted violence."). Some courts have responded to the uncertainty of psychiatric predictions by excluding expert testimony of a prediction of future violence. *See, e.g.*, People v. Martishaw, 29 Cal. 3d 733, 631 P.2d 446, 175 Cal. Rptr. 738 (1981), *cert. denied*, 455 U.S. 922 (1982).

141. AMERICAN PSYCHIATRIC ASSOCIATION, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 30 (Task Force Rpt. No. 8, 1974) [hereinafter CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL]. Almost a decade later, the American Psychiatric Association (APA), in an amicus brief for Barefoot v. Estelle, 463 U.S. 880, *reh'g denied*, 464 U.S. 874 (1983), involving the death penalty, urged the Supreme Court to excise from all trials psychiatric testimony on the prediction of future violent conduct. The Court dismissed the APA's position, however, and upheld the death penalty.

bly predict future violence remains unproved."[142] The American Bar Association (ABA) follows the consensus of the APA, and has proposed to exclude from criminal proceedings "expert opinion stating a conclusion that a particular individual will or will not engage in dangerous behavior in the future. . . ."[143] In adopting this position, the ABA relied expressly on the scientific consensus that such predictions are simply impossible to make.[144]

Despite the conclusions of the studies and reports,[145] the *Petersen* court nonetheless imposed liability on Dr. Miller for Knox's release. The jury found gross negligence, even though no information was available to the psychiatrist to predict that Knox would cause harm to that plaintiff. Without such information, there should not have been a question for the jury to decide.[146] It is precisely because dangerousness is so difficult to predict that liability should be imposed only where there is actual knowledge of a patient's dangerousness.[147]

---

142. CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL, *supra* note 141, at 30.

143. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-3.9(b) (First Tent. Draft 1983). *See also* 1 J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 330-47 (3d ed. 1981) [hereinafter ZISKIN].

144. *See, e.g.*, ZISKIN, *supra* note 143, at 330 (cited with approval in CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-3.9, commentary at 7.107 (First Tent. Draft 1983)):

> [Because of psychiatry's] failure to develop adequate systems of classification of its data, its failure to develop tested and/or testable theories, hypotheses and principles, its failure to use adequate scientific methods to validate its conclusions, and its use of primarily subjective rather than objective methods of investigation, it has failed to meet criteria ordinarily considered minimal for status as a science. It has been demonstrated that psychiatry fails to meet the legal criterion of acceptance as a science among the general scientific community, or even within its own ranks, for that matter, and has not crossed the line from the experimental to the demonstratable. It lacks generally agreed upon principles and therefore cannot be considered beyond the experimental stage.

145. The *Petersen* court was no doubt aware of reports and studies on the issue of predicting dangerousness because such studies and reports and other commentary are contained in *Tarasoff* upon which the court so heavily relies. And although the *Petersen* court cites the work of Fleming and Maximov and Ennis and Litwack for authority on determining a therapist's standard of care, the court fails to acknowledge that these works also thoroughly discuss limited psychiatric expertise in predicting violent behavior. *Petersen*, 100 Wash. 2d at 438, 671 P.2d at 242.

146. For a review of recent research on the prediction of violent conduct and patient dangerousness, see Wettstein, *The Prediction of Violent Behavior and the Duty to Protect Third Parties*, 2 BEHAV. SCI. & LAW 291 (1984); MONAHAN, CLINICAL PREDICTION, *supra* note 137.

147. *See, e.g.*, Hedlund v. Superior Court of Orange County, 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983). In *Hedlund*, the plaintiff alleged that the defendant psychologists had been told by their patient that he intended to harm the plaintiff.

IV. CONCLUSION

Empirical evidence demonstrates that psychiatrists are as yet unable to accurately predict dangerous behavior. Moreover, even when psychiatrists have the ability to predict such dangerousness, they are not always able to identify potential victims.

Despite the difficulty that experts encounter in attempting to forecast whether a patient presents a serious danger of harm, appropriate circumstances for imposing liability on a psychiatrist do exist. They are 1) actual knowledge of dangerous conduct on the part of the patient, including the failure to utilize commitment procedures when legally available, and 2) failure to warn an "identifiable" victim. In these limited instances, speculation and error are greatly diminished. Further, the choice to act protectively or defensively, at the risk of limiting a patient's liberty interests, is one more easily made when the victim is identifiable. Under these standards, conjecture and discretion all but disappear; if a psychiatrist predicts violence, the duty to protect arises.

Deference to the *Petersen* form of utilitarian justice will undoubtedly serve to compensate other plaintiffs, similar to Cynthia Petersen, from the deep pocket of the state. Adhering to the law of *Petersen*, which imposes a broad duty of due care on psychiatrists to the public at large, however, creates problems not yet contemplated by the courts. With *Petersen*, the risk of over-using the involuntary civil commitment pro-

---

Despite the fact that defendants knew of their patient's threats, the court declined to limit their holding to actual knowledge of dangerousness.

The court held the defendants liable, stating that they "should have known" that the patient posed a danger to the plaintiff. *Id.* at 700, 669 P.2d at 43, 194 Cal. Rptr. at 807. In his dissent, Justice Mosk argues that the appropriate standard should be actual knowledge of dangerousness:

> Thus it can be argued that defendants had *actual knowledge* and therefore should have communicated a warning to the potential victim. There is no reason to muse, as the majority do, about the result that would follow if defendants merely *should have known* of the threatened violence.

Id. at 709, 669 P.2d at 49, 194 Cal. Rptr. at 813 (Mosk, J., dissenting).

In addition, the standard of actual knowledge is implied when liability is imposed for failing to take affirmative steps to detain a patient when the criteria for further commitment are met. *See supra* notes 62-64. In contrast, although the *Peterson* psychiatrist, Dr. Miller, testified at trial that his patient was a "potentially dangerous person" who was "quite likely" to use angel dust again and was "likely to continue having delusions and hallucinations," Dr. Miller also knew that Knox could not be committed under the present mental illness law, which proscribed commitment solely because of drug abuse. 100 Wash. 2d at 428, 671 P.2d at 237.

cess is great. Overcrowding of current institutions will be certain as psychiatrists seek to avoid liability at all costs. The unfortunate result will not only be the lessening of fundamental personal liberty rights, but the inability of those individuals truly needing therapeutic care or treatment to receive services necessary to make them productive or contributing members of society. Whether the current goals of involuntary civil commitment can exist with this expanded liability is certain to spark intense and continuing social policy debate.