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# Current Analysis of the *Tarasoff* Duty: an Evolution towards the Limitation of the Duty to Protect

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**In 1976, the *Tarasoff* case established a new legal duty to protect third parties from a psychiatric patient's foreseeable violence. After the *Tarasoff* case, courts expanded the scope and role of a clinician's duty to protect, sometimes in novel ways. Later interpretations of *Tarasoff* began to limit significantly the situations in which a duty to protect would attach. Recent *Tarasoff*-type cases in which courts have rejected the clinician's duty to warn suggest that *Tarasoff* is declining in significance. The advent of state statutes that codify the establishment and discharge of *Tarasoff* duty have contributed to a further limitation of the duty to protect. Lastly, when faced with the management of dangerous patients, we advocate for a thorough, well documented assessment of risk of violence as the best means for addressing concern about potential legal liability.**
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*Tarasoff v. Regents of the University of California* (1974) was the first case to find that therapists may have a duty to warn third parties from foreseeable harm. In a later decision, the same court dropped "duty to warn" in favor of a "duty to protect" third parties from foreseeable harm (*Tarasoff v. Regents of the University of California*, 1976). The *Tarasoff* decision sparked considerable debate amongst courts, legal scholars, and mental health professionals concerning the extent to which confidentiality of the psychotherapeutic relationship should yield to the duty to protect third parties outside of the psychotherapy relationship (Beck, 1985a). The debate examined the difficulties of balancing the rights of patients to confidentiality against the duty to protect third parties from potential violence (Beck, 1985b).

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Until recently, courts and commentators have worked under the general understanding that most states that have addressed the *Tarasoff* issue have accepted it as a reasonable legal duty (Lake, 1994). It appears to be the general rule that *Tarasoff* has been "widely accepted (and rarely rejected) by courts and legislators in the United States as a foundation for establishing a duty of reasonable care among psychotherapists . . . " (Lake, 1994, p. 98).

New limitations on the application of the duty to protect in several state and federal court cases suggest that *Tarasoff* is declining in significance among those states which have recently addressed *Tarasoff* concerns. For example, in some states courts have either explicitly or implicitly rejected the *Tarasoff* duty (*Boynton v. Burglass*, 1991; *Nasser v. Parker*, 1995; *Evans v. US*, 1995; *Sharpe v. South Carolina Dept Mental Health*, 1987; *Thapar v. Zezulka*, 1999). Still others have found it necessary to limit, in significant but divergent ways, the application of the duty to protect that the original *Tarasoff* court and its early progeny had established (*Boulanger v. Pol*, 1995; *Jacobs v. Taylor*, 1989; *Moye v. US*, 1990; *Leonard v. State of Iowa*, 1992; *Adams v. Elgart*, 1995). These developments call into question the notion that *Tarasoff* espouses a well settled principle of law. At the very least, these recent cases undermine the notion that *Tarasoff* will continue to be widely accepted and rarely rejected by states that have yet to rule on a therapist's duty to protect.

The first section of this article offers background concerning the duty in cases alleging negligent release and by analyzing the salient elements of the *Tarasoff* decision. The following section identifies and explores divergent ways in which courts have construed the therapist's duty to protect. The next section presents limitations or rejections of *Tarasoff* decision. The fourth section discusses state legislative action taken since the *Tarasoff* decision, codifying in statutes the elements of the clinician's duty and the means by which to discharge that duty. Finally, we offer practical perspectives to clinicians concerning situations in which *Tarasoff* duties are triggered and advice for satisfying both clinical and legal obligations.

## BACKGROUND AND LEGAL ANALYSIS OF *TARASOFF* CASES

### Negligent Release

Prior to the *Tarasoff* decision, courts had addressed many times whether clinicians owed any duties to foreseeable victims of violence. Two cases from the 1950s and 1960s addressed duty to protect on theories of negligent release of hospitalized patients. While negligent release is an enduring clinical concern and the subject of subsequent lawsuits, it is actually separate from *Tarasoff* duty. In the 1956 case of *Fair v. United States*, an Air Force officer threatened to kill several individuals at his station, including a student nurse, the base commander, and other medical personnel. Medical personnel hospitalized the officer and the nursing school hired a guard to protect the student nurse. During hospitalization, the treating physicians promised to notify the nurse before the patient was to be discharged from

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the hospital. At the time of the officer's release from the hospital, the treating physicians did not notify the student nurse. After release from the hospital, the officer killed the nurse, two guards, and himself. The survivors sued and a lower court found for the defendant in summary judgment. On appeal, the Fifth Circuit reversed the lower court decision and remanded for retrial, finding the officer received "cursory psychiatric treatment" and that his release from the hospital was "negligent."

A subsequent case also involving the military further developed the concept of negligent release. In a 1966 case, *Underwood v. United States*, a divorced and distraught airman threatened his former wife and clinical personnel admitted him to a psychiatric hospital. A corpsman elicited a history of the airman's stalking, threatening, and assaulting his ex-wife. The first treating physician instructed the medical corpsman not to write the relevant history in the patient's chart. Instead, the treating physician said he would tell another physician who would shortly take over providing care. He failed to do so, and the airman's new treating physician never received the collateral history. The second physician released the airman from the hospital and placed him on restricted duty. Contrary to regulations, he then obtained a .45 caliber weapon with which he shot and killed his ex-wife and himself. When the ex-wife's relatives sued, a lower court granted summary judgment for the defendant. On appeal, the Fifth Circuit reversed this decision and remanded for rehearing against both the initial treating physician and the airman's weapons unit, citing negligence on behalf of both parties. These early cases illustrate that courts had considered issues of negligent release and medical malpractice in the context of cases of violence by recently released psychiatric patients.

## The *Tarasoff* Case

In 1968, Prosenjit Poddar and Tatiana Tarasoff were students at the University of California at Berkeley. Poddar confided to a university health service psychologist that he intended to kill "an unnamed girl, readily identifiable as Tatiana (Tarasoff)" in response to her rejecting his romantic advances (*Tarasoff v. Regents of the University of California*, 1974, p. 554). The psychotherapist did not attempt to communicate the threat to Tarasoff or to her family. After a consultation with a supervising psychiatrist, the psychologist notified the campus police of the threat, and requested that Poddar be committed to a mental hospital for observation. Although police located and interviewed Poddar for possible commitment to a mental hospital, the officers believed that he was "rational" when he denied any potential for violence. The police warned him to stay away from Tarasoff. Poddar had no further contact with the police or any clinician at the university health service. After Tarasoff returned from a summer in Brazil, Poddar located Tarasoff and murdered her by stabbing her with a butcher's knife. Tarasoff's family then sued the campus police and the university health service, alleging in a negligence suit that the police should have held Poddar for commitment and that clinicians should have notified Tarasoff of his threats.

The issue before the California Supreme Court in *Tarasoff* was whether Poddar's therapist, after determining that his patient posed a serious threat of violence towards a foreseeable victim, had a duty to protect Tarasoff by warning her or others likely to apprise her of that danger (*Tarasoff v. Regents of the University of*

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*California*, 1976, p. 340). Upon rehearing in 1976, the court held that under California law, a duty did indeed exist:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of that danger, to notify the police or to take whatever other steps are reasonably necessary under the circumstances (p. 340).

This finding appeared to expand the therapist's duty to an unprecedented extent and to disagree with elements of tort law. The *Tarasoff* court admitted that California had been committed to the "fundamental principle" that only special relationships between parties determined the extent of their duties to each other. Others unrelated to that relationship had previously been outside of the parties' sphere of liability (*Rowland v. Christian*, 1968). Similarly, the ruling appeared to conflict with the general common law rule that one does not have an affirmative duty to protect others even if action is necessary to prevent harm (2 Restatement Torts 2d, 1965). Moreover, the Restatement of Torts itself does not appear to extend the duties established by an actor's special relationships unless the actor actually has "control" of the violent person, or is under a duty to exercise such control. In the therapeutic relationship, therefore, the "special relationship" exception to the general rule required that the therapist be able to, or should have the right to, control the patient before he or she could be held liable for the patient's conduct.

In determining when harm to a potential victim is foreseeable to a therapist, the court explicitly admitted that the essence of the therapeutic relationship makes it difficult for therapists to predict their patients' violent outbreaks (*Tarasoff v. Regents of the University of California*, 1976, p. 345). Nevertheless, the court reasoned that the therapist is, in predicting violence, expected to exercise that "reasonable degree of skill, knowledge and care ordinarily possessed and exercised [by therapists] under similar circumstances" (p. 345). In *Tarasoff*, the court concluded, the therapists did in fact predict that Poddar would kill, but neglected to give the proper warnings (p. 345).

The court's conclusion on the issue of the therapist's knowledge of the victim's identity assumed that, although Poddar did not specifically mention Tarasoff by name, the essence of his conversations with his therapist should have made Tarasoff the foreseeable victim of his violence. In so reasoning, the court broadly defined what types of information volunteered by a patient should cause a therapist to conclude that violence towards a specific victim is foreseeable. Although the court considered it necessary that the therapist be able to ascertain the identity of the potential victim before the duty to protect attached, the decision was very unclear as to how specific a patient must be in identifying a victim in order to impose the duty to protect on a therapist. Indeed the *Tarasoff* court refused to provide any clear or concrete rule on the issue, but rather simply opined that "there may be cases where a moment's reflection will reveal the victim's identity" (p. 342).

Aside from the obvious legal hurdles in extending a therapist's duty to protect, the *Tarasoff* court faced difficult policy decisions concerning the effects of its decision on the therapeutic relationship. The court's main concern was the probable chilling

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effect of its decision on the "open and confidential character of the psychotherapeutic dialogue . . . " (p. 347). To cause a therapist to disclose all threats of violence would seriously disrupt a patient's relationship not only with the therapist but also with the potential victim (p. 347). Nevertheless, the court reasoned, "The protective privilege ends where the public peril begins" (p. 347). Although Poddar had a confidentiality interest in the information that he voluntarily gave to his therapist, the court concluded that any public policy favoring protection of the confidential character of the therapeutic relationship "must yield to the extent to which disclosure is essential to avert public danger" (p. 346).

*Tarasoff* requires that therapists "exercise reasonable care to protect the foreseeable victim of . . . danger" once the possibility of violence is identified (p. 346). Consequently, after *Tarasoff*, a therapist is under a duty of reasonable care both in determining the forseeability of harm to a potential victim and in undertaking to protect the potential victim. However, the decision provided no further guidance as to what specific steps are necessary for a therapist to adequately discharge the duty beyond advising the potential victim, a close associate, the police, or ultimately "taking whatever other steps are reasonably necessary." Exactly how far a therapist is expected to go to ensure that a warning is adequately conveyed is a question that was essentially left unanswered. Consequently, courts interpreting *Tarasoff* have resorted to "*post-facto* guesswork" in determining not only whether a duty to protect existed in any particular case, but also whether therapists in those cases have taken appropriate precautions to protect potential victims (Geske, 1988).

## EXTENSIONS OF *TARASOFF*

In *Jablonski v. United States* (1983), the Ninth Circuit further broadened *Tarasoff's* ambiguous definition of foreseeability and offered a strict standard for the types of warning that will properly discharge a therapist's duty to protect. The *Jablonski* court held that specific threats are not the only indicator of foreseeability, but rather that a patient's history of violence towards a specific victim or class of victims may be sufficient (p. 398). Moreover, *Jablonski* moved beyond *Tarasoff* by suggesting that therapists must meet very strict warning standards in order to properly discharge their duty to protect.

This case concerned a wrongful death suit in which Jablonski, a psychiatric patient with a history of rape and homicidal ideation against both his girlfriend and her mother, murdered his girlfriend after release from a psychiatric hospital. Before the murder, Jablonski had sought psychiatric treatment at a California Veterans Administration facility for continuing violent thoughts toward his girlfriend and her mother. Jablonski's therapist diagnosed him with antisocial personality with explosive features and further described him as "potentially dangerous" (p. 393). During voluntary inpatient treatment, the therapist recommended to the girlfriend that she leave Jablonski for her safety. The girlfriend declined to leave him and continued contact with the patient. The therapist gave no further warnings to the girlfriend, believing that she would not listen to his advice despite her own fears for her personal safety. A contributing factor in this case was the therapist's failure to obtain previous psychiatric records, which established that Jablonski previously had homicidal ideation towards his wife and had on "numerous occasions" tried to kill

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her. Unaware of this relevant history, the therapist did not seek to involuntarily hospitalize Jablonski. Shortly after his release from the hospital, Jablonski killed his girlfriend (p. 394). The victim's daughter brought a malpractice suit against the hospital and the psychiatrists for their failure to protect the victim (p. 394). The victim's daughter filed suit against the hospital and the therapist for breach of duty to protect her mother from Jablonski's violence. The trial court ruled for the plaintiff. On appeal, the Ninth Circuit affirmed the lower court's decision in favor of the victim's daughter.

The *Jablonski* court, after carefully considering the issues of foreseeability and warnings, held that although Jablonski had never made specific threats towards his girlfriend during therapy, his history indicated that he would be likely to direct his violence towards her (p. 398). The court reasoned that Jablonski's history of violence to women close to him should have indicated to his therapists that he was a threat to both his girlfriend and her mother. The therapists had argued that they had adequately warned the girlfriend by repeatedly suggesting that she avoid him during treatment, but the court affirmed the District Court's findings that the warnings were "totally unspecific and inadequate under the circumstances" (p. 398).

In its ruling, the *Jablonski* court essentially reshaped the *Tarasoff* holding by expanding the definition of foreseeability. The *Jablonski* case represents the concept that a history of violent behavior can reveal a threat of danger that will be sufficient to indicate the foreseeability of harm to a particular victim or even class of victims. Illustrative of this concept are cases from Arizona, Nebraska, North Carolina, and Wisconsin. In Arizona, a state appellate court found that a foreseeable victim was one who is "within the zone of danger... [and] subject to the probable risk of the patient's violent conduct" (*Hamman v. County of Maricopa*, 1989). In a 1986 North Carolina case, a federal court found that limiting a defendant's duty to readily identifiable victims represents an "overly restricted view of foreseeability" (*Currie v. United States*, 1986). In *Lipari v. Sears, Roebuck and Co.* (1980), a federal district court in Nebraska found that, under Nebraska law, a therapist has a duty to protect anyone foreseeably endangered by a patient. Perhaps the most expansive interpretation of a therapist's duty to protect came in a 1988 Wisconsin case, *Schuster v. Altenenberg*. The court held that where a duty to protect existed, the therapist was potentially liable for any harm that occurred, regardless of foreseeability. However, in a trial on the facts in which one of this article's authors (JCB) was an expert witness for the defense, the jury did not find liability and thus returned a verdict for the defendant (Beck, personal communication).

There are contrasting decisions that have offered more restricted interpretations of *Tarasoff*. These courts will recognize a therapist's duty to protect only in cases of specific threats to a specific victim. Limitations of the *Tarasoff* foreseeability concept began in the California Supreme Court, with a case not involving mental health but rather the juvenile detention system, *Thompson v. County of Alameda* (1980).

In *Thompson*, a juvenile delinquent murdered a child after release from a county juvenile detention facility. Before release, the juvenile indicated that he would, upon release, kill a small child in his neighborhood (p. 730). In refusing to recognize that the county's juvenile facility staff had a general duty to warn the neighborhood of the danger the juvenile posed, the court reasoned that such generalized warnings would be difficult, overly time consuming, and therefore ultimately ineffective (p. 737).

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Concerned with creating an affirmative duty to warn such a "large, amorphous public group of potential targets," the court drew limits on California's increasingly broad construction of the *Tarasoff* duty by refusing to recognize a duty to protect where a patient makes "non-specific threats of harm directed at non-specific victims" (p. 737). The *Thompson* court suggested that therapists should be under no duty to protect the public at large when patients make generalized threats (p. 737).

Although a number of states began to follow *Thompson's* requirements for predictable threats before liability would attach, even under this standard some states have interpreted the specific threat requirement to render it essentially meaningless. In *Davis v. Lhim* (1983), the Michigan Court of Appeals reviewed the case of a schizophrenic patient who killed his mother after receiving voluntary psychiatric treatment at a hospital. While receiving inpatient psychiatric care, the patient never specifically threatened his mother or voiced any general threats of violence towards her. Nevertheless, the court found that since the patient had "pace[d] the floor, and act[ed] strangely and [kept] threatening his mother for money," his threats were not directed to the general public, but rather towards a specific person, as in *Tarasoff* (p. 490). Therefore, the therapist had a duty to protect the patient's mother by warning her of the danger he posed towards her. In support of its decision, the court considered the patient to have clearly directed a serious threat towards his mother because "[w]hen Patterson (the patient) entered [the hospital] for the last time before the shooting, the hospital records reveal[ed] that he had no money with him. Presumably he would continue to need money after his release and would have the same motivation to threaten his mother" (p. 490). The Michigan Supreme Court later overturned this case opinion when the court re-examined the issue of governmental immunity in the 1988 case *Canon v. Thumudo*.

## LIMITATIONS OF *TARASOFF*

In the late 1980s through the 1990s, several courts have either rejected or greatly limited *Tarasoff*'s applicability in their jurisdictions. Courts that have explicitly rejected *Tarasoff* have done so by asserting that the decision misinterpreted fundamental tort law relative to an actor's duty to third parties. Other courts have refused to apply *Tarasoff* by either explicitly or implicitly dismissing the decision as non-binding authority. Some courts have also refused to impose a *Tarasoff* duty where patients are hospitalized voluntarily. Finally, others that have accepted *Tarasoff* as legally binding have curtailed its impact by recognizing that the victim's prior knowledge of the patient's potential for violence will relieve a therapist of the duty to protect.

Several state courts have found significantly limited scope of circumstances under which a therapist's duty to protect might be triggered. In a 1992 Iowa case, the Iowa Supreme Court refused to acknowledge any clinician's duty to protect the general public (*Leonard v. Iowa,* 1992). In this case, a man who had been diagnosed with bipolar disorder, and alcohol abuse and who had a history notable for violence was involuntarily hospitalized and treated for 24 days. He was released into the community when his psychiatrist thought he was psychiatrically stable. Two weeks

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later, he kidnapped and assaulted a coworker. After a criminal court convicted the patient of attempted murder, the victim filed suit against the hospital. The Iowa Supreme Court found that his clinicians had discharged him negligently, but the court also found that the duty to control the patient applied only to "reasonably foreseeable victims" and not to the public at large.

Florida, Virginia, Mississippi, Texas and South Carolina have either explicitly or implicitly rejected the *Tarasoff* doctrine of a duty to protect (*Boynton v. Burglass*, 1991; *Nasser v. Parker*, 1995; *Evans v. US*, 1995; *Sharpe v. South Carolina Dept of Mental Health*, 1987; *Thapar v. Zezulka*, 1999). Among these states, the Florida Court of Appeals in *Boynton v. Burglass* (1991) provides the most persuasive arguments against recognizing a *Tarasoff* duty to protect. In this case, Lawrence Blaylock, while under the outpatient psychiatric care of the defendant therapist, shot and killed Wayne Boynton. Boynton's family sued the psychiatrist, alleging that the therapist "knew, or in the exercise of reasonable due care should have known that prior to May 13, 1986 [Blaylock] had threatened serious harm to [Boynton]" and, despite this knowledge, failed "to warn Boynton, Boynton's family or the police that Blaylock was violence-prone and had threatened serious harm to Boynton ... " (p. 447).

Without analysing the specifics of what the therapist knew or should have known about his patient, the court refused to apply *Tarasoff*, "reject[ing] [its] 'enlightened approach.'" The court reasoned that the field of psychiatry is too complicated and fraught with uncertainty and unpredictability for a court to impose liability based on a defendant's failure to control patients. To do so, the court explained, would be to "embark upon a journey that 'will take us from the world of reality into the wonderland of clairvoyance.'" (p. 447). The court asserted that psychiatry is an "inexact science," "represents the penultimate gray area ... particularly in regard to issues of foreseeability and predictability of future dangerousness" (p. 447).

In rejecting *Tarasoff's* underlying legal justifications, the *Boynton* court held that the *Tarasoff* decision misunderstood the "special relationship" exception to the general rule that a person owes no duty to control the conduct of another person (p. 448). The "special relationship" was premised on the recognition that the person on whom the duty is to be imposed has the ability to control the other person, in this case, the patient. The *Tarasoff* decision, the *Boynton* court concluded, did not address the crucial issue of a therapist's control over the patient. Rather, the California Supreme Court "simply opined that 'such a relationship may support affirmative duties for the benefit of third persons'" (p. 449). The *Boynton* court concluded, that, because there was no evidence that the therapeutic relationship between Blaylock and his therapist contained any element of control, the case did not meet the exception to the common law rule (p. 449).

The *Boynton* court also rejected *Tarasoff* for policy reasons. The court was mainly concerned that imposing a duty to protect third parties would require a therapist to foresee harm depending on "the clarity of his crystal ball" (p. 450). Moreover, the resulting burden on therapists charged with accurately making predictions and sharing them with others would not only be unreasonable and unworkable, it would also "wreak havoc with the psychiatrist–patient relationship" and "severely hamper, if not destroy, the relationship of trust and confidence that is crucial to the treatment of mental illness" (p. 450).

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In a somewhat similar fashion in a case in which clinicians had treated on a voluntary basis a man with a history of violence towards women, the Virginia Supreme Court rejected the concept of a "special relationship" in *Nasser v. Parker* (1995). This case concerned a suit for damages brought by the father of a woman shot to death by a psychiatric patient recently released from an inpatient hospital. The victim's boyfriend both had a history of violence towards women and had threatened to kill the victim who rejected him. He was voluntarily psychiatrically hospitalized for one day and then signed himself out of the hospital. Upon release, the boyfriend's psychiatrist did not warn the girlfriend even though he knew of the recent threat. Six days later the boyfriend shot his girlfriend to death. The suit alleged that there was a special relationship between the patient and the doctor that would create a duty to prevent physical harm to the victim. The *Nasser* court assessed whether one has a duty to control the patient's conduct toward a third person. The court rejected the *Tarasoff* "duty to warn" as the court believed that the voluntary inpatient–physician relationship is insufficient to create such a duty (p. 505).

In Mississippi, a federal district court ruled that absent a specific state statute establishing a *Tarasoff* duty to protect, no such duty existed. This case, *Evans v. United States* (1995), concerned a wrongful death suit brought by the mother and brother of a woman killed by her father, a Vietnam veteran. The patient had received inpatient and outpatient psychiatric treatment for serious emotional and psychiatric problems. The plaintiffs alleged that the doctor was liable for the daughter's death due to an alleged failure to warn the victim and failure to notify the police. The *Evans* court noted that Mississippi law was "silent" on the subject of the *Tarasoff* duty at the time of the murders. The court dismissed the suit, writing that, although *Tarasoff* is the law in California, "the plaintiff cited no authority that this decision represents the law in Mississippi" (p. 129).

In South Carolina, courts have refused to acknowledge that a *Tarasoff* duty exists. In *Sharpe v. South Carolina Department of Mental Health* (1987), the estate of a deceased man and his friend brought suit against the psychiatrist of a patient who fired a shotgun at the two men who were repairing a car next to the trailer in which a former mental health patient lived. The patient had a history of six years of psychiatric treatment. Several months before the incident, the patient received voluntary inpatient psychiatric treatment; he was treated and released after twice requesting discharge. The plaintiff alleged that the doctor was negligent in releasing the patient and in failing to warn the community. The trial court found for the defendants and dismissed the case. On appeal, the Court of Appeals for South Carolina upheld the trial court's ruling. The *Sharpe* court explicitly stated that South Carolina has not recognized a duty to warn of the dangerous propensities of others (p. 780). The court also distinguished this case from *Tarasoff* in that no identifiable threats were made to the decedent prior to the violent act.

The most recent rejection of the duty to warn was established by a 1999 Texas case, *Thapar v. Zezulka*. In this case, Freddy Ray Lilly was a psychiatric patient who received treatment from Dr. Thapar for three years for diagnoses of severe post-traumatic stress disorder, alcohol abuse, and paranoid and delusional beliefs concerning his step-father, Henry Zezulka. During the last of six inpatient psychiatric hospitalizations under Dr. Thapar's care, Lilly disclosed that he "feels like killing" his stepfather. The psychiatrist also wrote that the patient "has decided not

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to do it, but that is how he feels." Tharpar did not notify Zezulka or the police of the threat. Within one month after release from the hospital, Lilly killed his stepfather. Lilly's mother then sued Thapar for wrongful death, first alleging that Thapar owed a duty not to negligently diagnose or treat a patient when that negligence caused harm to a third party. Secondly, the plaintiff also argued that Thapar owed a duty to warn third parties of Lilly's threats. In pretrial proceedings, the court granted summary judgment for dismissal after it accepted the defendant's argument that Thapar had no treatment relationship with, and thus no duty to, Zezulka. On appeal, an intermediate appellate court reversed the summary judgment. On further appeal, the Texas Supreme Court affirmed the trial court's summary judgment for the defendant. The *Thapar* court rejected the plaintiff's first argument, citing Texas case law (*Bird v. W.C.W.*, 1994) that a therapist owes no duty to third parties for negligent diagnosis or treatment. In evaluating the plaintiff's second argument, the *Thapar* court considered the 1979 Texas statute governing patient confidentiality which created an exception that permitted discretionary disclosure of a patient's threat only to law enforcement, not to potential victims (Tex. Health & Safety Code Ann, §611.004). The court reasoned that disclosure of Lilly's threat to Zezulka would have violated the state confidentiality statute. The Texas Supreme Court thus concluded that therapists who make warnings to third parties on reasonably breached confidentiality are not shielded from liability for such disclosures whether or not made in good faith. The *Thapar* court thus refused to acknowledge any duty to warn third parties of patients' threats.

Other jurisdictions have accepted the general concept of a *Tarasoff* duty, but have limited its significance by recognizing exceptions to the *Tarasoff* duty. *Tarasoff* did not address the relevance of the victim's prior knowledge of a patient's violence as a defense or an exception to the duty to protect (*Tarasoff v. Regents of the University of California*, 1976, p. 334). Indeed, the facts in *Tarasoff* did not indicate that the victim was aware of Poddar's violent intent, so the issue of prior knowledge was not before the *Tarasoff* court. More recent interpretations of *Tarasoff* in other jurisdictions have held that the victim's prior knowledge of a patient's violent tendencies will relieve a therapist of the duty to protect third parties. In a 1989 case, *Jacobs v. Taylor*, police arrested a voluntary psychiatric hospitalized patient in Georgia for making "terroristic threats" against his former wife. He later murdered her and others after release from the hospital (p. 563). The therapists never warned the patient's ex-wife of his threats. The victim's children brought suit against the therapists claiming, in part, that the therapist breached a duty to protect the victim from the patient's violence.

In determining that the defendant therapists did not have a duty to protect the patient's ex-wife from his threats by notifying her of the threats, the Georgia Appeals Court considered it critical that the patient's ex-wife was fully cognizant of his threats (p. 565). The court noted that the ex-wife had filed criminal proceedings against her former husband due to his threats against her. In deciding that such knowledge relieved the defendants of the duty to protect via communicating a warning, the court admitted that the therapists at one point in time may have had a duty to communicate the threat to the victim concerning the danger the patient posed to his ex-wife. Nevertheless, the victim's own knowledge of that precise danger, once acquired, "absolved the doctors of any liability in their failure to warn her" (p. 568).

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Several other jurisdictions that have accepted *Tarasoff* have also held that therapists are simply relieved of the duty to warn victims of what they already knew or should have known without referring to either proximate cause or contributory negligence issues. Examples of this recent trend come from North Carolina and Kansas. In a 1990 case, *Moye v. United States*, the estate of the patient's father brought suit for negligence after Moye murdered his parents. Moye had received psychiatric treatment from a Veterans Administration Hospital for drug dependency, personality disorder, and paranoia until his doctors determined that he was not benefiting from treatment. The patient then sought voluntary treatment at a private psychiatric facility and was discharged for non-compliance. Although the parents were well aware of their son's potential for violence, they took the patient home and refused the doctor's offer of psychiatric medication. When suit was brought against the Veterans Administration, the federal district court for North Carolina ruled that "assuming *arguendo* that [the duty to warn] exist[s], the duty [does] not arise where the foreseeable victim [knows] of the danger associated with the patient . . . " (p. 181). In addition, the court found that the doctor never had a duty to control Moye since he was always admitted to the hospital on a voluntary status (p. 182).

In a 1995 Kansas case, *Boulanger v. Pol*, a patient with a history of physical and mental disabilities, as a result of brain injury, assaulted his uncle. The patient had been hospitalized on three occasions on a voluntary basis. Ten days after he was released from an extended psychiatric hospitalization, the patient shot his uncle with a shotgun. The uncle brought suit against the doctor, alleging negligent release, failure to warn, and failure to control (involuntarily commit) the patient. Both the defendant psychiatrist and amicus curiae argued that a therapist does not have the requisite control over a voluntary patient that would establish the imposition of a duty to control. A trial court granted summary judgment for the defendant. Upon appeal, the Kansas Supreme Court arrived at a finding that the "defendants had no duty to warn plaintiff of what he already knew" where evidence illustrated that the plaintiff (victim) was fully cognizant of the patient's feelings towards him and the patient's propensity for violence (p. 835). In addition, the *Boulanger* court agreed with the defendant's assertions that as a voluntary patient, the defendants lacked the control that would be necessary to establish a duty under the Restatement of Torts (p. 835).

An Alabama court relieved therapists of the duty to protect by adopting a restrictive view of the "special relationship" that generally must exist between the psychiatrist and patient before the duty attaches. In *King v. Smith* (1989), the Supreme Court of Alabama reviewed whether a psychiatrist who had what the court determined was "minimal personal contacts" with his patient was under a duty to protect third parties from the patient's violence (p. 262). In this case, a psychiatrist involuntarily committed David King to a psychiatric ward after he threatened to kill one of his daughters. Dr. Smith, the psychiatrist who conducted the initial psychiatric evaluation, diagnosed alcohol abuse and mild mental impairment. After discharge, King attended six voluntary outpatient sessions supervised by Dr. Smith. Subsequently, he tried to poison and shoot his family. Later, while attending an outpatient alcohol rehabilitation program also supervised by Dr. Smith, King killed both of his daughters and himself. The decedent's family sued, claiming that Dr. Smith owed a duty to provide proper treatment and care to King. Dr. Smith's failure

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to discharge this duty to protect King's family allegedly resulted in foreseeable violence (p. 263).

The *King* court rejected the plaintiff's arguments, adopting a conservative view of the special relationship required in order for the duty to protect to attach. The court ruled that Dr. Smith's therapeutic relationship with King consisted of "minimal personal contacts . . . especially in view of the outpatient character of their relationship." Thus, the court concluded, the therapeutic relationship in this case did not rise to the level necessary to establish Dr. Smith's duty to protect King's daughters from his violence (p. 264).

Courts have also been reticent to attribute *Tarasoff* duties to non-mental health medical personnel. Examples of this trend include two 1987 Michigan cases that found no *Tarasoff* duty for primary care physicians or for emergency room physicians (*Paul v. Plymouth General Hospital*, 1987; *Hinkelman v. Borgess Medical Center*, 1987).

Courts have also further narrowed the *Tarasoff* duty, to protect only specific victims and only in cases where the victim did not have specific prior knowledge. In a somewhat unusual case, *Adams v. Elgart* (1995), a New York appellate court examined whether a nurse injured by a violent patient could sue the patient's physician for negligence and breach of duty to warn. In this case, a patient received treatment in the medical–psychiatric inpatient ward of a hospital for delirium tremens. The patient exhibited violent behavior twice during three days and attacked and injured his nurse. Staff notified the patient's physician of each attack. The nurse, who was injured in an attack, filed suit against the patient's physician, arguing that the physician owed her a warning of the patient's violent behavior and that the physician was negligent in not transferring the patient to an inpatient psychiatric ward. The *Adams* court refused to impose a duty on the doctor to the patient, stating "a defendant generally has no duty to control the conduct of third persons as to prevent them from harming others, even where as a practical matter defendant can exercise such control" (p. 638). The court held that public policy required a finding that the doctor owed no duty to the public at large or to the plaintiff in particular to control the patient. The court also found that the location for the patient's treatment of a patient with delirium tremens was appropriate for the medical–psychiatric ward. The *Adams* court also rejected the imposition of a duty to warn given the plaintiff's knowledge of the patient's violence since she had communicated his assaultive behavior to the physician (p. 638).

Another example of courts limiting the creation of *Tarasoff* duty comes from a recent 1999 Maryland case, *Falk v. Southern Maryland Hospital, Inc.* In this case, a paranoid schizophrenic, drug-abusing patient was hospitalized on an inpatient psychiatric unit. Without any known prior threat or aggression, he assaulted another patient, who died of her injuries. The decedent's estate filed suit against the hospital and the assailant's psychiatrist, alleging that they had failed to properly supervise the other patient and had not protected the decedent from harm. Maryland courts previously had not held psychiatrists responsible for a patient's attack on an unforeseeable victim (*Furr v. Spring Grove State Hospital*, 1983). Prior to the instant case, Maryland had created a duty to protect based on a statute codifying *Tarasoff* (Maryland Annotated Code, §5-315). The trial court granted summary judgment to the psychiatrists, finding that the plaintiff failed to state a valid claim under state law. On appeal, the intermediate appellate court found that the meaning of the statute

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indicated that a duty to protect could not be imposed absent the assailant making a specific threat to inflict injury on a victim or group of victims or absent the defendant's knowledge of the patient's propensity for violence. On these grounds, there was no imposition of a *Tarasoff* duty to unforeseeable victims.

In addition to the decline in the significance of *Tarasoff* as suggested by the cases discussed above, there is empirical evidence of the declining importance of *Tarasoff* as a principle of law. Recently, there have been very few cases where there have been verdicts for the plaintiff in outpatient cases (*Boynton v. Burglass*, 1991; *Sharpe v. South Carolina Department of Mental Health*, 1987; *Hinkelman v. Borgess Medical Center*, 1987). Further evidence of the declining significance of *Tarasoff* comes from the fact that among the malpractice cases reported to the APA-sponsored malpractice insurance program, duty to protect cases no longer appear on the list of the most common causes of action against psychiatrists (American Psychiatric Association Professional Liability Insurance Program, 1994). However, the decline could also reflect the growing awareness by psychiatrists for this duty and taking appropriate measures.

One recent North Carolina case initially ran counter to the limitations of *Tarasoff* trend until a state appellate court reversed a jury verdict. In the case of *Williamson v. Liptzin* (2000), a psychotic college student was treated for his psychosis by a psychiatrist through the college's student health service. The psychiatrist, Dr. Liptzin, was retiring from practice at the conclusion of the academic year and had counseled his patient, Wendell Williamson, to continue his psychiatric treatment with either his replacement at the student health service or through a community mental health center near his parents' residence. At the conclusion of the academic year, Williamson returned to live with his parents and discontinued his psychiatric mediations and treatment. Williamson returned to college, and completed another semester without re-starting his psychiatric treatment. After the completion of the fall semester, Williamson returned to school but did not attend classes. He lived in his car and to began to collect a gun and ammunition. Eight months after terminating treatment with Dr. Liptzin, Williamson shot and killed two unarmed strangers in his college town. Police disabled Williamson by wounding him in the legs for which Williamson had surgery. A trial court found Williamson not guilty by reason of insanity on two counts of first degree murder and ordered him committed to a North Carolina forensic facility.

Williamson filed suit against Liptzin in 1997, alleging that the psychiatrist had been negligent in providing psychiatric treatment and that this negligence caused him to be shot in the legs, to endure a murder trial and to be confined indefinitely to a mental institution. Before the trial, Liptzin moved for summary judgement and the court denied the motion. The case was then tried before a jury. At the conclusion of the presentation of the plaintiff's evidence, the court again denied a defense motion for a directed verdict. The jury determined that Williamson was damaged by Liptzin's negligence and that Williamson was not contributorily negligent. The trial court awarded $500,000 to Williamson. Liptzin then appealed to the trial court and subsequently to the North Carolina appelate court. The North Carolina Court of Appeals noted that expert testimony presented at trial "established what was merely possible and not what was reasonably foreseeable" (pp. 12–13). The appeals court found "the defendant's alleged negligence was not the proximate cause of the plaintiff's injuries" (p. 16). Thus the appeals court reversed the trial court's denial

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of a judgement notwithstanding the verdict and remanded the case to the trial court. Although this case was not truly a *Tarasoff* case but rather a negligent termination of treatment case, the appellate court's findings were congruent with other courts' increasingly limited interpretations of foreseeability of harm.

## FURTHER APPLICATIONS OF *TARASOFF*

Early cases invoked *Tarasoff* to attribute liability for the damage caused by negligent drivers with histories of treatment for a mental illness. In a case before the Washington State Supreme Court, *Petersen v. Washington* (1983), the issue of unintentional but foreseeable injury to potential victims was placed before the court. A man with a history of reckless driving and drug-induced psychotic disorder was hospitalized for treatment of his psychosis. His psychosis gradually cleared and the treating psychiatrist scheduled him for release. One day before his release while driving, hospital security stopped and cited him for reckless driving. Although the psychiatrist considered this information, the treatment team decided that he did not continue to meet criteria for involuntary commitment and released him from the hospital. Five days after release, while intoxicated, the patient drove recklessly and his car collided with another, injuring the other driver. In following the logic of the *Lipari* case, the *Petersen* court found that the doctor had not fulfilled his duty to protect others who may be foreseeably endangered by the patient even if the nature of the harm was unintentional.

In a 1988 case before the Delaware Supreme Court, *Naidu v. Laird*, the court used logic similar to that in *Lipari* and *Petersen*. In this case a court ascribed a failure of the therapist's duty to protect when a psychiatric patient was involved in an unintentional, negligent injury involving an automobile. This case is also notable for the substantial delay, five and one half months, between the last treatment encounter and the injury.

On the other hand in 1991, a Utah court, when faced with a similar case, rejected the acknowledgement of a *Tarasoff* duty under these circumstances. In this case, a patient who had been diagnosed with schizoaffective disorder escaped from an inpatient ward, stole an automobile, and struck and killed another motorist while fleeing from police. Reasoning that the hospital could foresee neither the patient's driving nor the harm to the killed motorist, the court did not find any liability for the hospital defendant (*Rollins v. Petersen*, 1991).

Several commentators in the forensic psychiatric community expressed concern with the use of a *Tarasoff* theory to hold clinicians liable for patient's driving associated violence (Pettis & Gutheil, 1993). In response to these concerns, the APA responded with an official statement on assessing driving ability. The APA asserted that this issue is not a psychiatric issue and rather is the proper concern of drivers' license bureau (American Psychiatric Association, 1995).

Another unusual case involved the question of whether a *Tarasoff* duty to warn the sex partners, hence persons at potential risk, of a patient known to be HIV positive. In *Reisner v. Regents of the University of California* (1995), the California Supreme Court heard a case in which a woman, exposed to HIV-contaminated blood, later infected her male partner. When the male partner brought suit against her physicians, the court found that the physicians were negligent in not notifying

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the transfusion patient of her HIV exposure, so that she could subsequently notify her male partner. Although not a clear extension of a *Tarasoff* duty to a third party, this case touches on some of these issues. There is significant variation among state laws with respect to notification to third parties at potential risk for HIV infection (Rosmarin, 1990). The APA and the AMA have both taken the position that it is ethically permissible to make such disclosures to either a victim or to a public health authority, barring state law prohibiting such a disclosure (American Psychiatric Association, 1988; Council on Ethical and Judicial Affairs, 1988).

Three recent California cases reflected a new facet of the duty to warn—compelled testimony in murder cases after *Tarasoff* warnings were issued (*California v. Clark*, 1993; *California v. Wharton*, 1991; *Menendez v. Superior Court*, 1993). These cases are not central to studying the evolution of *Tarasoff* but rather represent a complex ancillary issue. Other commentators have discussed the novel clinical and ethical facets of these cases at length (Leong, Eth, & Silva, 1991, 1992, 1994a, b). While not yet accepted by any state other than California, these cases have led commentators to question whether or not a *Miranda*-like warning concerning the criminal justice ramifications of third party warnings should be given to potentially violent patients (Leong, Silva, & Weinstock, 1989).

## ADVENT OF STATE STATUTES FOR CODIFYING THE *TARASOFF* DUTY AND ITS DISCHARGE

In response to clinicians' concerns in the late 1970s and early 1980s over a seemingly ever-expanding scope of the *Tarasoff* duty, mental health associations in some states became involved in legislative responses to this legal problem. State mental health professional societies began to lobby for the passage of laws which clearly establish what conditions create a duty to protect and what measures should be taken to discharge this duty. In 1987, the APA also became involved in this legislative advocacy. The APA Council on Psychiatry and the Law issued a model duty-to-protect statute for use in advocating the creation of *Tarasoff* limiting laws (Appelbaum *et al.*, 1989). To date, at least 22 states have legally codified the therapist's duty to protect and outlined the discharge of that duty (see the appendix).

State *Tarasoff* limiting statutes limit the duty to protect to specific victims and limit liability to therapists once the duty is discharged. In most statutes, the duty to protect arises only after one of two conditions is met. First, the patient explicitly threatens a named or otherwise clearly identifiable victim. Second, if the patient makes no explicit threat, but has a history of violence and there is very good reason to believe that the patient will commit serious violence, this may also trigger a duty. The therapist satisfies the duty by warning the potential victim or appropriate authorities, or by hospitalizing the patient either on a voluntary or involuntary basis. All statutes immunize therapists against suit for breach of confidentiality when the therapist makes a good faith warning. Three states' statutes (California, Colorado, and Washington) require the therapist to warn both the potential victim as well as the police. When a statute provides a variety of options from which the clinician may choose, some commentators have argued that the best practice is to do what is clinically prudent, including exercising more than one option if a single option is

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insufficient to protect a potential victim from violence (Anfang & Appelbaum, 1996). The state statutes which codify *Tarasoff* duties are welcome, as they limit the likelihood of the extension of *Tarasoff* into cases where courts considerably expanded the scope of *Tarasoff*.

## ADVICE TO CLINICIANS

When asked to perform forensic consultation to colleagues in various settings, we frequently encounter clinicians who are very concerned about the legal (and specifically, malpractice) implications of their cases in which there is a threat or potential for a patient's violent behavior. In counseling our colleagues, it has been useful to re-orient the consultation to clinical issues. Clinicians should address potential violence as primarily a clinical rather than a legal issue. Other commentators have also emphasized this approach (Felthous, 1999). The core of evaluating the clinical issue is a thorough exploration of any threat or potential of violence and documentation in the clinical record. In addition to the exploration of threats, eliciting a relevant history of violence, including exploration of previous clinical records, is clearly important. Although there is not yet a specific standard for the prediction of violence, there are very good tools available to the clinician for assessment of risk of violence (Monahan, 1993; Monahan & Steadman, 1994). As one of this article's authors articulated, while there is no standard for prediction, there is a standard for assessment of dangerousness (Beck, 1985a). If litigation ensues, clinicians should be aware that the primary determinants in a malpractice case would likely be the quality and thoroughness of their assessment of risk of violence rather than whether their prediction was accurate.

Another very important consideration in the management of potentially violent patients is the need to communicate openly and directly with the patient about the clinical concerns for the potential for violence. Commentators have suggested that discussing clinical concerns with the patient and involving the patient in the notification process may actually have the therapeutic effect of strengthening the clinician-patient alliance (Wulsin, Bursztain, & Gutheil, 1983). Several commentators have stressed that when the clinician and the patient agree that a warning is appropriate, it is constructive for the clinician to warn with the patient present. An effort to avoid surprising patients in relation to third party warnings is good clinical practice. In addition, the clinician should make the minimal disclosure necessary to convey the warning.

The more concern there is for violence, the more complete the documentation should be. We counsel clinicians to write a careful and complete mental status examination and to include direct quotes from the patient. We encourage clinicians to explain their choices in writing and to document why they chose one option over another. If there is a conflict between clinical judgment and a lawyer's advice, the clinician should rely on clinical judgment. If in doubt about clinical judgment, the clinician should seek consultation from a colleague or forensic professional. We encourage every clinician to know the law in his or her jurisdiction. More specifically, clinicians should know whether there is a duty to protect foreseeable victims from a patient's violence by virtue of either a statute or case law. With

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respect to political action, if the clinician practices in a state that does not have a *Tarasoff* limiting statute, it can be useful to work with a local medical society to try to get one written and passed.

## CONCLUSION

This article has described the establishment of the clinician's duty to protect third parties from violence that was established in the 1976 landmark case of *Tarasoff v. Regents of the University of California*. Since the establishment of this duty, courts initially adopted and dramatically expanded the scope of a clinician's duty to protect. Concurrent with this expansion was the adoption of *Tarasoff*-like duties to parties in a variety of unusual and often ill conceived ways. There has been a discernable trend over the past 15 or so years gradually to limit the scope of a clinician's *Tarasoff* duty. Courts have taken more critical views of the degree of control that a therapist may have over a patient, resulting in less liability in some states for outpatient's acts of violence. Concurrent with this general trend has been the establishment of state statutes that explicitly codify the *Tarasoff* duty and the discharge of this duty. The effect of these statutes has been to limit the duty and insulate clinicians from liability. In our opinion, these statutes are a welcome addition to the evolution of *Tarasoff*, as they reduce the likelihood of expansive interpretations of the *Tarasoff* duty.

The legal analysis presented in this article shows a demonstrable legal trend toward the limitation, and at times the rejection, of *Tarasoff* duties in many states. Negligent release may continue to play an important role in malpractice litigation, as it should. However, this issue is independent of the *Tarasoff* duty. Finally, we argue that the assessment and prediction of the risk of violence are clinical issues. Any legal considerations should be less salient and should not play a role in critical decision making.

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# APPENDIX

The following is an alphabetized list of the relevant citations of each state with a *Tarasoff* law.

Alaska Statutes, §08.86.200
Arizona Revised Statutes Annotated, §36-517.02
California Civil Code, §43.92
Colorado Revised Statutes, §13-21-117
Florida Revised Statutes, §455.2415
Idaho Code §6-1901 to 1904
740 ILCS 110/11
Indiana Statutes Annotated Code, §34-4-12.4
Kentucky Revised Statutes Annotated, §202A.400
Louisiana Revised Statutes Annotated, §9.2800.1-2.
Maryland Annotated Code, §5-315
Ma§achusetts General Laws, Ch.112, §129A; Ch. 123, §36B
Michigan Compiled Laws, §946
Minnesota Statutes, §148.975-976.
Mi§i§ippi Code Annotated §41-21-97
Montana Code Annotated, §27-1.
New Hampshire Revised Statutes Annotated, §329.31.
New Jersey Statutes Annotated, §2A.62A-16.
Ohio Revised Code Annotated, §5122.34
Tenne§ee Code Annotated, §33-10-302
Utah Code Annotated, §78-14a-202
Virginia Code, §54.1.2403.2
Washington Revised Code, §71.05.120(2)

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