

# Expanded Liability for Psychiatrists: *Tarasoff* Gone Crazy?<sup>1</sup>

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## INTRODUCTION

The *Tarasoff*<sup>3</sup> decision has been branded “one of the most significant developments in medico-legal jurisprudence of the past century”.<sup>4</sup> For the first time, a court held that psychotherapists have a duty to protect third parties from patients who pose a serious danger of violence to others.<sup>5</sup> That ruling of the Supreme Court of California has generated a great deal of litigation and controversy. Decision-makers and commentators remain divided on the wisdom and proper application of *Tarasoff*.<sup>6</sup> The decision continues to be the subject of significant debate both within the United States and abroad.

This paper is intended to serve as an update for psychiatrists on notable developments of the *Tarasoff* doctrine in the United States and United Kingdom. Most clinicians will be familiar with the basic *Tarasoff* doctrine. However, the author suspects that many clinicians will be troubled to learn the extent to which *Tarasoff* liability has extended in some jurisdictions.

Accordingly, the first part of this paper addresses notable judicial treatment of *Tarasoff* in several state jurisdictions within the United States. The second part discusses the more conservative approach of the United Kingdom, which affords clinicians discretion to warn potential victims in certain circumstances. The United Kingdom has struggled with, and so far rejected, the imposition of a *Tarasoff*-duty. However, a recent decision of the European Court of Human Rights opens the door for something comparable to *Tarasoff* in the United Kingdom.<sup>7</sup> The final part offers a critique of the *Tarasoff* doctrine and suggests that other jurisdictions, including the United Kingdom, may be wise to avoid this problematic doctrine.

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1 The author acknowledges the support of the Canadian Institutes of Health Research, which has made research into the subject-matter of this article, possible.

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3 *Tarasoff v Regents of University of California* (1976) 551 P2d 334 [*Tarasoff*].

4 Thomas Gutheil, “Moral Justification for *Tarasoff*-Type Warnings and Breach of Confidentiality: A Clinician’s Perspective” (2001) 19 *Behav. Sci. Law* 345 at 345.

5 Alan Stone, “The *Tarasoff* Decisions: Suing Psychotherapists to Safeguard Society” (1976) 90 *Harvard Law Review* 358 at 358.

6 Ann Hubbard, “The Future of ‘The Duty to Protect’: Scientific and Legal Perspectives on *Tarasoff*’s Thirtieth Anniversary” (2006) 75 *U. Cin. L. Rev.* 429 at 429.

7 *Osman v UK* [1999] 1 FLR193. See Colin Gavaghan, “A *Tarasoff* for Europe? A European Human Rights perspective on the duty to protect” (2007) 30 *International Journal of Law & Psychiatry* 255 at 256.

## PART ONE: THE UNITED STATES

Before considering the development of the *Tarasoff* doctrine, it is worth briefly revisiting some key aspects of the *Tarasoff* judgment.

### A duty to protect

Mental health professionals worldwide will be familiar with the protective duty fashioned by Tobriner J in *Tarasoff*:

*Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.*<sup>8</sup>

Essentially, the *Tarasoff* Court weighed the public interest in confidentiality and effective treatment of mental illness against the public interest in safety from violent assault.<sup>9</sup> The majority concluded: “The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins”.<sup>10</sup> The majority’s rationale for creating the protective duty was: “In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal”.<sup>11</sup> Thus, the duty was created to protect third persons from serious harm caused by dangerous patients.<sup>12</sup>

### The “special relationship”

It is noteworthy that the duty of care found to exist in *Tarasoff*, and which is central to the Court’s conclusion, is exceptional to the common law. It is a general rule of the common law that one does not owe a duty to control the conduct of another, or to warn those endangered by such conduct.<sup>13</sup> At common law there is no general duty to prevent others from suffering foreseeable loss or damage caused by the deliberate wrongdoing of third parties.<sup>14</sup> For example, there is no legal obligation on a bystander to intervene to prevent a murder. The fundamental reason is that the common law is reluctant to impose liability for “pure omissions” to act.<sup>15</sup> Nonetheless, some exceptions have been carved out of the general rule.

In *Tarasoff*, the Supreme Court stated that an exception exists when a defendant therapist stands in a special relationship either with the wrongdoer, or the foreseeable victim.<sup>16</sup> The Court held that there is such a “special relationship” between a patient and therapist, sufficient to support the existence of a duty to protect foreseeable victims. The Court’s construction of this duty is central to its conclusion of liability against the therapist.

In a critical passage of reasoning, the majority held that the doctor-patient relationship was a “special relationship” sufficient to support the existence of a duty to exercise reasonable care to protect others from dangers emanating from the patient’s illness.<sup>17</sup> The Court stated that therapy alone is sufficiently

8 *Tarasoff*, *supra* note 3 at 350.

9 *Ibid.* at 351.

10 *Ibid.* at 352.

11 *Ibid.* at 353.

12 Alan Felthous & Claudia Kachigan, “To Warn and to Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?” (2001) 19 *Behav. Sci. Law* 355 at 355.

13 *Tarasoff*, *supra* note 3 at 342.

14 *Smith v Littlewoods* [1987] 1 All ER 710 at 729.

15 *Ibid.*

16 *Tarasoff*, *supra* note 3 at 342.

17 *Ibid.* at 348.

controlling for a duty to exist when the patient's potential for violence to another is foreseeable.<sup>18</sup> The Court did not require either a verbal threat from the patient, or control through hospitalisation, for the duty to be triggered.<sup>19</sup>

### “Reasonably necessary” steps

The Court stated that the protective duty may require a therapist to take various steps depending on the facts of the individual case: “Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances”.<sup>20</sup>

The Court's ruling leaves open to interpretation what actions would discharge the duty to protect an intended victim.<sup>21</sup> Thus, even if a therapist unequivocally warns a third party of threats made by a patient, if harm ensues a court may still hold that a therapist has failed to take sufficient steps to protect the victim.

Chaimowitz states that while the purpose of informing or warning is to protect, in some situations a warning may be insufficient, or even increase the risk to the victim.<sup>22</sup> Similarly, Appelbaum states that warnings are of “dubious utility”<sup>23</sup> and notes that the *Tarasoff* doctrine grants considerable scope to clinicians in the selection of a course of action that would protect potential victims:

Although the first *Tarasoff* decision in 1974 established a “duty to warn” likely victims, when the case was redecided in 1976, the obligation was broadened to a “duty to protect”, an approach adopted by subsequent courts. This change means the responsibility to protect third parties is not limited to a warning; other steps may be required. Clearly, when unidentifiable victims are involved, other measures must be taken. Depending on the circumstances, one might chose to hospitalize the patient (voluntarily or involuntarily), to transfer an already hospitalized patient to a more secure ward, or to maintain the outpatient status but begin medication, intensive individual therapy, family therapy, or other systems-oriented therapy, which might even involve the potential victim. Many clinicians will choose one of these steps whenever possible in preference to breaching confidentiality by issuing a warning.<sup>24</sup>

McNiel notes that several interventions besides warnings have been widely recommended for managing the risk of violence in patients who make threats.<sup>25</sup> McNiel states that additional options include involuntary hospitalization, intensified outpatient treatment, psychotropic medication, removal of weapons and conjoint sessions which may involve the person who is the target of the threat.<sup>26</sup>

Givelber states that while there may be some situations in which warning the victim is the most reasonable response, many therapists have suggested, since even before the *Tarasoff* decision, that

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18 *Felthous & Kachigian, supra note 12* at 358.

19 *Ibid.*

20 *Tarasoff, supra note 3* at 340.

21 Michael Huber, et al., “A Survey of Police Officers’ Experience with Tarasoff Warnings in Two States” (2000) 51 *Psychiatr. Serv* 807 at 807.

22 Gary Chaimowitz, Graham Glancy & Janice Blackburn, “The Duty to Warn and Protect – Impact on Practice” (2000) 45 *CJP* 899 at 900.

23 Paul Appelbaum, “*Tarasoff and the Clinician: Problems in Fulfilling the Duty to Protect*” (1985) 142:4 *Am J Psychiatry* 425 at 427.

24 *Ibid.* at 426.

25 Dale McNiel, Renee Binder & Forrest Fulton, “Management of Threats of Violence Under California’s Duty-to-Protect Statute” (1998) 155:8 *Am J Psychiatry* 1097 at 1099.

26 *Ibid.*

different measures will be appropriate in other situations.<sup>27</sup> Liability will be determined by what a “reasonable” therapist would have done in the circumstances.

### The impact of *Tarasoff*

*Tarasoff* was initially greeted with prophecies of doom from many within the mental health professions. They predicted that *Tarasoff* would extinguish the trust and confidentiality essential to effective psychotherapy.<sup>28</sup> However, the duty to protect has not been applied uniformly across the United States.<sup>29</sup> The issue of whether or not such a duty exists is a state tort law issue, not a matter of federal law.<sup>30</sup> States have variously embraced, expanded, restricted or rejected *Tarasoff*.<sup>31</sup>

### California extends *Tarasoff*...

California is one state that has expanded the duty to protect far beyond its original limits. As a direct response to the *Tarasoff* decision, the legislature of California limited the broad duty to protect that it introduced, by codifying a narrower “duty to warn”. The duty to warn is triggered only when a patient communicates to a therapist a serious threat of physical violence against a readily identifiable victim.<sup>32</sup> However, the courts of California have once again expanded the liability of therapists.

... to emergency settings...

In *Jablonski*<sup>33</sup>, the Ninth Circuit Court of Appeals extended the duty to an emergency setting.<sup>34</sup> In that case, Jablonski was brought to the emergency department of a hospital by his girlfriend after he threatened her mother with a knife and attempted to rape her.<sup>35</sup> Dr Kopiloff examined Jablonski and diagnosed him with an anti-social personality disorder that rendered him “potentially dangerous”.<sup>36</sup> However, Dr Kopiloff concluded that there was no basis for involuntary hospitalisation.<sup>37</sup> No attempt was made to locate Jablonski’s past medical records, which would have revealed a history of schizophrenia and violence.

Shortly after his release from hospital, Jablonski attacked and murdered his girlfriend.<sup>38</sup> Despite the absence of any specific threat directed towards an identifiable person, the Court held the hospital liable for its failure to obtain Jablonski’s past medical records and adequately warn the victim. Thus, *Jablonski* expanded *Tarasoff* by holding that a history of violent behaviour can reveal a danger that will be sufficient to indicate the foreseeability of harm to a particular victim or class of victims.<sup>39</sup> Further, a protective duty may be imposed on a treating psychiatrist even in an emergency setting.

27 Daniel Givelber, William Bowers & Carolyn Blich, “*Tarasoff*, Myth and Reality: An Empirical Study of Private Law in Action” (1984) *Wisconsin Law Review* 443 at 465.

28 Daniel Shuman & Myron Weiner, “The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege” (1982) 60 *North Carolina Law Review* 893 at 914.

29 Fillmore Buckner & Marvin Firestone, “Where the Public Peril Begins: 25 Years After *Tarasoff*” (2000) 21 *The Journal of Legal Medicine* 187 at 200.

30 *United States v. Chase* 340 F.3d 978 at 996.

31 Hubbard, *supra* note 6 at 429.

32 *Cal. Civ. Code* 43.92.

33 *Jablonski v. United States* 712 F.2d 391 (9th Cir. 1983) [*Jablonski*].

34 Buckner & Firestone, *supra* note 29 at 201.

35 *Jablonski*, *supra* note 33 at 393.

36 *Ibid.*

37 *Ibid.* at 394.

38 *Ibid.*

39 Damon Walcott, Pat Cerundolo & James Beck, “Current Analysis of the *Tarasoff* Duty: an Evolution towards the Limitation of the Duty to Protect” (2001) 19 *Behav. Sci. Law* 325 at 330.

... to threats reported by family members

In *Ewing*<sup>40</sup>, the California Court of Appeal for the Second District held that the communication of a threat by a close family member was equivalent to a threat communicated directly by a patient and triggered a duty to warn the potential victim.<sup>41</sup> In *Ewing*, the patient confided to his father that he was considering harming his ex-girlfriend's new partner. The father notified the patient's therapist, Dr Goldstein, who arranged for the patient's voluntary hospitalisation at a nearby medical centre by a staff psychiatrist. The following day, the staff psychiatrist discharged the patient because he was not suicidal, despite Dr Goldstein urging him to keep the patient hospitalised.

Dr Goldstein had no further contact with the patient.<sup>42</sup> At no stage did Dr Goldstein warn the victim who was the subject of the patient's threat. The day after he was discharged the patient shot his intended target and then committed suicide. Dr Goldstein was held liable in negligence for failing to warn the victim based on the credible threat disclosed by the father.<sup>43</sup>

*Ewing* has been criticised by some scholars for extending the duty to warn beyond the scope and intent of the Californian legislation.<sup>44</sup> The legislation specifically states that a duty arises only when a patient communicates a threat to a psychotherapist.<sup>45</sup> The author shares Edwards's concern that *Ewing* opens the door to the imposition of liability on clinicians based on third-party, hearsay communications.<sup>46</sup> Edwards states: "There is no way Dr Goldstein could have truly known the intent or seriousness of the threat without the threat being conveyed directly to Dr Goldstein".<sup>47</sup> Yet, one phone call was enough for the Court to impose a duty upon Dr Goldstein.<sup>48</sup>

In a similar vein, Smith has criticised *Ewing* because, in her view, therapists will have no way of confirming whether "the communication is accurate, is made by a family member, or whether the family member is acting maliciously or in the best interests of the patient".<sup>49</sup> In Smith's view, *Ewing* creates "amorphous liability standards" for therapists.<sup>50</sup>

### Nebraska: extending *Tarasoff* to the protection of strangers

In *Lipari*<sup>51</sup>, the Federal District Court recognised a duty on therapists that extends to protecting strangers. In that case, a patient was receiving psychiatric care from a Veterans Administration. The patient purchased a shotgun and used it in a random attack at a crowded nightclub, killing one person.<sup>52</sup> The Court held that a duty to protect would arise, even though no specific threats were made by the patient against any specific person. Thus, the Court dispensed with the need for an identifiable victim and required "only that the doctor reasonably foresee that the risk engendered by his patient's condition

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40 *Ewing v. Goldstein* 15 Cal Rptr. 3d 864 [*Ewing*].

41 Robert Weinstock, Gabor Vari, Gregory Long & Arturo Silva, "Back to the Past in California: A Temporary Retreat to a *Tarasoff* Duty to Warn" (2006) 34 (4) *Journal of the American Academy of Psychiatry and the Law* 523 at 526.

42 *Ewing*, *supra* note 40 at 867.

43 Weinstock, Vari, Long & Arturo Silva, *supra* note 39 at 526.

44 Gwynneth Smith, "Ewing v. Goldstein and the Therapist's Duty to Warn in California" (2006) 36 *Golden Gate U. L. Rev.* 293 at 296.

45 Edwards, Deborah, "Duty to Warn – Even if it may be

*Hearsay? The Implications of a Psychotherapists Duty to Warn a Third Person when Information is Obtained from Someone Other than his Patient*" (2006) 3 *Ind. Health L. Rev.* 171 at 182.

46 *Ibid.*

47 *Ibid.* at 183.

48 *Ibid.*

49 Smith, *supra* note 44 at 299.

50 *Ibid.* at 297.

51 *Lipari v. Sears, Roebuck & Co.* 497 F.Supp. 185 (D. Neb. 1980) at 187 [*Lipari*].

52 *Buckner & Firestone*, *supra* note 29 at 200.

would endanger other persons".<sup>53</sup> Following *Lipari*, Nebraskan therapists have a duty to protect anyone foreseeably endangered by a patient.<sup>54</sup>

## PART TWO: THE UNITED KINGDOM

### Current position

The United Kingdom Court of Appeal has confirmed that UK psychiatrists have discretion, but not a duty, to warn potential victims in certain circumstances. *Egdell*<sup>55</sup> and *Crozier*<sup>56</sup> confirm that a psychiatrist is permitted to depart from the duty of confidentiality to issue warnings about a patient who is believed to present a real and serious threat to third parties.<sup>57</sup> Less certain, however, is whether a psychiatrist could be duty-bound to give a warning or take other steps to protect third parties from foreseeably dangerous patients.<sup>58</sup>

Whilst the courts in *Egdell* and *Crozier* recognised discretion to depart from the duty of confidentiality, they were not asked to, and did not recognise, a duty upon psychiatrists to do so. To date no such duty has been acknowledged in a United Kingdom court.<sup>59</sup> However, the European Court of Human Rights' ruling in *Osman*<sup>60</sup> has opened the door to the introduction of a doctrine analogous to *Tarasoff* in the United Kingdom.<sup>61</sup> Notwithstanding *Osman*, doubt surrounds the question of whether such a duty would be recognised by domestic courts.<sup>62</sup>

### *Osman*

The United Kingdom is a signatory to the European Convention on Human Rights ("ECHR").<sup>63</sup> Accordingly, the ECHR applies to all residents of the United Kingdom<sup>64</sup> and it is unlawful for a public authority to act contrary to an ECHR right.<sup>65</sup> The ECHR may well impose obligations on healthcare professionals, including psychiatrists employed by the National Health Service ("NHS").<sup>66</sup> In particular, obligations might flow from Article 2 of the ECHR which affirms the right to life.<sup>67</sup> In *Osman*, the European Court of Human Rights' (ECtHR) used Article 2 to introduce a positive obligation to protect third parties into United Kingdom law.<sup>68</sup>

In *Osman*, Mrs Osman sued local police for failing to protect her now deceased husband. Mr Osman was shot dead by a teacher, Paget-Lewis, who had formed an obsessive attachment with their son. Mrs Osman argued that the police had failed to act on warning signs that Paget-Lewis represented a serious threat to her family.<sup>69</sup> The evidence indicated that Paget-Lewis was jealous of her son's relationship with another student at school. Paget-Lewis had allegedly vandalised the Osmans' property, wrote slanderous graffiti on school premises and stole a shotgun that was used in the shooting of Mr Osman. The English Court of Appeal dismissed the claim on a public policy ground – that the police could not be negligent for failures relating to the investigation of crime.<sup>70</sup>

53 *Lipari*, *supra* note 51 at 194.

54 *Walcott, Cerundolo & Beck*, *supra* note 39 at 330.

55 *W v Egdell* [1990] Ch 359 [Egdell].

56 *R v Crozier* [1991] Crim LR 138 [Crozier].

57 *Gavaghan*, *supra* note 7 at 255.

58 *Ibid.*

59 *Ibid.*

60 *Osman v UK* [1999] 1 FLR 193 [Osman].

61 *Gavaghan*, *supra* note 7 at 256.

62 *Ibid.*

63 *Ibid.* at 257.

64 Michael Perlin, "You Got No Secrets to Conceal: Considering the Application of the Tarasoff Doctrine Abroad" (2006) 75 U. Cin. L. Rev. 611 at 618.

65 Section 6(1) Human Rights Act 1998 (qualified by section 6 (2)).

66 *Gavaghan*, *supra* note 7 at 257.

67 Perlin, *supra* note 64 at 619.

68 *Gavaghan*, *supra* note 7 at 258.

69 *Osman*, *supra* note 60 at 199.

70 *Ibid.* at 207.

Mrs Osman then petitioned the ECtHR for a remedy. On the facts, the Court dismissed the claim under Article 2 because the criminal conduct of Paget-Lewis was not reasonably foreseeable by the police. The Court held that Mrs Osman had:

[F]ailed to point to any decisive stage in the sequence of the events leading up to the tragic shooting when it could be said that the police knew or ought to have known that the lives of the Osman family were at real and immediate risk from Paget-Lewis. While the applicants have pointed to a series of missed opportunities which would have enabled the police to neutralise the threat posed by Paget-Lewis, for example by searching his home for evidence to link him with the graffiti incident or by having him detained under the Mental Health Act 1983 or by taking more active investigative steps following his disappearance, it cannot be said that these measures, judged reasonably, would in fact have produced that result or that a domestic court would have convicted him or ordered his detention in a psychiatric hospital on the basis of the evidence adduced before it.<sup>71</sup>

Despite the dismissal of Mrs Osman's claim on the facts, critically, the Court stated that Article 2 could give rise to "a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual".<sup>72</sup> As to the scope of this obligation, the Court stated:

[B]earing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.... In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.<sup>73</sup>

It is worth noting that the above passage from *Osman*, bears a close resemblance to the reasoning of the Supreme Court of California in *Tarasoff*. *Osman* has since been interpreted by one scholar as imposing a duty to protect third parties upon state employees in the United Kingdom, including psychiatrists employed by the NHS.<sup>74</sup> The duty is derived from Article 2 of the ECHR, which protects the right to life. However, unless and until an expanded duty is recognised, any legal recourse against state employed psychiatrists for failure to protect third parties would lie against the United Kingdom government and not against a psychiatrist personally.<sup>75</sup>

### **Palmer**

*Osman* was considered by the English Court of Appeal in *Palmer*.<sup>76</sup> That case concerned a former psychiatric patient who abducted, sexually assaulted and murdered a 4 year-old girl.<sup>77</sup> One year prior to the murder, the patient stated that he had sexual feelings towards children and that a child would be

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71 *Ibid.* at 220.

72 *Ibid.* at 218.

73 *Ibid.*

74 *Gavaghan*, *supra* note 7 at 267.

75 *Ibid.* at 266.

76 *Palmer v Tees Health Authority* [1999] *Lloyd's Rep Med* 351 [*Palmer*].

77 *Ibid.* at 351.



murdered after he was discharged from hospital.<sup>78</sup> The victim's mother sued the hospital for failing to foresee the risk of the patient committing serious sexual offences against children.<sup>79</sup>

At first instance, the judge struck out the claim and this decision was subsequently upheld by the Court of Appeal. On the facts, the Court of Appeal distinguished *Osman* because in the present case there was no prior relationship between the patient and the victim.<sup>80</sup> The Court held that because there was no pre-existing connection between the patient and the specific victim, the requisite degree of proximity for negligence was absent.

Significantly, Stuart-Smith LJ expressed reservations about the propriety of the *Osman* decision in the English context: "I respectfully agree with Lord Browne-Wilkinson that it is not easy to understand the decision of the Strasbourg Court in the context of the English law of negligence".<sup>81</sup> Further, the Court proceeded to reject *Tarasoff* itself. Lord Stuart-Smith stated that the *Tarasoff* duty proceeded on "the premise that there is a special relationship between the defendant and either the third or the foreseeable victims. In English law it is plainly not sufficient that this relationship exists only between the defendant and third party".<sup>82</sup>

## Discussion

In the author's view, *Palmer* is an early indication that domestic English courts will be reluctant to apply *Osman* reasoning to cement a tort law duty on psychiatrists to protect third parties. Gavaghan states that the notion of a positive duty to protect third parties under domestic British law is a "very radical one".<sup>83</sup> However, some scholars view *Osman* as the first step towards the recognition of a European *Tarasoff*. In Hubbard's view, the *Osman* decision is "an early sign of how the law on duties to third parties may develop" in the United Kingdom.<sup>84</sup> Similarly, Perlin argues that *Osman* represents a move towards the recognition of a duty to protect. Perlin states that: "Of course, *Osman* was not, strictly speaking, a '*Tarasoff* case'. But there is no question in my mind that it helped create a judicial environment that will be more sympathetic to such claims".<sup>85</sup> Time will tell whether Perlin's prediction proves accurate. However, the early judicial indication from *Palmer* is that domestic English courts will be slow to impose a *Tarasoff* duty in that jurisdiction.

## PART THREE: A CRITIQUE OF TARASOFF

There are several reasons why United Kingdom decision makers should be sceptical about *Tarasoff's* "enlightened approach".

### Lack of control over patients

In many cases, a psychiatrist will lack the necessary degree of control over a patient to justify the imposition of a duty. For instance, psychiatrists usually have little control over voluntary patients who do not satisfy the criteria for involuntary commitment. Similarly, psychiatrists will have little control over outpatients.<sup>86</sup> For example, *Tarasoff* itself concerned a voluntary outpatient who was not in treatment at the relevant time; whose potential victim was out of the country at the time of the threats; and who

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78 *Ibid.*

79 *Ibid.*

80 Perlin, *supra* note 64 at 623.

81 Palmer, *supra* note 76 at 354.

82 *Ibid.* at 359.

83 Gavaghan, *supra* note 7 at 267.

84 Hubbard, *supra* note 6 at 441.

85 Perlin, *supra* note 64 at 625.

86 Stone, *supra* note 5 at 366.



committed the murder three months after revealing his feelings during therapy.<sup>87</sup>

Support for this view can be found in the judgment of the Florida Court of Appeals in *Boynton*.<sup>88</sup> The Florida Court of Appeals strongly rejected the *Tarasoff* approach:

Although other jurisdictions have followed the lead of the California Supreme Court in the landmark decision of *Tarasoff v Regents of Univ. of California*, we reject that “enlightened” approach. Florida courts have long been loathe [*sic*] to impose liability based on a defendant’s failure to control the conduct of a third party.<sup>89</sup>

The Court stated that the “special relationship” between a patient and therapist relied on in *Tarasoff* to create the protective duty, is implicitly premised on a psychiatrist’s ability to control their patient.<sup>90</sup> Yet, the *Tarasoff* Court did not address the issue of control.<sup>91</sup> In *Tarasoff*, the Supreme Court of California simply stated that:

[T]here now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient.<sup>92</sup>

In stark contrast, the Florida Court of Appeals recognised that most therapeutic relationships will not contain any element of control.<sup>93</sup> The Court held that the relationship between a psychiatrist and a voluntary outpatient lacked the necessary element of control for the creation of a duty to protect other parties.<sup>94</sup> It is submitted that the Court’s reasoning is persuasive. Moreover, there must be strength in Stone’s analysis: “Once the suggestion of control is eliminated, there is nothing in the nature of the relationship between a psychiatrist and his patient to support an exception to the tort law presumption”.<sup>95</sup> In the absence of control, the *Tarasoff* Court appeared to rely upon the responsibilities inherent in social living and human relations, and the spirit of the Good Samaritan. The *Boynton* Court declined to “fashion a rule of law from such social duties”.<sup>96</sup>

### Causation problems

The second reason why *Tarasoff* should be avoided relates to causation. It is submitted that there are glaring problems of causation with the *Tarasoff* doctrine. Put simply, it is not clear that the psychologist’s failure to warn the victim in *Tarasoff* could be said to have caused the victim’s death. Conspicuously, there is no causation analysis in the *Tarasoff* decision.

It will be recalled that in *Tarasoff*, Tobriner J stated that the protective duty may require a therapist to take various steps depending on the facts of the individual case, including warning the potential victim, notifying the police, or taking whatever other steps might be reasonably necessary to protect the potential victim.<sup>97</sup> Further, Tobriner J stated: “Some of the alternatives open to the therapist, such as warning the victim, will not result in the drastic consequences of depriving the patient of his liberty”.<sup>98</sup> However, a

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87 *Gutheil, supra note 4 at 346.*

88 *Boynton v. Burglass* 590 So. 2d 446 [*Boynton*].

89 *Ibid.* at 448.

90 *Ibid.* at 448.

91 *Ibid.* at 449.

92 *Tarasoff, supra note 3, at 349.*

93 *Boynton, supra note 88 at 449.*

94 *Ibid.*

95 *Stone, supra note 5, at 366.*

96 *Boynton, supra note 88 at 451.*

97 *Tarasoff, supra note 3 at 340.*

98 *Ibid.* at 350.

therapist who has failed to warn a victim should not be liable for a victim's injuries or death if their failure to warn was not a cause in fact of such injuries or death.

Settled principles of tort law require factual causation before liability will be imposed in negligence. The 'but for' test is used to ensure this minimum level of factual causation. To satisfy this test, the plaintiff would have to prove that had Ms Tarasoff been warned of Mr Poddar's threat, she would have avoided being killed by Mr Poddar. It is far from clear whether a warning would have averted the danger. It is entirely conceivable that Mr Poddar would have killed Ms Tarasoff, notwithstanding that she was aware of the very danger posed by Mr Poddar. The most that can be said is that, due to the psychologist's failure to warn her, Ms Tarasoff lost the opportunity to avoid being harmed by Mr Poddar. Based on traditional common law principles of causation, this would be insufficient to establish causation.

Of course, it was open to the *Tarasoff* Court to relax the ordinary rules of causation and apply a lower standard of causation in the particular circumstances of the case. However, the Court did not do so. Moreover, the Court failed to explain how causation was established on existing principles.

It is submitted that a *Tarasoff* duty can only ever make sense in terms of causation if one interprets it as requiring a therapist to commit for involuntary treatment a patient who poses a serious danger to others. 'But for' causation would be established because the victim would certainly have avoided the harm had the therapist properly committed the patient. However, the majority in *Tarasoff* was careful to avoid establishing a duty on therapists to civilly commit a patient. Therefore, in the author's view, *Tarasoff* liability sits uncomfortably with traditional common law principles of causation.

### Uncertain standard of care

A third reason to avoid a *Tarasoff*-type duty relates to the uncertain standard of care that the decision purports to impose upon therapists. The standard of care required by *Tarasoff* is that of the reasonable therapist:

[T]he therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.<sup>99</sup>

Mosk J stated that a psychiatrist's prediction of violence stands to be examined against "conformity to standards of the profession".<sup>100</sup> Yet, one must wonder what common standards the court is referring to, when no such standards exist within the profession itself. Of course, psychiatry has developed a range of risk assessment tools designed to predict dangerousness. However, it appears that there is little consensus within the profession as to what constitutes reasonable practice. In his dissenting judgment in *Tarasoff*, Clark J referred to evidence that suggested:

[T]he chances of a second psychiatrist agreeing with the diagnosis of a first psychiatrist are barely better than 50-50; or stated differently, there is about as much chance that a different expert would come to some different conclusion as there is that the other would agree.<sup>101</sup>

Unlike a physician's diagnosis, which can be verified by x-ray or surgery for example, a psychiatrist cannot verify his diagnosis, treatment or predicted prognosis except by long-term follow-up and reporting.

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99 *Ibid.* at 349.

101 *Ibid.* at 371.

100 *Ibid.* at 361.

The Court in *Boynton* described the problem in this way: “The outward manifestations of infectious diseases lend themselves to accurate and reliable diagnoses. However, the internal workings of the human mind remain largely mysterious”.<sup>102</sup>

Although *Tarasoff* purports to impose a standard of reasonableness, the reality is that the decision imposes an uncertain, higher standard of care that is determined by the hindsight judgment of a court. Because the standard is without meaningful content within psychiatry, the reality is that psychiatrists are exposed to potential liability unless they do in fact accurately predict dangerousness.<sup>103</sup> The question of whether a psychiatrist actually did predict dangerousness becomes indistinguishable from whether they should have done so.<sup>104</sup> The question will be whether a reasonable psychiatrist would have made that prediction, albeit under the guise of ascertaining whether this psychiatrist actually did so.<sup>105</sup> Surely it is unfair to impose such an uncertain, retrospective duty on psychiatrists.

### The problem of confining a duty to protect

It has been seen that some jurisdictions within the United States have expanded the protective duty to emergency settings, to threats notified by family members and even to unknown victims. The possibility that the adoption of a protective duty in the United Kingdom might lead to a similar expansion must be of some concern.

The United Kingdom would be wise to note that many courts in the United States have struggled to confine the *Tarasoff* doctrine. Attempts to place reasonable limits on the duty have been fraught with difficulty. For example, the specificity rule (which requires specific threats against specific victims before a duty to protect will be imposed on a therapist) was created to limit and clarify the circumstances that would trigger the duty. Prima facie, the rule appears to successfully limit the protective duty. Indeed, variations of the rule have since been adopted in a number of states. The specificity rule is not, however, without weakness.

Borum and Reddy argue that the specificity rule creates an arbitrary precondition to the existence of a duty because, “threats should not be regarded as a necessary or exclusive factor for precipitating an inquiry about clinical concern”.<sup>106</sup> They state that as a clinical and ethical matter, there may be circumstances when a psychiatrist is legitimately concerned about potential violence in the absence of a direct threat made by the patient.<sup>107</sup> Further, they argue that it is crucial to distinguish between a patient who communicates a threat and a patient who poses a threat by engaging in behaviour that indicates planning and preparation for violence.<sup>108</sup> It is true that some patients who verbalise threats ultimately act on them, but many do not.<sup>109</sup> A patient may pose a threat even though they have not communicated a threat to anyone.<sup>110</sup> Borum and Reddy state that it is those who appear to pose a threat that provoke the greatest level of concern.<sup>111</sup>

By excluding those patients who pose, rather than verbalise threats, the specificity rule may conceal the very danger that the duty was designed to protect against. It is submitted that the construction of the specificity rule is indicative of a broader judicial struggle to confine the duty to protect within reasonable bounds.

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102 *Boynton*, *supra* note 88 at 452.

103 *Stone*, *supra* note 5 at 371.

104 *Gavaghan*, *supra* note 7 at 263.

105 *Ibid.*

106 Randy Borum & Marisa Reddy, “Assessing Violence Risk in *Tarasoff* Situations: A Fact-Based Model of Inquiry”

(2001) 19 *Behav. Sci. Law* 375 at 380.

107 *Ibid.*

108 *Ibid.*

109 *Ibid.*

110 *Ibid.*

111 *Ibid.*

## CONCLUSION

Courts in the United States and, to a lesser extent, the United Kingdom, have acknowledged that in certain circumstances the public interest in protecting psychiatrist-patient confidentiality must yield to the public interest in preventing innocent third parties from violence. Notwithstanding the striking similarity in reasoning between *Tarasoff* and the decision of the European Court in *Osman*, early case law from England favours the more conservative, discretionary model enunciated in *Egdell*. For the reasons discussed above, the United Kingdom would be wise to stop short of converting the discretion to breach confidentiality in the public interest, into a tort law duty to protect third party victims. The Supreme Court of Texas summarised the tension inherent in the protective duty in the following extract:

If a common law duty to warn is imposed, mental health professionals face a Catch-22. They either disclose a confidential communication that later proves to be an idle threat and incur liability to the patient, or they fail to disclose a confidential communication that later proves to be a truthful threat and incur liability to the victim and the victim's family.<sup>112</sup>

Finally, it is important that we keep in mind that the public may be safeguarded in more traditional ways.<sup>113</sup> Prior to *Tarasoff*, hospitalisation was the primary means of protecting potential victims from a patient's violent acts in the United States.<sup>114</sup> The author tends to agree with Felthous and Kachigian that hospitalisation remains "the most prudent and preventative measure to handle a patient who is seriously mentally ill, and as a result is dangerous to others".<sup>115</sup> Likewise, he agrees with Stone that, "emergency civil commitment generally remains the safest and least destructive way to deal with a crisis of violence in a mentally ill person".<sup>116</sup>

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112 *Thapar v. Zezulka* 994 S.W.2d 635 (Tex. 1999) at 639 [Thapar].

113 Stone, *supra* note 5 at 374.

114 Felthous & Kachigian, *supra* note 12 at 356.

115 *Ibid.* at 370.

116 Stone, *supra* note 5 at 374.

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