

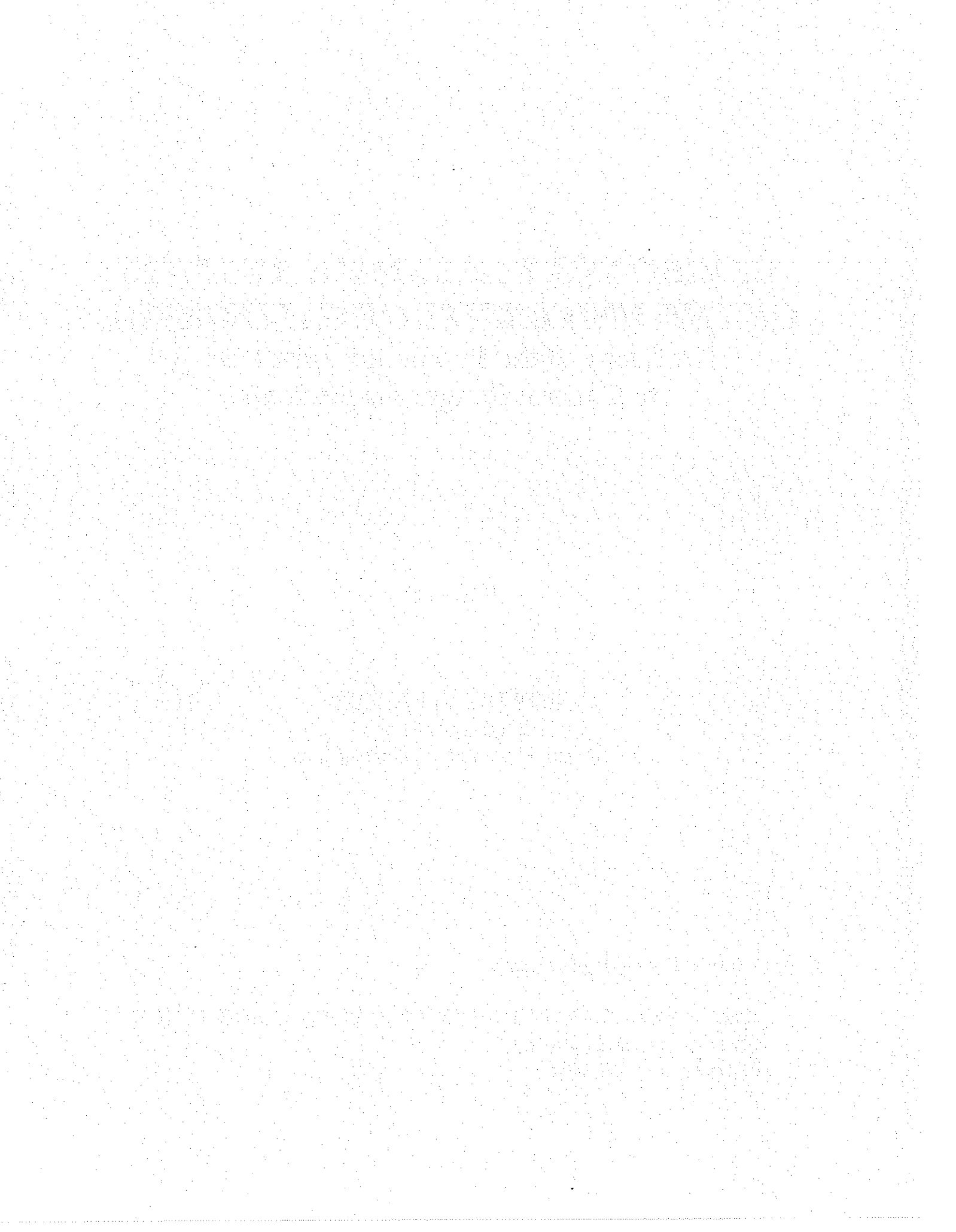
**REVISITING *TARASOFF* v. *REGENTS*
OF THE UNIVERSITY OF CALIFORNIA:
The Scope of the Psychotherapist's Duty
to Control Dangerous Students**

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THE CONCEPT OF LIMITED DUTY REQUIRING REASONABLE CARE

Modern American negligence law principles have generally recognized that a *limited* duty exists to assist others, at least where certain special relationships exist between the person in peril, and the person in a position to provide assistance. As Professors Ellen Wertheimer and Frank Vandall point out, 'duty' is a term of art and courts use it to find liability or limit liability.² Classic legal texts and casebooks on negligence law explain that, because legal duty is the result of a social policy analysis, it considers one's moral obligation to assist another person who is in peril; however, American negligence law refuses to generally accept the notion of a universal legal duty to assist others. Thus, the mere fact that you know another person is in peril imposes no *legal* duty to rescue him, although you – or your beliefs – may embrace a *moral* duty.³ In sum, a legal duty to act affirmatively to assist another person is, in most jurisdictions, dependent upon the existence and recognition of the relationship between them – assuming that you have done nothing to create the perilous situation.⁴

¹ I have 'borrowed' this title from Professor Peter F. Lake's noteworthy work "Revisiting Tarasoff", 58 Albany Law Rev. 97 (1994).

² F. Vandall and E. Wertheimer, "Torts: Cases & Problems" (Michie, 1997), p. 123.

³ The 'classic' case is *Yania v. Bigan*, 155 A.2d 343 (Pa. 1959).

⁴ The 'classic' case is *Farwell v. Keaton*, 240 N.W.2d 217 (Mich. 1976). *Yania* and *Farwell* are studied by most law students and discussed in depth in my courses on Torts. The *Farwell* court cites standard 'hornbook' explanations of the rule: "The law has persistently refused to recognize the moral obligation of common decency and common humanity, to come to the aid of another human being who is in danger....The remedy in such cases is left to the 'higher law' and the voice of conscience, which, in a wicked world, would seem to be singularly ineffective either to prevent the harm, or to compensate the victim." Prosser, Torts (4th ed.), § 56, pp. 340-341. The *Farwell* majority's famous language explains that "Courts have been slow to recognize a duty to render aid to a person in peril. Where such a duty has been found, it has been predicated upon the existence of a special relationship between the parties. In such a case, if the defendant knew or should have known of the other's peril, he is required to render reasonable care under all the circumstances." Common examples, noted by the *Farwell* majority, included employers, innkeepers and their guests; premises owners and their business or public invitees; common carriers and

Nowhere has this duty rule been subjected to a more critical analysis than in defining the scope of the therapist's duty to control a dangerous patient, or warn a person who is at risk because of the patient's conduct or statements. The seminal case is, of course, *Tarasoff v. Regents of the University of California*.⁵ *Tarasoff* is best known for its precise holding: Once a therapist⁶ does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, [the therapist] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.⁷ Reasonable care might include – depending upon the nature of the case – warning the intended victim, or others likely to apprise the victim of the danger, notifying police, obtaining family intervention, *etc.*⁸

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 were 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,*

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.

⁵ 551 P.2d 334 (Cal. 1976)(*en banc.*)

⁶ 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. See *Lake, supra.*, at 98, n.6; *Estates of Morgan et al., infra.*, 673 N.E.2d 1311, 1321 (Ohio 1997).

⁷ See Peter F. Lake, *Revisiting Tarasoff*, 58 Albany L. Rev. 97, 98 (1994).

⁸ *Estates of Morgan, et al., supra.*, n. 40, 673 N.E.2d 1311, 1320.

knowledge and care ordinarily possessed and exercised by members of the medical specialty under similar circumstances.

Tarasoff has been viewed by scholars on the subject, and courts, as an important judicial commentary on the principles of negligence law embodied in the Restatement of Torts (Second), §§ 314-319, which deal with the duty to control the conduct of a third person.⁹ Professor Peter Lake observes that a majority of jurisdictions consider *Tarasoff* favorably, and only a few have rejected its holding, or openly questioned its rationale.¹⁰ 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:

- 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;
- To impose such a duty based upon society's "interest in public safety," which subordinates society's interest in confidentiality; and/or
- 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.¹¹

The foreseeability of risk appears to be prominent in the analysis, where conduct is involved; but it should be noted that, where liability is based upon the imposition of an affirmative duty – a duty to act affirmatively – foreseeability is traditionally not sufficient

⁹ Section 314 of the Restatement (Second) reaffirms the principle of *Yania v. Bigan*, *supra.*, that the fact that the actor realizes or should realize that action on his part is necessary for the protection of another does not, in itself, impose upon him a duty to take such action; Section 315 explains that such a duty exists only where (a) a special relation exists between the actor and the third person which imposes upon the actor a duty to control the third person's conduct, or (b) a special relation exists between the actor and the person in peril which gives that person a right of protection.

¹⁰ 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.

¹¹ 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.

in the absence of a "special relationship" (between the therapist and the assailant, or the therapist and the victim).¹²

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 (even in an outpatient setting) 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.¹³ In the second part of its analysis in support of a duty to warn, the court determined that the interest of public safety outweighed the confidentiality that characterizes the psychotherapist-patient relationship, and the difficulty in predicting dangerous behavior.¹⁴



REVISITING TARASOFF

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 he 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 judgement? (3) Does a uniform standard of care in psychotherapist negligence cases reflect sound social policy.

¹² 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; Lake, *supra.*, n.7, at 123; *Estates of Morgan*, 673 N.E.2d 1311, 1319 (Ohio 1997).

¹³ *Tarasoff, supra.*, 551 P.2d at 344.

¹⁴ G. Wardle and J. Maloon, "The Strict Application of the Restatement, Ohio Law and the Rules of Civil Procedure: *Estates of Morgan v. Fairfield Family Counseling Center*," 45 *Clev. State L. Rev.* 649 (1997).

A Case Study

During his senior year of high school, Matt Mullins began to have difficulties at school and home. He became disrespectful and verbally abusive toward his parents, to the point that they grew afraid of him. These problems continued for eight months, and in January, 2000, Matt left his parents' home, and 'drifted' homeless, throughout four states. In April, 2000, he presented himself at the emergency room of Jefferson University Hospital in Philadelphia. There, he was diagnosed by Dr. Sam Smith, M.D., as suffering from schizophreniform disorder. On Dr. Smith's orders, Matt was transferred to the Jefferson Mental Health Center, and further evaluated (His medical history stated, among other things, abuse of parents, recent drifting, and homelessness). Symptoms were noted suggesting schizophreniform disorder, including Matt's belief that his mind was being controlled, and that he had a strong feeling of persecution from others. Matt was admitted to the Center's residential facility and referred to a treating physician, Dr. Joyce Jones, who prescribed Navane, a neuroleptic drug.

Dr. Jones noted in Matt's medical records that he suffered from schizophreniform disorder, and also that, "according to the natural progression of the disorder, it will only be a matter of months before the patient will develop schizophrenia." Dr. Jones noted further that Matt had developed a "fixed, delusional system involving his family." She noted that Matt believed his thoughts were being read and controlled by others, and that he always became agitated when discussing his parents. Matt's treatment at the Center included intensive psychotherapy, Navane and other medication to control the side effects of Navane. Gradually, Matt's paranoia decreased and he began to gain insight into his mental illness. In August, 2000, with this medical plan in place, Dr. Jones agreed that Matt could return to his home in Ohio, and resume his relationship with his family and friends (which was his desire). However, Dr. Jones insisted that Matt continue his therapy, and she referred him to the Wilson Health Center and Retreat in his hometown.

Matt presented himself at the Wilson Center and was seen by Dr. Kernitt Greene, M.D., a contract consulting psychiatrist. Following a thirty minute evaluation, Dr. Greene indicated on Matt's medical record that "the patient had recently been discharged by a mental health facility of some sort in Philadelphia, on Navane," and that "he entered this facility because he is out of medication and seeks help in applying for social security benefits." Dr. Greene indicated further that "the patient's Philadelphia experience sounds like the effects of homelessness, and perhaps some sort of atypical psychosis. He does not presently indicate symptoms of schizophrenia." Dr. Greene glanced at Matt's records from the Jefferson Center and discussed his evaluation of Matt with other members of the Wilson Center staff, including Peggy Moss, a social worker, whose training included a master's degree in social work. Greene told Moss that he "suspected malingering," and also suspected that "the patient may be desiring to file disability forms, and qualify for government disability benefits." Greene explained that he "sees a lot of people that seek SSI with histories similar to this patient's history." Greene saw Matt once a week for the next three weeks and thereafter indicated his strong suspicion of "malingering, and overstating symptoms to gain SSI benefits." He reduced Matt's medication gradually to one half (within four weeks), and suggested that he be referred to Moss for "vocational counseling, with the involvement of parents," and that "medication be discontinued after ten weeks." Final diagnosis was indicated as "atypical psychosis in remission." This plan was implemented.

Within six weeks, Matt became increasingly agitated at home and uncooperative with Moss. He failed to show up for job interviews, and his parents informed Moss that he was argumentative and hostile. They indicated that there were episodes of name-calling, that Matt had twice slapped his father, and that he had spoken of buying a gun. Moss indicated that Matt had resisted her suggestion that he resume medication, and that she did not have authority to prescribe medication, or order that Matt be involuntarily committed as an inpatient. She suggested that she would consult Dr. Greene about amending the treatment plan. She consulted Greene, who suggested that he re-evaluate Matt in thirty days. Moss communicated this to Matt's parents. A week later, during a game of cards with his parents, Matt excused himself. He went to his room and got a gun that he had purchased. He came back downstairs and shot and killed his father.

CONSIDER THE
FOLLOWING
QUESTIONS
ABOUT THE
CASE STUDY

What issues may be identified that relate to the legal duties of the psychotherapist, social worker, and their employer, under the facts of this case study?

- Would you conclude that Dr. Greene, Ms. Moss and the Wilson Center had a duty to Matt's parents under the circumstances? If the Center had no affirmative duty to accept and treat Matt, did it nevertheless *assume* a duty to protect his parents once it accepted him for treatment and altered his treatment plan?
- Should Dr. Greene and the Center be immune from civil liability for the death of Matt's father because Dr. Greene's decision was based upon his medical judgement as an expert in his field – *i.e.*, to what extent is Dr. Greene's professional judgement protected when his recommended course of treatment differs from the treatment plan of prior treating therapists?
- Does the case study present any particular concerns for a college or university regarding full time staff? Contract arrangements? Student life environments, *e.g.* campus housing?

Stop here - discuss the study questions - and make recommendations about policy or practice which will successfully resolve the legal and medical issues that characterize the instant scenario - or similar situations faced by college and university mental health professionals and legal counsel

This case study is drawn from the facts of one of the latest cases to define the scope of the therapist's duty to control the conduct of a dangerous patient, or warn those at risk of harm because of his dangerous propensities. In *Estates of Morgan v. Family Counseling Center*,¹⁵ the Supreme Court of Ohio 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.¹⁶ 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

¹⁵ 673 N.E.2d 1311 (Ohio 1997).

and he began to gain insight into his mental illness.¹⁷ The treating physician, a third year psychiatric 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 initially withheld, but the psychiatrist observed that:

- (1) Morgan was out of medication;
- (2) Morgan desired additional medication and help in completing a social security disability form;
- (3) 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.¹⁸ Morgan initially received psychotherapy, but after the third visit with the contract psychiatrist, he was referred to a social worker at the center, 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.'¹⁹

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. She concluded on two or more separate 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:

- (1) The failure to review Morgan's prior medical records or consult his previous physician;

¹⁶ It was also noted in his medical records that he had to be put out of his parents' home by police. *Id.*, at 1314.

¹⁷ 673 N.E.2d at 1315.

¹⁸ The first meeting was a 30 minute evaluation; the second and third meetings lasted 15 minutes. *Id.*

¹⁹ *Id.* The psychiatrist also observed that to give SSI benefits to undeserving persons is a disservice to them.

- (2) the failure of the center's psychiatrist to diagnose schizophrenia;
- (3) the discontinuation of medication which would have controlled Morgan's impulse to shoot his parents, and
- (4) the improper delegation of medical decisions to a social worker who had absolutely no training to make medical decisions, but did so without consulting medical staff.²⁰ The court concluded that a question of fact existed whether the counseling center's staff were 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 upon 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.²¹ *Tarasoff* invites no such bright line distinction.²²

In *Estates of Morgan*, Justice Resnick wrote 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. A majority of courts appear to agree that *Tarasoff* recognizes that the psychotherapist-outpatient relationship is also one which supports a duty of reasonable care – *i.e.*, the imposition of a professional standard of care for the protection of third parties.²³

Revisiting *Tarasoff*, Justice Resnick observed in *Estates of Morgan*, that the resolution of the issue of the duty of a therapist to protect third persons involves consideration of:

- The therapist's ability to control the outpatient;
- The public's interest in protection from violent assault;

²⁰ *Id.*, at 1323-1324.

²¹ See *e.g.*, *Boynton v. Burglass*, 590 So.2d 446 (Fla. App. 1991); *King v. Smith*, 539 So.2d 262 (Ala. 1989).

²² See *Estates of Morgan*, *supra.*, n.48, at 1322.

²³ Justice Resnick observes in *Estates of Morgan*, that the *Tarasoff* court's analysis did not rely explicitly upon Restatement, § 319, but rather saw § 315 of the Restatement as reflecting an affirmative duty to control the conduct of a third party whenever the nature of the relationship warranted social recognition as a 'special relationship.' 673 N.E.2d at 1320; and see G. Wardle and J. Maloon, "The Strict Application of the Restatement, Ohio Law, and The Rules of Civil Procedure: *Estates of Morgan v. Fairfield Family Counseling Center*," 45 *Clev. State Law. Rev.* 649, 653 (1997).

- The difficulty inherent in attempting to predict whether a patient represents a substantial risk of harm to others;
- The goal of placing a mental patient in the least restrictive environment and safeguarding his right to be free of unnecessary confinement; and
- The social importance of maintaining the confidential nature of psychotherapeutic communications.²⁴

Writing for the majority of the court, Justice Resnick concluded that, in a case such as the one before the court, the outpatient setting embodies sufficient elements of control to warrant the imposition of a duty to exercise reasonable care for the protection of third parties, and that such a duty serves the public's interest in safety from the violent acts of dangerous mental patients without imposing an unreasonable burden on the therapist, or encouraging the overcommitment of persons with mental impairments.²⁵ Justice Resnick 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."²⁶

Finding duty as a matter of law, Justice Resnick noted that sufficient evidence existed to deny defendants' Motion for Summary Judgement, and allow the issue of negligence to be determined by a jury. That evidence included the testimony of the treating psychiatrist and other employees of the defendant, that neuroleptic medication controls symptoms of schizophrenia in approximately 70% of cases – and that removing such medication increased the risk that Morgan would be dangerous to himself or others. Plaintiffs' experts added that, in their opinion: (1) Morgan would have remained compliant with his medication and therapy, if the treating psychiatrist had not removed these elements of his medical plan; and (2) other measures could have been taken, including medical monitoring and intervention upon indications of deterioration.²⁷

²⁴ *Id.*, at 1322.

²⁵ *Id.*, at 1327.

²⁶ *Id.*, at 1323. Justice Resnick explained that, although the outpatient setting affords the psychotherapist lesser control over the patient than does the hospital setting, it permits sufficient control to support a duty of reasonable care.

²⁷ Such intervention, the court noted, could have included insistence that Morgan resume his medication, or be subjected to involuntary commitment. Indeed, plaintiffs' experts suggested that the treating psychotherapists had authority to order involuntary commitment.

THE SPECIFIC THREAT RULE

In duty to warn cases, 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);
- 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,²⁸ 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.²⁹

THE PRINCIPLE OF ASSUMED DUTY

As the case study illustrates, 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.³⁰ In other words, once Morgan was evaluated, and his treatment plan altered, a duty was assumed to exercise

²⁸ 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).

²⁹ 673 N.E.2d at 1330.

reasonable care not to worsen his condition, or the danger he presented to himself or others. It might be argued that, given its disinclination to accept inpatients, the Ohio center should have referred Morgan to a more appropriate facility. However, once it made the decision to accept him as a patient and alter his treatment plan, it assumed a duty not to worsen his condition, and the risk that discontinuance of medication presented to others – particularly his parents. The assumption of care does not make the second medical actor – here the Ohio center – liable for Morgan’s condition *ab initio*; rather the Ohio center is subject to liability under an assumed duty theory only if its affirmative conduct makes the prior or existing situation worse and unreasonably increases the risk that Morgan would harm his family.



PROTECTING THE PSYCHOTHERAPIST’S JUDGEMENT

The duty imposed on the therapist does not mandate liability for errors in judgement. To prevail in psychotherapist negligence cases, 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 judgement. 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.³¹

Factors reviewed by the court include: (1) the competence and training of the therapist; (2) whether relevant documents were adequately, promptly and independently reviewed; (3) whether the advice of another therapist was sought; and (4) whether the decision for or against commitment was made with attention to applicable legal standards in the jurisdiction. In sum, within the range of professional practice, where opinion and judgement may differ, the therapist is free to exercise his or her own best judgement

³⁰ See *Estates of Morgan*, 673 N.E.2d 1311, 1320.

³¹ 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.

without fear of liability. Proof that another therapist, aided by hindsight, would find error in fact, is not in itself sufficient to establish negligence.³²

This qualified immunity appears vital to the practicing therapist. Dr. Richard Grocz, in his paper for this conference, suggests that, although the Ohio court's holding in *Estates of Morgan* may be an appropriate application of the professional standard of care, there is *dicta* that raises doubt about the court's appreciation of the difficulty that a therapist encounters in attempting to prevision whether a patient presents a serious danger of violence. The law of the case is, of course, limited to its facts. More important, the majority of the jurisdictions which accept *Tarasoff's* seminal principles should remember its holding: That the defendant therapists did, in fact, predict that Poddar would kill, but were negligent in failing to warn Ms. Tarasoff or – in her absence – her parents.

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. Again writing for the majority in *Estates of Morgan*, Justice Resnick recognizes the difficulty inherent in forecasting whether a particular patient may pose a danger to others; however, this difficulty does not justify an absolute immunity – *i.e.*, immunity from a professional standard of care. Nor does an undifferentiated fear of overcommitment justify a blanket immunity from civil liability. In the end, *Estates of Morgan* reaffirms that the *Tarasoff* standard preserves the social policy that mental patients be placed in the least restrictive environment, and not be subjected to unnecessary involuntary commitment in violation of their right to liberty.³³

The rulings in *Tarasoff*, and *Estates of Morgan* do not make the therapist liable for placing his patient in the least restrictive environment. More is required than showing

³² For a discussion of other cases, see Lake, *supra.*, *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. Zezulka*, 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).

³³ *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. Simply put, the therapist who treats outpatients is held to the same standard as the therapist who treats inpatients.

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. In medical terms, the psychotherapist is expected to consider all viable treatment alternatives. 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.³⁴

DUTY TO WARN AND CONFIDENTIALITY

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*,³⁵ 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,³⁶ and that to require warnings to the public at large would be of little value. The case study is not, however, a duty to warn case. While issues of warning could have been raised – *i.e.*, whether the communications between the center staff and Matt's parents gave the parents sufficient warning of Matt's danger to his father – the case study is more concerned with the duty to control a dangerous patient.

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

³⁴ G. Wardle and J. Maloon, *supra.*, note 23, at 659-660, citing *Littleton v. Good Samaritan Hospital & Health Center*, 529 N.E.2d 449 (Ohio 1988): "A psychiatrist will not be held liable for the violent acts of a voluntarily hospitalized mental patient subsequent to the patient's discharge, if (1) the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge; (2) a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant factors and a good faith decision was made by the psychiatrist that the patient had no violent propensities; or (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. 528 N.E.2d at 449 (syllabus).

³⁵ 614 P.2d 728, 735-38 (Cal. 1980).

³⁶ *E.g.*, those in close relationship or proximity to the victim.

compromise of the communication privilege between the psychotherapist and the patient, where an identifiable third person is in imminent danger. This public policy concern for the protection of those in immediate danger is embraced by medical associations, and is embodied in many state statutes that support judicial application of *Tarasoff* to permit disclosure in cases involving *Tarasoff*-like fact patterns.³⁷



CONCLUSIONS AND CAVEATS

Dr. Todd Waller, M.D., observes that the strength of the *Estates of Morgan* court's rationale is its blending of traditional tort law accountability with the professional judgement 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 judgement rule is also an acknowledgement by courts of the difficulty of determining who may need protection and how to best provide it. *Morgan's* rationale, he observes, properly reflects how *Tarasoff* and its progeny have affected the practice of psychotherapists. 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 court's rationale – *i.e.*, its reliance on the "ability [of the psychotherapist]

³⁷ 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.

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 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.³⁸ Dr. Waller’s observations are valuable in reassessing the case study, and in discussing the general subject of this paper. His 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 some degree of mental health care.³⁹

³⁸ T. Waller, “Estates of Morgan v. Fairfield Family Counseling Center: Application of Traditional Tort Law Post-Tarasoff,” 31 Akron Law Rev. 321 (1997).

³⁹ 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.

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