A BRIEF COMMENTARY ON
THE CONCEPTUAL PARAMETERS
OF THE AFFIRMATIVE DUTY DOCTRINE
AND CAMPUS MENTAL HEALTH PROFESSIONALS
THE SO-CALLED “TARASOFF” RULE OR STANDARD

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English common law, as reflected in the seminal American
decisions defining negligence, recognized a general affirmative duty to
exercise reasonable care, whenever the failure to do so would create
unreasonable risk of injury to others. These American decisions,
including Tarasoff v. Regents of the University of California,1 do not
embrace this concept of universal duty. Instead, modern American
negligence principles have recognized that a limited duty exists to assist
others, usually where certain special relationships exist between the
person in peril, and the person in a position to provide assistance.2

The seminal case for health care professionals is, of course,
Tarasoff. The case is best known for its precise holding: Once a
therapist3 determines, or under applicable professional standards
reasonably should have determined, that a patient poses a serious
danger of violence to others, the therapist has a duty to exercise
reasonable care to protect the foreseeable victim of that danger.4
Reasonable care might include – depending upon the nature of the case –

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1 551 P.2d 334 (Cal. 1976) (en banc.)
2 Common examples include employers, innkeepers and their guests; premises owners and their business or
public invitees; common carriers and their passengers. Some jurisdictions extended the rule to subsume
other, less formal relationships, e.g., parents and a babysitter who has not been informed of a child’s
dangerous behavior. See Ellis v. D’Angelo, 253 P.2d 675 (Cal. App. 1953); and see Johnson v. State of
California, 447 P.2d 352 (Cal. 1968), holding a state social services agency to a duty to warn foster parents
of the dangerous behavior of a child placed in their care.
3 This term is usually held to mean a psychologist, psychotherapist, or psychiatrist. The court’s opinion
uses the term ‘therapist’. See 551 P.2d at 340 n.2. A number of courts, relying on Tarasoff, have applied the
case in circumstances closely analogous to the therapist/patient context, holding for example that the duty
may be imposed on social workers.
4 See Peter F. Lake, Revisiting Tarasoff, 58 Albany L. Rev. 97, 98 (1994).
warning the intended victim, or others likely to apprise the victim of the danger, notifying police, or obtaining family intervention.

*Tarasoff* is especially meaningful to therapists who work with college and university students because it arose in a university setting. A male patient – Prosenjit Poddar – disclosed to a university employed psychologist his intention to kill Ms. Tarasoff, who was herself unaware of the threat. According to pleadings submitted to the court, campus police detained Poddar at the request of the psychologist, but released him when he appeared rational. No further action was taken and neither Ms. Tarasoff nor her parents was warned of the threat. Sometime later, Poddar killed Ms. Tarasoff.

The state supreme court held that the relationship between Poddar and the university’s psychotherapists was sufficient to impose an affirmative duty for the benefit of an identified third person who was placed in peril by Poddar's threatened action. The duty may be described as requiring the therapist to exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical specialty under similar circumstances.

Professor Peter Lake observes that a majority of jurisdictions consider *Tarasoff* favorably, and only a few have flatly rejected its holding, or openly questioned its rationale. Lake and other legal scholars note however, that the court's opinion is susceptible to different interpretations as to the scope of the psychotherapist's duty. Lake observes that *Tarasoff* may be interpreted, alternatively:

- To impose a duty to protect an "identifiable" stranger;
- To impose such a duty because of the "special relationship" between the therapist and the assailant;

5 Lake, supra., n.7, at 100; Florida is in the minority. See Boynton v. Burglass, 590 So.2d 446 (Fla. App. 1991). While Boynton rejected Tarasoff outright, the Florida legislature has adopted legislation that uses a Tarasoff-like test. However, the statute's standard is permissive, and may not impose liability. See Lake, supra., n.7, at 100, n.13.
To impose a duty based upon society's "interest in public safety," which subordinates society's interest in confidentiality; To impose a duty of care to all persons who are foreseeably endangered whenever a relationship exists between one who can protect and the person causing the threat.6

Foreseeability of risk is prominent in the analysis, where affirmative conduct (e.g., the assumption of custody or control) is involved; but where liability is based upon the legal imposition of an affirmative duty - a duty to act affirmatively - foreseeability alone may not be sufficient in the absence of a "special relationship" (between the therapist and the assailant, or the therapist and the victim).7

This threshold is not imposing. Drawing an analogy to cases imposing a duty on physicians to diagnose and warn about a patient's contagious disease, and the duty of hospitals to control the behavior of a patient who may be dangerous to others, the Tarasoff court reasoned that, by entering into a doctor-patient relationship, the therapist becomes sufficiently involved to assume some responsibility for the safety not only of the patient, but a third person whom the doctor knows to be threatened by the patient.8

In the second part of its analysis in support of a duty to warn, the Tarasoff court determined that the interest of public safety outweighed the confidentiality that characterizes the psychotherapist-patient

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6 See Lake, supra., n.7, at 106, citing John M. Adler, Relying Upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others, 1991 Wis. L. Rev. 867; James P. Murphy, Evolution of the Duty of Care: Some Thoughts, 30 DePaul L. Rev. 147 (1980). Murphy observes that the duty is one of reasonable care. It is not a mandatory duty to warn, but rather requires whatever steps are reasonably necessary under the circumstances. Murphy further describes the duty as guided by tests of foreseeability and considerations of social policy. The court in Tarasoff identifies seven major considerations in determining duty: (1) foreseeability; (2) the degree of certainty that plaintiff's injury occurred; (3) the closeness of the conduct and injury; (4) moral blame; (5) the policy of preventing future harm; (6) the burden and consequences of imposing a duty on the defendant and the community; and (7) insurance cost, availability and prevalence. See Lake, supra., n.7, at 107, 119.

7 In Tarasoff, Justice Tobriner observes: "Since the relationship between a therapist and his patient satisfies this requirement, we need not...decide whether foreseeability alone is sufficient to create a duty to exercise [reasonable] care to protect a potential victim of another's conduct." Tarasoff, supra., 551 P.2d at 343.

8 Tarasoff, supra., 551 P.2d at 344.
relationship, and the difficulty in predicting dangerous behavior. Although Tarasoff enjoys wide acceptance, the scope of its pronouncements continue to be the subject of discussion among attorneys and therapists. Questions remain whether and when the affirmative duty announced in Tarasoff extends beyond the duty to warn, to require a duty to control a dangerous patient; and second, whether a therapist who takes charge of a patient's medical treatment plan assumes a duty to control that patient to prevent him from harming others, even where the therapist does so in an ‘outpatient' setting. More specifically, therapists and lawyers ask: (1) Is control in fact a precondition to the imposition of duty? (2) May a so-called professional standard of care be applied in a way that will protect the therapist from liability for error in judgment? (3) Does a uniform standard of care in psychotherapist negligence cases reflect sound social policy?

In Estates of Morgan v. Family Counseling Center, the Supreme Court of Ohio discussed Tarasoff at length, and held that therapists and social workers employed by a family counseling center in Ohio were subject to liability when their outpatient – Matt Morgan – shot and killed his parents. Morgan, a high school senior, was referred to the counseling center by a mental health facility in Philadelphia that had diagnosed Morgan as suffering from schizophreniform disorder and predicting schizophrenia, following episodes of drifting and homelessness. At the Philadelphia facility, Morgan had been treated for twelve weeks with intensive therapy, as well as Navane and other medications. Eventually, his paranoia regarding his family decreased and he began to gain insight into his mental illness. The treating physician, a third year psychiatric

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10 673 N.E.2d 1311 (Ohio 1997).
11 It was also noted in his medical records that he had to be put out of his parents' home by police. Id., at 1314.
12 673 N.E.2d at 1315.
resident, suggested that Morgan could return to his parents' Ohio home, but that further treatments and medication were necessary.

Following referral, the Ohio counseling center saw Morgan for one year. Initially, the treating consultant contract psychiatrist noted Morgan’s ‘experience' in Philadelphia, but neither read Morgan’s medical records, or called the treating physician in Philadelphia. Diagnosis was withheld, but the psychiatrist observed that: Morgan was out of medication; Morgan desired medication and help in completing a social security disability form; Morgan’s experience indicated some sort of “acute atypical psychosis.” On the basis of three visits with Morgan, the contract psychiatrist gradually discontinued Morgan's medication over ten weeks.13 Morgan initially received psychotherapy, but after the third visit with the psychiatrist, he was referred to a social worker, with instructions that she engage him in vocational counseling. Although the psychiatrist did not make a final determination of Morgan’s condition, he observed that “a lot of people...show up with SSI in mind [who have] a history very similar to Mr. Morgan’s.”14

During the next six months, Morgan became abusive with his parents, lost weight, and exhibited signs of paranoia. His parents became afraid of him, and on several occasions reported his symptoms to the social worker and sought involuntary commitment. The social worker concluded on two or more occasions - in consultation with other social workers and a psychologist, but without the assistance of a psychiatrist - that Morgan was not a candidate for involuntary commitment, and that she could not require medication. Plaintiff’s experts testified at trial that the counseling center’s conduct was unacceptable according to prevailing professional standards, and that its negligence was the proximate cause of the deaths of Morgan's parents. The expert witnesses cited: The failure to review Morgan's prior medical

13 The first meeting was a 30 minute evaluation; the second and third meetings lasted 15 minutes. Id.
records or consult his previous physician; the failure of the center's psychiatrist to diagnose schizophrenia; the discontinuation of medication which would have controlled Morgan's impulse to shoot his parents; and the improper delegation of medical decisions to a social worker who had no training to make medical decisions, but did so without consulting medical staff.\textsuperscript{15} The court concluded that a question of fact existed whether the center's staff was negligent and that plaintiff was entitled to trial on this issue.

Recent judicial debate has raised the issue whether this duty principle should be dependent upon whether the dangerous patient is an inpatient or outpatient, and the Ohio Supreme Court focused on this question. While such a bright line makes judicial administration of the duty rule easier, it does not seem consistent with the basis of liability. Nonetheless, some courts adopt it as a test for liability, reasoning that the typical outpatient-psychotherapist relationship lacks sufficient elements of control necessary to the imposition of duty.\textsuperscript{16}

Justice Resnick wrote for the majority of a divided court that settled law – as reflected in Restatement (Second) of Torts, § 319 – recognizes a special relationship between a psychiatrist and his patient in the hospital setting, because the psychiatrist has taken charge and control over the patient. In such a setting, where the psychiatrist knows, or should know that his patient is likely to harm others if not controlled, he has a duty to exercise reasonable care to control the patient to prevent harm to third persons. The majority observed that the resolution of the issue of the duty of a therapist to protect third persons involves consideration of: (1) The therapist's ability to control the outpatient; (2) the public's interest in protection from violent assault; (3) the difficulty inherent in attempting to predict whether a patient represents a

\textsuperscript{14} Id. The psychiatrist also observed that to give SSI benefits to undeserving persons is a disservice to them.
\textsuperscript{15} Id., at 1323-1324.
\textsuperscript{16} See e.g., Boynton v. Burglass, 590 So.2d 446 (Fla. App. 1991); King v. Smith, 539 So.2d 262 (Ala. 1989).
substantial risk of harm to others; (4) the goal of placing a mental patient in the least restrictive environment and safeguarding his right to be free of unnecessary confinement; and (4) the social importance of maintaining the confidential nature of psychotherapeutic communications.17

The majority of the court concluded that the circumstances of the case showed sufficient elements of control - even in an outpatient setting - to warrant the imposition of a duty to exercise reasonable care for the protection of third parties, and that such a duty served the public's interest in safety from the violent acts of a dangerous mental patient without imposing an unreasonable burden on the therapist, or encouraging the over-commitment of persons with mental impairments. The majority rejected the assertion that duty should be dependent upon actual restraint or confinement, holding rather that the duty to control should be commensurate with “...such ability to control as the defendant [e.g., psychotherapist] actually has at the time.”18

The Ohio legislature reacted to the state supreme court's decision by enacting a qualified immunity statute for the purpose of rejecting the scope of liability of mental health professionals imposed by the Court's majority. The statute19 provides, inter alia, that boards of alcohol, drug addiction, and mental health services and community mental health agencies, acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge, determination of appropriate placement, or in judicial proceedings of a person under this chapter, do not come within any criminal provisions, and are free from any liability to the person hospitalized or to any other person, for any harm that results to any other person as a result of failing to disclose any confidential information about the mental health client or patient, or

17 Id., at 1322.
18 Id., at 1323. Tarasoff is, quite arguably, an "outpatient" case.
19 Revised Code § 5122.34.
failing to otherwise attempt to protect such other person from harm by such client or patient.

While the statute does not preclude the finding that a special relation exists between the psychotherapist and the outpatient which imposes a common-law duty on the therapist to take affirmative steps to control the patient's violent conduct, it precludes a finding of liability for the dangerous acts of voluntarily hospitalized mental patients when: (1) the patient did not manifest violent propensities while hospitalized and there was no reason to suspect the patient would become violent after discharge, or when (2) there was a thorough evaluation of the patient's propensity for violence - taking into account all relevant factors - and a good faith decision was made by the psychiatrist that the patient had no violent propensity, or when (3) the patient was diagnosed as having violent propensities and, after a thorough evaluation of the severity of the propensities and a balancing of the patient's interests and the interests of potential victims, a treatment plan was formulated in good faith which included discharge of the patient. (emphasis added)

The qualified immunity conferred by Ohio's “good faith” standard does not reject the concept of affirmative duty, but clearly limits the scope of liability by the application of a subjective standard. When the statutory language is considered in light of the reasoning of the dissenting justices in Morgan, it appears that the concern is about the possible scope of liability - especially in outpatient scenarios.20

Duty to control vs. duty to warn: In duty to warn cases,21 courts disagree whether the scope of the therapist's duty:

- Extends only to those potential victims actually known to the therapist (e.g., identified or specifically targeted by the patient);

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20 The legislature appears to recognize the legitimacy of a “knew or should have known” standard in cases involving the release of inpatients.

21 Recall, the holding in Tarasoff is important, not only because it permits a relationship between a therapist and a patient to support a duty to a third party, but because the court recognizes a duty to warn in situations where a duty to control might not be imposed.
Extends to persons within the zone of danger (those in close relationship with the patient, or close proximity to the victim); Extends to any foreseeable victim.

Courts seem to favor a “readily identifiable victim” rule in duty to warn cases, but such a rule is not necessary in failure to commit cases, where the policy considerations in failure to warn cases are not present. Thus many jurisdictions requiring a specific threat threshold in duty to warn cases might hold that it is not necessary in failure to commit cases that the therapist should have anticipated the particular injury. What is necessary is that the patient’s act is likely to injure someone, and that the therapist knows or should know of that likelihood.

In Estates of Morgan, the court explained that Ohio law supports the involuntary commitment of a mentally ill patient when his dangerousness to others is found to be imminent as demonstrated by evidence of other violent behavior or evidence of present dangerousness, and the statutory response does not appear to discourage such action. It may be argued that once the therapist, or mental health facility assumes control over a patient they know, or should know, is likely to harm others if not subjected to control, they assume a duty to exercise reasonable care to control the patient to prevent him from harming others. Either Tarasoff or Estates of Morgan could have been decided upon this principle without expanding the definition of legal relationships supporting affirmative duties to control others. In other words, once Morgan was evaluated, and his treatment plan altered, a duty was assumed to exercise reasonable care not to worsen his condition, or the danger he presented to himself or others. It might be argued that, given

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22 See e.g., Little v. All Phoenix South Community Mental Health Center, 919 P.2d 1368 (Az. App. 1995)(Issue of fact existed whether defendants determined or should have determined that patient posed serious danger of violence to others, and whether plaintiff was a readily identifiable person who might suffer harm if defendants were negligent in diagnosis or treatment of patient); and see Thompson v. Alameda Cty., 614 P.2d 728 (Cal. 1980)(Absent threats to specific persons, governmental agency cannot be held to have duty to warn general community about undifferentiated threats by juvenile).

23 673 N.E.2d at 1330.
its disinclination to accept inpatients, the Ohio center should have referred Morgan to a more appropriate facility. However, the statute does appear to evaluate that decision according to a subjective “good faith” standard, which permits a wide qualified immunity.

Although this writer believes the Morgan majority was correct in its view of Tarasoff, the legislative response may not be entirely unfair to victims of assault. Indeed, while recognizing a duty analysis that values foreseeability as its lodestar, the Tarasoff court also recognizes a qualified immunity in its negligence analysis: To prevail in psychotherapist negligence cases under any reading of Tarasoff, the plaintiff must prove that the therapist's conduct was unacceptable, according to accepted professional standards – that is, that the therapist failed to exercise professional judgment. The rule protects the good faith, independence and thoroughness of the therapist's decision not to commit a patient, when the therapist follows accepted procedures or protocols for the involuntary commitment of patients.\(^\text{25}\) Proof that another therapist, aided by hindsight, would find error in fact, is not in itself sufficient to establish negligence.\(^\text{26}\) The essence of the application of the rule is the identification of the scientific line between “speculation” and “reasonable care” in light of professional knowledge and skill, coupled with the actual or constructive knowledge of the treating psychotherapist.\(^\text{27}\) In sum, if Tarasoff's affirmative duty rule is applied to the treatment of outpatients,

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\(^\text{24}\) See Estates of Morgan, 673 N.E.2d 1311, 1320.

\(^\text{25}\) The issue therefore in Estates of Morgan, was whether plaintiffs' experts' opinion, when contrasted with the testimony of the defendants, demonstrated a genuine difference of opinion as to the propriety of defendants' actions in treating Matt Morgan – under a professional standard of care. See G. Wardle and J. Maloon, supra., n. 23, at 656.

\(^\text{26}\) For a discussion of other cases, see Lake, Revisiting Tarasoff, 58 Albany L. Rev. 97 (1994); and see Bradley v. Ray, 904 S.W.2d 302 (Mo. App. 1995)(Failure of psychologists to report incidents of known or suspected child abuse by stepfather to law enforcement authorities); Little v. All Phoenix South Community Mental Health Center, 919 P.2d 1368 (Az. App. 1995); But see, Thapar v. Zeeulka, 994 S.W.2d 635 (Tex. 1998); Nasser v. Parker, 455 S.E.2d 502 (Va. 1995); and Garcia v. Lifemark Hospitals of Florida, 24 Fla. L. W. D. 2387 (Fla. App. 1999)(Refusing to impose duty).

\(^\text{27}\) Tarasoff respects the constitutional principles announced in O'Connor v. Donaldson, 422 U.S. 563 (1975), that mentally ill persons may not be involuntarily confined in mental hospitals merely because their behavior is inconvenient or offensive to others.
its holding does not make the therapist liable for placing his patient in the least restrictive environment.

More is required than showing that the patient was placed in an outpatient setting, and in fact harmed a third party. Liability should be imposed only where the decision of the therapist fails to assess the risks of an outpatient placement in accord with an appropriate professional standard of care, and the facts of the particular case. The therapist’s decision is protected if the therapist, acting in good faith, makes a decision after evaluating all treatment options – even if the treatment plan followed proves ineffective in fact: In this respect, the Ohio statute is a legitimate reflection of Tarasoff, so long as it is not applied to create an immunity identified with a “no-duty” rule.

As Tarasoff suggests, psychotherapists and other mental health professionals frequently encounter situations that may not demand confinement, but that do raise the issue of the duty to warn persons who might be the victim of a patient’s dangerous conduct. Thompson v. Alameda County,28 is viewed as the seminal case, holding that, where the issue is duty to warn, a specific threat rule is appropriate. The court reasoned that the duty to warn depends upon the existence of a prior threat to a particular identified or identifiable victim, and that to require warnings to the public at large would be of little value.

In true duty to warn cases, like Tarasoff, the issue of confidentiality is more legitimately raised. Since Tarasoff, the majority of state courts would support some compromise of the communication privilege between the psychotherapist and the patient, where an identifiable third person is in imminent physical danger. This public policy concern for the protection of those in immediate danger is embraced by medical associations, and is embodied in many state

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statutes that support judicial application of Tarasoff to permit disclosure in cases involving Tarasoff-like fact patterns.29

Dr. Todd Waller, M.D., observes that the strength of the Estates of Morgan majority rationale is its blending of traditional tort law accountability with the professional judgment rule - thus capturing and acknowledging the difficulty inherent in predicting a person's behavior. Dr. Waller emphasizes that the expertise of the psychotherapist, a specialist who is responsible for assessing a patient's propensity for violence, is essential to the operation of the rule of professional negligence. He explains further that the professional judgment rule is also an acknowledgement by courts of the difficulty of determining who may need protection and how to best provide it. In sum, he suggests that psychotherapists are responsible only to be more careful and thorough, and to consult with other professionals more often with respect to their patient's threatened violence toward others. Dr. Waller does suggest a weakness in the Morgan majority's rationale - its reliance on the "ability [of the psychotherapist] to control" the outpatient, rather than considering the traditional common law means of establishing a "special relationship" exception to the general "no-duty" rule. Finally, he suggests that an ambiguity remains in defining the "readily identifiable" or "foreseeably endangered" victim, and he sees a need for further

29 HB 1941, "The Health Information Privacy Act," introduced in Congress in May, 1999, contains provisions which would, if enacted, limit disclosure of health care information. Section 2 of the proposed Act, as a part of the sponsors' program of proposed health care reform, suggests Congressional findings that the wrongful disclosure of health information may unfairly affect the ability of an individual to obtain employment, education, credit, or other necessities, and that current protections that vary from state to state are inadequate to protect the privacy of an individual's health information and insure fair information practices standards. While it is questionable whether the provisions of the proposed legislation would apply to the disclosure issue raised in Tarasoff and its progeny, the Act seems to embrace nonconsensual disclosure as currently permitted in health care emergencies. Section 307 of the proposed Act provides that: "A health information custodian, to the extent the Secretary determines appropriate, may disclose protected health information, without obtaining an authorization under section 103 - (1) where necessary to prevent or lessen a serious threat to the health or safety of an individual; (2) to a next of kin; (3) to individuals with close personal relationships with the protected individual."
clarification of the precise role of the medical expert, whose expertise may not reach the actual decision-making as to how to best protect others from a patient's violent propensities.\textsuperscript{30} Dr. Waller's observations facilitate efforts to clarify the rule of law and its application in the college or university environment, and provide a basis for the assessment of the adequacy of staffing; the expertise of campus counseling and mental health professionals; the resources devoted to inpatient or outpatient care; the role of contract consulting professionals; and the education of others in the college community - e.g., housing staff, campus law enforcement - who might become involved in situations of potentially dangerous behavior by students in need of mental health care.\textsuperscript{31}

**Duty & Causation:** The failure to warn does not automatically impose liability. It must be the cause-in-fact and proximate cause of harm to the victim. *Bishop v. South Carolina Department of Mental Health*,\textsuperscript{32} is illustrative. Bishop signed an affidavit that her daughter, Tammi Hatley, had made threats to her three year old daughter (Bobbi Hatley) and to Bishop herself. Tammi Hatley was thereafter subjected to involuntary commitment to the Patrick B. Harris Psychiatric Hospital where she was examined by a physician, observed by nurses, and interviewed by a social worker. Following a determination that she was not mentally ill, Hatley was released by order of the probate court. Two days later, Tammi came to Bishop's home and, after a visit lasting several hours, Bishop allowed her to leave with Bobbi. When Tammi returned with Bobbi to Bishop's home several hours later, Bishop noticed that Bobbi had green felt tip magic markings on her arms and body, including her abdominal and vaginal areas. Bobbi was examined by a


\textsuperscript{31} This paper is not intended to provide legal advice and should not be regarded as a legal opinion in any particular situation. Administrators needing legal assistance in particular situations should consult college or university legal counsel.

\textsuperscript{32} 502 S.E.2d 78 (S.C. 1998).
physician at Greenville Memorial Hospital; no evidence of penetration or other trauma was found. Bishop filed a civil action against the State Department, alleging that the Department was negligent in releasing Tammi and failing to warn Bishop of her release, and in failing to properly diagnose and treat Tammi.

The trial court granted summary judgment in favor of the Department, holding that under the provisions of S.C. Code Ann. §§ 15-78-60 (Supp. 1997) and 44-17-900 (1976), the Department had no duty to warn Bishop of her daughter's release, for the benefit of her granddaughter. The court found that Bishop had actual knowledge of Tammi's threats and that any duty to treat was owed to Tammi, not Bishop. The Supreme Court affirmed, but held that when a state mental health facility has the ability to monitor, supervise, and control an individual's conduct, a special relationship exists between the state and the individual, and the state may have a common law duty to warn reasonably identifiable potential victims of the individual's specific threat, citing Tarasoff.

The Court held that the Department had a special relationship with Tammi because the Department had custody and control of her. Thus, if the Department knew or should have known that Tammi was a threat to Bishop or Bobbi, the Department had a duty to warn Bishop of Tammi's release, whether or not Tammi made specific threats to Bishop or Bobbi while in the custody of the hospital. However, since Bishop had actual knowledge of Tammi's alleged threats to Bobbi only two days prior to the commitment, the Department (Hospital) could not reasonably foresee that Bishop would allow Tammi to engage in unsupervised contact with Bobbi. Thus, assuming a duty to warn Bishop of Tammi's discharge, the Department's failure to inform Bishop was not actionable, as it was not the proximate cause of Bobbi's injury; Bishop's own
negligence in allowing the unsupervised visit, knowing of Tammi's threats, was the proximate cause of those injuries. Bishop's permission was an intervening act which relieved the Department of liability for its antecedent negligence, unless it was foreseeable by the Department.

The holding could be criticized, and was in a dissenting opinion, because Bishop's act might have been reasonably foreseeable by the hospital under the circumstances. If Bishop assumed that Tammi was released because the hospital had properly treated her for the disorder that made her dangerous, she might have allowed the unsupervised contact between mother and daughter. This would appear to be a question of fact, not appropriate for summary judgment. The distinction between the rule regarding duty and proximate cause, and the application of the rule to the facts of the case - which appears erroneous - is important. Tort law generally recognizes intervening causes, and subjects the antecedent actor to liability only where the intervening act was reasonably foreseeable. The Bishop case correctly reflects doctrine, but may have wrongly applied the legal rules governing the rights and responsibilities of the parties.

The victim's knowledge or lack of knowledge of the threat to her physical safety does not, a fortiori, determine duty and liability. Long v. Broadlawns Medical Center,33 a domestic violence case, holds that a medical center's duty to notify a patient's wife of his discharge from the center - when it had promised her it would notify her - was not abated merely because she knew of his violent propensities. The duty to notify arose from the center's affirmative indication to the wife that she would be notified of her husband's discharge, whether or not the Tarasoff rule would have imposed a duty to warn in the absence of the promise. Jillene Long was shot and killed by her husband following his release from Broadlawns. He had sought treatment following an episode of violence

33 2002 WL 31828440 (Iowa, 2000).
during which he fired a gun at his wife. While an inpatient at Broadlawns,\(^3\) he was observed exhibiting homicidal and suicidal tendencies, hallucinations and flashbacks, and stating that he was “losing control.”

The center diagnosed Long as suffering from post-traumatic stress disorder versus [dissociative] disorder and dependencies on alcohol, marijuana, and methamphetamine. The decision was made by the treating physicians to transfer him to the University of Iowa Hospitals and Clinics for inpatient substance abuse treatment. Although Jillene Long was well aware of her husband's diagnosis, and his prior episode of violence toward her, she was assured that she would be notified if her husband were released from inpatient care. Following his discharge from Broadlawns, and a brief assessment period at the Iowa facility, he walked away from the latter treatment center, returned home, and killed Jillene. The Iowa Supreme Court recognized the fundamental relational analysis supporting duty in Tarasoff – that a special relationship between a psychotherapist and his or her patient “may support affirmative duties for the benefit of third persons.”\(^3\) Without adopting the Tarasoff rule imposing an affirmative duty to warn, the Iowa court held that the defendants in the instant case had voluntarily assumed a duty to notify Jillene Long of her husband's discharge, and had failed to fulfill that duty. Thus, the issue of her knowledge of the threat her husband posed to her – a valid question where affirmative duty is concerned – is not determinative of liability where she was promised a warning.

The holding in Long is based not upon a “Tarasoff rule” imposed duty to Jillene based on the defendants' relationship with her husband (it is not an affirmative duty case); rather liability is based upon the failure to fulfill a duty the defendants owed to Jillene herself, by

\(^{3}\) Long originally sought treatment at a veteran's hospital but was transferred to Broadlawns.

\(^{3}\) 551 P.2d at 343.
Codification of the *Tarasoff* rule, and expanded immunity: In 1985, California Codified and expanded *Tarasoff's* qualified immunity rule in Cal. Civ. Code § 43.92 (2001). The statute provides a qualified immunity to psychotherapists for the failure to protect or warn third parties of a patient's threatened violent behavior, or to predict a patient's violent behavior, and warn third parties, except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims (emphasis added). The limited duty imposed by the statute requires reasonable efforts by the therapist to communicate the threat to the victim or victims and to a law enforcement agency. In *Barry v. Turek*, the court observed that the statute was enacted to limit the liability of psychotherapists under case law for failing to warn a person who was threatened by a patient. The nature of the immunity is illustrated in a recent application of the statute in *Tilley v Schulte*. In *Tilley*, the court held that § 43.92 did not impose a duty on a psychotherapist to a police officer shot by the therapist's patient, where the patient's homicidal threats were identified with his supervisor, and he had not told the doctor that he harbored either generalized homicidal feelings, or that he desired to harm the officer. These recent cases indicate that, under the statute, the *Tarasoff* duty to warn is recognized, but immunity is provided from *Tarasoff* claims unless the plaintiff proves that the patient of a psychotherapist has communicated to the therapist a serious threat of physical violence against a reasonably identifiable victim.

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36 The Iowa court suggests that, in a traditional “*Tarasoff*” case, an affirmative duty to warn would not be imposed where the victim knew of the threat.
38 82 Cal Rptr. 2d 497(Cal. App. 1999).
The Tarasoff rule is further limited, or rejected, in some jurisdictions. In *Thapar v. Zezulka*, the Texas Supreme Court held that the legislature had rejected a Tarasoff rule, thus precluding a common law cause of action against a mental health professional for alleged failure to warn a third party of a patient's threats. Dr. Thapar's patient—Lilly—had a history of mental-health problems and psychiatric treatment, and was diagnosed by Thapar as suffering from moderate to severe post-traumatic stress disorder, alcohol abuse, and paranoid and delusional beliefs concerning his stepfather, Zezulka, and people of certain ethnic backgrounds. Thapar treated Lilly, primarily on an outpatient basis, with a combination of psychotherapy and drug therapy for three years. However, like Matt Morgan in the Ohio *Estates of Morgan* case, Lilly had episodes with his family—and unlike Morgan was admitted for inpatient treatment on at least six occasions. On the occasion of Lilly's admission for treatment in 1988, Thapar's notes included the observation that Lilly "feels like killing Henry Zezulka [but] has decided not to do it, but that is how he feels." Within a month, Lilly killed Zezulka, and Zezulka's wife brought a civil action against the therapist, alleging that he failed to warn the family of Lilly's threats, or the danger he presented.

The Supreme Court held, *ab initio*, that under Texas law, the therapist owed no duty to a third party nonpatient, for negligent misdiagnosis or negligent treatment of Lilly, and that, a fortiori, Zezulka had no cause of action for misdiagnosis. The court then noted the Tarasoff duty to warn, but held that the Texas confidentiality statute governing communications between mental health professionals and their patients prohibited disclosures to third parties, even where a threat to an identifiable third party is communicated by the patient to the

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39 994 S.W.2d 635 (Tex. 1999).
therapist.

The court held that no exception in the statute provides for disclosure to third parties threatened by the patient. The statute's exception for disclosure to law enforcement agencies in circumstances of imminent physical injury permits disclosure, but does not impose an affirmative duty to disclose, and thus provided no cause of action for the benefit of Zezulka.40

The Tarasoff rule and prescribing decisions by physicians: In a very recent case, the Supreme Court of Hawaii has held that a physician does not owe a duty to non-patient third parties injured in an automobile accident caused by the patient's adverse reaction to a medication that is not a controlled substance, where the alleged negligence involves such "prescribing decisions" as whether to prescribe the medication in the first instance, which medication to prescribe, and the dosage prescribed. A physician does owe a duty to such non-patient third parties where the physician has negligently failed to warn the patient that the medication may impair his driving ability, and where the circumstances are such that the reasonable patient could not have been expected to be aware of the risk without the physician's warning.41 The Hawaii court's ruling suggests agreement with Kaiser v. Suburban Transportation System, 398 P.2d 14 (1965). In Kaiser, a physician prescribed a sedating antihistamine to his patient, knowing that he was a bus driver. After taking the first dose of the medication the following morning, the driver went to work and was involved in an accident after falling asleep while driving the bus. The driver had apparently felt groggy before the accident

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40 Indeed, the court noted that a therapist discloses such communications at his or her peril, and may be subject to civil liability for wrongful disclosure. In contrast, Tarasoff – the seminal case – recognized the legitimacy of disclosure under state law, and the appropriateness of disclosure under the state's evidence code; and cf. New Hampshire has codified the Tarasoff rule, recognizing a duty to warn in situations where the therapist's patient communicates a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims. The statute provides immunity for reasonable disclosure in fulfillment of the duty to warn.

41 McKenzie v. Hawaii Permanente Medical Group, 47 P.3d 1209 (Hawaii 2002).
but continued to drive. A passenger on the bus was injured in the accident and sued the doctor and the bus company. The state supreme court noted that the evidence suggested that the doctor may not have informed his patient of “the dangerous side effects of drowsiness or lassitude” from the drug and that expert evidence suggested that it was negligence not to do so. The court held that the plaintiff was entitled to judgment as a matter of law on the issue of liability against either the bus driver, the doctor, or both, depending upon whether the doctor had informed the driver of the risk of drowsiness and whether the driver was contributorily negligent.

In the Hawaii case, the State Supreme Court observed that warning a patient not to drive because his or her driving ability may be impaired by a medication could potentially prevent significant harm to third parties. Moreover, since the physician already owes a duty to his or her patient under existing tort law to warn the patient of such a potential adverse effect, the imposition of a duty for the benefit of third parties is not likely to require significant changes in prescribing behavior.
Questions of law & questions of fact: The summary judgment phase of Tarasoff rule cases presents an opportunity to understand the duty and proximate cause relationship, and also facilitates a prevention based approach to the administration of the Tarasoff rule. Schlegel v. New Milford Hospital is illustrative. Schlegel cites Fraser v. United States, holding that Connecticut recognizes Tarasoff as imposing a duty on the psychotherapist to protect the foreseeable victim(s) of an outpatient. However, there is no duty to control the psychiatric outpatient to prevent harm to a third person unless the therapist knows or has reason to know that a particular person will be harmed, i.e., that the victim was a specifically identifiable victim of the uncontrolled patient, or that the victim was a member of a class of identifiable victims. There must be objective indicia of the uncontrolled patient's propensity to cause harm. Such a duty rule usually presents fact questions regarding foreseeability. The Fraser Court recognized the public policy concern for balancing the interests of those injured by psychiatric outpatients against the interests of the mental health profession in honoring the confidentiality of the patient-therapist relationship, and respecting the humanitarian and due process concerns that limit the involuntary hospitalization of outpatients. That balancing limits subjecting a mental health professional to civil liability for harm to unidentifiable victims or unidentifiable classes of victims of outpatients with no history of dangerous conduct or communicated threats of dangerous behavior.

In Schlegel, a patient of New Milford Hospital was released to his mother's care, and killed her within twenty-four hours of his release. Prior to his commitment, Schlegel had engaged in irrational, delusional and violent behavior towards or in the presence of loved ones and

43 674 A.2d 811.
caregivers, including attempts to choke his friend and housemate, Jeffrey Morgan, violently struggling with ambulance personnel who transported him to the Hospital, spitting at and kicking members of the hospital staff, attempting to bite at least one physician, and making inappropriate and delusional utterances. While Schlegel was an inpatient, the hospital learned from his New York psychiatrist that he had had a long history of mental health problems and substance abuse, and that he had engaged in bizarre behavior towards his mother. Blood tests also revealed that he had a potassium deficiency which increased the risk of further psychotic disturbances. Notwithstanding this information, doctors medicated him with Thorazine, at a dosage sufficient only to last him until 6 A.M. the following morning, and released him to his mother's care and custody without further evaluation, testing or treatment. On these facts, the court concluded that the hospital was not entitled to judgment as a matter of law. Although there was evidence that Schlegel had taken mushrooms or drugs, his drug-related history did not include episodes of violence; in contrast, his most recent behavior was both delusional and violent, suggesting another cause. The fact question presented in such a case is not whether a rational adult would kill his mother, but whether a non-rational, delusional adult, who demonstrated violent behavior toward loved ones and caregivers, would create a concern for the safety of his custodial mother if he were released to her care. This question is one of fact, for a jury, requiring the denial of summary judgment.44

*Schlegel* indicates that *Tarasoff* rule cases may present mixed questions of law and fact which influence whether the therapist may be entitled to summary judgment on the question whether an uncontrolled patient presents a foreseeable risk which subjects the therapist to a duty to act affirmatively. Subjecting factual circumstances in the patient care

44 See, *Lundgren v. Fultz*, 354 N.W.2d 25 (Minn. 1984)(“Close questions on foreseeability should be given to the jury....”).
environment to this kind of analysis facilitates a prevention-based approach to the Tarasoff rule, and can increase the likelihood of avoiding litigation.

**The issue of therapist-patient confidentiality:** Tarasoff respects the concern of therapists for confidentiality by limiting the duty to disclose to situations of imminent physical peril to identified or identifiable third parties, and its holding is described as consistent with statutory approval of disclosure where such peril exists. However, justification for disclosure remains a cautious aspect of Tarasoff rule cases, and wrongful disclosure may subject the therapist to liability. An example occurs in *Runyon v. Smith*, a case in which the New Jersey Supreme Court emphasizes that disclosure of confidential patient communications by the patient’s psychologist is appropriate only where it is required by circumstances which present concern for “imminent serious physical violence.” In a custody case, the court holds that where children were not exposed to such a level of danger, disclosure of confidential communications in testimony before the court, subjects the patient’s psychologist to liability. Such cases demonstrate the therapist’s concern for the seemingly conflicting duties which influence the relationship between the therapist and her/his patients and non-patients, and the argument for a subjective “good faith” standard in such cases.46

**Conclusion:** Tarasoff rule cases continue to present issues of great public importance to state supreme courts, and generate a significant number of intermediate appeals applying the tort law concepts considered in Tarasoff. Although the case is one of the most

46 The dissent in *Runyon* suggests that this concern is particularly legitimate in child custody cases, where the therapist places the interests of the child at the forefront, and is likely to be counseling the parties jointly, or testifying in a suit between the custodial parents.
influential cases in the law of torts – bringing law and science together in the balancing of the rights and responsibilities of mental health professionals, their patients, and non-patients, its concepts remain the subject of debate among both scientists and lawyers. Its fundamental principles are widely – but not universally – accepted, and the factual aspects of cases subject to its standard present challenges in civil actions, and in the preventative administration of those principles. In spite of the variations in the acceptance of its concepts (by courts and legislatures), and in the reasoning and judicial view of the capacities of the parties which influence the application of its concepts, *Tarasoff* has achieved distinction in guiding lawyers and mental health professionals by facilitating a balancing of the accountability sustained by tort law principles with an informed respect for professional judgment.