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The Fin de Millénaire Duty to Warn or Protect*

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ABSTRACT: At the turn of the millennium, the authors summarize the evolution of a clinician's duty to protect third persons from a patient's violent acts over the past half century, with special emphasis on jurisprudential developments in the last decade. Four evolutionary periods are identified: Pre-Tarasoff, Inception, Diversification, and Retreat. The period of Retreat from Tarasoff in the nineties is characterized by the following approaches to Tarasoff: adoption, statutory containment, rejection of a duty to warn, rejection of a duty to control voluntary patients, and proactive circumscription of any protective duties. A more rational jurisprudential approach would permit some measure of flexibility for the proper exercise of clinical discretion.

KEYWORDS: forensic science, duty to warn/protect, Tarasoff, third party liability

At the end of the second millennium, a clinician's legal duty to warn or protect potential victims from her/his patient's violent acts is diverse and in flux. Here, we will attempt to understand the duty to protect jurisprudence by examining its development and evolutionary changes over the second half of the twentieth century. Within this semicentennial time span, essentially four periods are more or less distinguishable: 1) The Pre-Tarasoff Period (1950–1974) when there was no legal duty to warn victims of a patient's foreseeable violence; 2) Inception of the Tarasoff Principle (1974–1980) when courts began to espouse a duty to warn victims of an outpatient's violence; 3) the period of Diversification (1980–1989) wherein courts applied an expanding smorgasbord of diverse rules, and 4) the period of Retreat from Tarasoff in the last decade of the century (1990–1999).

In examining each of these four periods, the authors will assume the reader is already familiar with the Tarasoff principle and early Tarasoff progeny cases about which an extensive literature already exists (1–5). Our goal here is to summarize various and contrasting evolutionary branches of duty to protect jurisprudence and to propose that this evolution can be meaningfully divided into the aforecited four periods. This classification into periods or phases of jurisprudential evolution is accomplished with full realization of overlapping and continuous trends from one period to the next as various principles are developed, expanded, restricted, or modified according to the political power behind competing public policy interests and the individual views and preestablished rules of courts that shape this ever changing law.

The Pre-Tarasoff Period (1950–1974)

Until the California Supreme Court's Tarasoff I and II decisions (6,7), in 1974 and 1976 respectively, liability for a patient's violently inflicted harm on other persons was essentially limited to situations wherein the clinician had control of the patient through hospitalization and the patient was either negligently/wrongfully discharged or allowed to escape or rarely where the physician failed to establish control (Greenberg v. Barbour, 1971 (8)). (Although Tarasoff II in 1976 vacated Tarasoff I in 1974, the first Tarasoff decision is included in the inception of duty to protect jurisprudence, as it was the first decision of its kind and remained in full effect as a guiding principle until vacated by the same court in 1976.) Liability of clinicians for not warning the victim or the police was unknown. Moreover, three principles in particular served to protect the clinician from liability when a patient attacked another person: 1) the nonresponsibility rule, 2) sovereign immunity, and 3) the honest error in professional judgment rule (8).

Following the common law rule of nonresponsibility, treaters were not held liable for a patient's violent acts against others unless the patient was negligently discharged or poorly supervised and negligently allowed to escape from the hospital (9). In 1965, the American Law Institute published its Restatement (Second) of Torts (10) and therein articulated the common law rule of nonresponsibility together with specific exceptions that allow for liability. According to the *special relation* exception, Section 315, one person may have a duty to control and prevent another from harming a third person if:

- A special relation exists between the actor and the [second] person which imposes a duty upon the actor to control the [second] person's conduct, or
- A special relation exists between the actor and the [third person] which gives the [third person] a right to protection (11).

Of the various relations specified in the following sections, the one that seems most suited to a treatment relationship, especially regarding hospitalized patients, is the *custodial relationship* defined by *control,* Section 320:

> One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or to subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of [these] persons as to prevent them from inten-

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> tionally harming others or so conducting themselves as to create an unreasonable risk of harm to him, if the actor:
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> - knows or has reason to know that he has the ability to control the conduct of the [other] person, and
> - knows or should know of the necessity and opportunity for exercising such control (12).

The takes charge exception, Section 319, further emphasizes the essential element of control in the relationship:

> One who takes charge of a . . . person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the . . . person to prevent him from doing such harm (13).

Thus, from 1950 until the first Tarasoff I decision in 1974, court decisions were uniformly consistent with the common law rule of nonresponsibility and this takes charge exception. In other words, liability for violence inflicted on third persons occurred where the patient had been controlled through hospitalization but not through an outpatient relationship, however "special" such a relationship might have been considered.

The second source of protection against liability for violence patients inflict on others was sovereign immunity. One cannot sue the government for policy decisions that resulted in some harm, or a judge for an adverse judgment (judicial immunity). Likewise, to the extent that decisions regarding control or release of a hospitalized patient were discretionary, a party injured as a result of a patient having been discharged from a hospital could not sue the government-employed individual clinician or the hospital. The recognition of the fallibility of decisions concerning potentially violent mental patients implicitly respected the clinician's inability to accurately predict future violence.

Sovereign immunity, it must be emphasized, has not been equally protective of government employees in all jurisdictions. The Federal Tort Claims Act (FTCA) (14) was enacted to ensure that victims of negligence at the hands of the governmental employees have equal access to redress and compensation as victims of negligence in the private sector. Courts have differed in whether they consider a clinician's decisions to discharge a patient as discretionary, and immune from liability (e.g., *McDowell* v. *County of Alameda* (15)), or ministerial, involving "implementation" of regulations or policies (e.g., *Fair* v. *United States,* 1956 (16), *Merchants National Bank & Trust Co. of Fargo* v. *United States,* 1967 (17)), and subject to litigation as allowed by the FTCA. Nonetheless, even if unevenly applied, sovereign immunity further protected clinicians from liability, especially earlier in the century.

The third prong of this pre-Tarasoff immunity-serving trident was the honest error in professional judgment rule (8). According to this rule, courts resisted upholding liability where the only error was an honest mistake in medical judgment; for liability to exist there must have been some negligence beyond a simple, good faith misjudgment. This rule was advanced eloquently by a New York appellate court in *St. George* v. *State* in 1954 (18); and subsequent court decisions cited St. George when invoking this rule to the benefit of the medical defendant.

The ethic of confidentiality was strongest in the pre-Tarasoff period. The ethical code published by the American Medical Association (19) in 1956 cited the communicable disease exception to confidentiality but was absolutely silent about violent behavior. The 1957 revision (20) permitted protective disclosures, but did not address the nature of such disclosures. One year before Tarasoff I (6), in its 1973 edition of The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (21), the American Psychiatric Association allowed violation of confidentiality with respect to an imminent danger. In 1965, the California legislature enacted a law allowing psychotherapists to breech confidentiality to prevent a threatened danger (22). Such statutory violence prevention exceptions to privileged and confidential communications were, nonetheless, unusual. In practice, the rule was, when in doubt, error on the side of confidentiality. Presumably most clinicians considered confidentiality to be sacrosanct unless a legal duty mandated its violation.

Clinicians during the pre-Tarasoff period relied upon hospitalization, not warnings, to protect others in the community from their patients' violent acts. The most prudent guiding operative principle was to error on the side of caution and hospitalize the patient thought to be dangerous. Hospitalization and involuntary commitment were more easily accomplished and discharge was not to be rushed.

However, even during this period of greater reliance on hospitalization, public policies moved inexorably toward more outpatient treatment and far less hospitalization of even the seriously mentally ill. Among factors driving this change were more effective pharmaceuticals, fiscal considerations, greater legal restrictions on involuntary hospitalization, and the community mental health and de-hospitalization movements. Advocates of releasing patients from state hospitals naturally wanted to emphasize the negative aspects of custodial care such as adverse labeling and stigma, over-dependence, lack of autonomy, and atrophy of self-care skills. The term "institution" not only emphasized these negative aspects of hospitalization, but also served to detract from the treatment and restoration-of-function missions pursued by some, albeit few, mental hospitals. The trouble with the term "de-institutionalization" is that it suggests patients not only left the state hospitals, but remained free of institutions in general. We can now appreciate the sad reality that in the United States, the numbers of seriously mentally ill patients have increased substantially in other institutions that are far more depersonalizing and controlling, i.e., jails and prisons, and that many under-treated, under-supported homeless individuals with mental illness would be better managed with more "institutional" involvements such as partial hospitalization settings with quality programs. An innovation in the California Mental Health Code (23) intended to promote outpatient over inpatient treatment was its immunity provision regarding decisions to hospitalize or discharge patients. Thus, after this immunity became effective in California, a plaintiff could not recover based on a claim of failure to hospitalize or negligent discharge.

Inception of the Tarasoff Principle (1974–1980)

The Tarasoff principle of Tarasoff II, (hereafter, Tarasoff) was a formulation of a duty for psychotherapists to take reasonable measures to protect potential victims from a patient's foreseeable violent acts. The Tarasoff principle states: "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 of 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 the dan-

ger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances" (7, p. 431). Contrary to such cases in prior years, the protective duties of Tarasoff included but were not limited to hospitalization; rather, other duties or protective responses, such as warning the victim, were specified, yet the potential protective measures extended beyond whatever the court specifically identified, and included as well, "whatever other steps are reasonably necessary under the circumstances" (7, p. 431).

Provided the court was not itself dogmatically against hospitalization as a protective duty, it might have upheld the first of the plaintiffs' claims, "failure to detain a dangerous patient," if this were not already disallowed by the mental health code (23). There would, nonetheless, have been a problem of ascribing causation and breach of duty to the psychotherapist, since in the Tarasoff case it was the campus police who dropped the ball and foiled Dr. Lawrence Moore's attempt to have Prosenjit Poddar hospitalized.

The attractive alternative claim, "failure to warn of a dangerous patient" would have been frustrated by the common law rule of nonresponsibility and the fact that Tatiana Tarasoff, the homicide victim, could not have been readily warned by Dr. Moore because she was out of the country. Her parents complained that the defendants failed to warm *them* of the danger to their daughter, but they did not claim that they had a special relationship with the defendants. Based on its earlier decision, *Minsky* v. *City of Los Angeles* (24), the court found that the complaint could be corrected by amendment. Thus, the Tarasoff case involved a fourth party, Tatiana's parents.

Of far greater importance to this genre of jurisprudence was the court's approach to the common law rule of nonresponsibility in establishing a duty to protect other persons, the violation of which would be considered as a public policy violation and not professional malpractice. Relying heavily on a law review article written by Fleming and Maximov (25), the court found warnings to be less depriving of the patient's liberty interests than involuntary hospitalization. The court concluded that enough "control" exists, even in an outpatient psychotherapeutic relationship, for the "special relation" exception to the rule of nonresponsibility to allow protective warnings enforced by the liability of tort litigation.

Three years after the 1976 Tarasoff decision, the Superior Court of New Jersey, Law Division, in *McIntosh* v. *Milano* (26), adopted the Tarasoff duty to protect in a factual scenario in which the patient had not made a threat of violence against the victim. The court left it to the jury to determine whether Dr. Michael Milano should have known that the patient, Lee Morgenstein, presented "a clear danger or threat" to the victim, Kimberly McIntosh, and suggested that the jury look for retaliation fantasies in making their determination (23, p. 511). If so, there could be a "substantial issue in fact" as to whether the psychiatrist breached his duty to warn the victim's mother, the victim, or "appropriate authorities" (23, p. 500).

If the Tarasoff principle could be applied to a factual scenario that lacked a specific threat against a reasonably identifiable victim, and if psychiatrists, according to the American Psychiatric Association's brief in 1975 to the Supreme Court of California, lacked a standard for predicting future violence (27); how would courts determine when a violent act should have been foreseeable? The Supreme Court of California addressed this issue in 1980 in *Thompson* v. *County of Alameda* (28), a case wherein a youth in a facility for delinquents made good his threat to kill a young child in the same neighborhood where he would be living. The gruesome killing was committed less than 24 hours after his release. Here, the court found no duty to issue a protective warning; however, two situations were identified by the court wherein treaters or custodians could have protective legal duties.

The first situation is where by virtue of a special relationship with a potential victim, the facility may have a duty to warn the victim, even if a specific threat is not expressed against that specific victim. This can occur, for example, when a facility transfers the care of a forseeably violent person to the care of another.

The second situation is where care is not transferred to another, no special relation exists with the victim, and no peril is created. Here, no protective duties occur unless the assailant presents a "predictable threat of harm to a named or readily identifiable victim who can be effectively warned of the danger" (28, p. 738). This became known as the "specificity rule"; however, with later California cases (29,30) it became clear that no specific threat needs to be expressed for a duty to arise and the victim need not be named to be identifiable. Therefore, the two part elaboration as to when protective duties arise should probably be referenced by the eponymous designations Thompson Rule or Tarasoff-Thompson Rule, though even in these denotions, the first part of the formulation, which does not require a readily identifiable victim, is typically not included.

The Period of Diversification (1980–1989)

The Foreseeability Rule

Between 1980 and 1988, several landmark decisions upheld a clinician's duty to warn or protect without an expressed threat or an identifiable victim (31–34). In *Lipari* v. *Sears, Roebuck and Co.* (31), *Durflinger* v. *Artiles* (32), and *Petersen* v. *State* (33), Tarasoff (7) was cited in support of a clinician's duty to protect individuals with whom he has no therapist-patient relationship, but the Thompson rule, by the same California court, limiting the duty to at least a reasonably identifiable victim was not referenced in these cases. The Wisconsin Supreme Court in *Schuster* v. *Altenburg* (34) based its support of multiple protective duties, which did not require a foreseeable victim, on the Wisconsin case law and found no need to consider the Tarasoff court's special relation exception to nonresponsibility.

Naturally, hospitalization provides reasonable protection where the danger of violence is vectored at unnamed members of the general public. Yet a Tarasoff duty to warn was referenced in the first three cases even if not applicable to the facts of the case. In two of the four cases, Petersen (33) and Schuster (34), the violence was due to vehicular crash involving random victims. Other automobile accident cases involving Tarasoff-like protective duties also occurred in the eighties, e.g., *Cain* v. *Rijken* (35), in Oregon in 1986, and *Naidu* v. *Laird* (36), in Delaware in 1988.

The Foreseeable Victim Rule

Nineteen eighty-three brought a sally of cases that broadened the clinician's protective duties and heralded a more extensive series of cases to come with rules so diverse, it would appear as though courts collectively were experimenting with a wide range of approaches. In *Hedlund* v. *Superior Court of Orange County* (29), the Supreme Court of California in 1983 expanded its definition of foreseeable victims to include victims not threatened by the patient. If the object of a patient's violent intent is the mother of a young child, the child can be expected to stay close to its mother and within her sphere of danger; thus, even "unidentified" young children can become foreseeable victims by virtue of their close relationship to their threatened, identifiable mothers.

In the same year, the United States Court of Appeals for the Ninth Circuit affirmed a finding of failure to warn in *Jablonski by Pahls* v. *United States* (30), wherein the patient had expressed "no specific threats concerning any specific individuals" (30, p. 392). Because the patient had abused his prior wife and shown on psychological testing a likelihood of attacking a woman close to him, the psychiatrist should have known, and had he conducted an appropriate evaluation, would have known, of this danger. Other courts, too, found no need for a specific threat for the duty to warn/protect to arise. The Court of Appeals of Michigan was especially active in developing this genre of liability in the eighties (37,38).

For example, in *Davis* v. *Lhim* (37), John Patterson had a history of numerous hospitalizations before shooting and killing his mother, Mollie Barns. Though John had not expressed to his treaters a threat to harm his mother, a notation had been placed in the record of another hospital two years before the killing, that he was observed pacing the floor and "threatening his mother for money" (34, p. 490). Whether this constitutes a "specific threat" is questionable, but the court of appeals in 1983 found these notes sufficiently pointed to Mollie Burns as to indicate her as a readily identifiable victim to whom protective obligations applied.

In *Bardoni* v. *Kim* in 1986 (38), the patient Richard Bardoni had been delusional, believing his brother was trying to kill him, and he expressed to his wife, Evelyn, that he wanted to kill his brother, although she never conveyed this to the physician. After hospitalization and discharge, voluntary admission at another hospital was attempted, but Bardoni declined, and three months after discontinuing outpatient therapy, killed his brother and mother and assaulted his wife. The appellate court upheld a duty to warn. His mother was not a readily identifiable victim. Whether his brother had been was to be determined by the fact finder.

The Identifiable Victim Rule

A number of courts limited protective duties to *identifiable* victims without further requiring threats against the victim. In *Leedy* v. *Hartnett* (39), The United States District Court for the Middle District of Pennsylvania in 1981 found no duty to warn the victims because there were no identifiable victims. The United States District Court for the Eastern District of Virginia in its 1982 *Holmes* v. *Wampler* (40) decision, declined to rule on whether or not a duty to warn exists, because the case facts did not include foreseeable violence and an identifiable victim. In *Furr* v. *Spring Grove State Hospital* (41) in 1983, a Maryland court declined to accept or reject a Tarasoff duty to warn, because the victim was not identifiable. In *Sellers* v. *United States* (42) the Sixth Circuit, United States Court of Appeals in 1989, without finding a duty in the instant case, acknowledged "only a relatively narrow duty to warn *readily identifiable potential victims*" (42, p. 1099, emphasis added).

The Specificity Rule

A number of courts in the eighties attempted to contain the duty to warn or protect further by limiting the duty to the cases which satisfied the *specificity rule* wherein the patient threatened to harm an identifiable individual. The Court of Special Appeals of Maryland in *Shaw* v. *Glickman* (43), declined to accept or reject Tarasoff-like liability, because the patient had expressed no intent to harm anyone. The most limited specificity rule of the decade was formulated by the Supreme Court of Minnesota in its 1982 *Cairl* v. *State* (44) decision; ". . . if a duty to warn exists, it does so only when specific threats are made against specific victims . . . Moreover, . . . if a duty to warn exists at all, it is a duty to warn of latent dangers" (44, p. 26). In *Doyle* v. *United States* (45) the United States District Court, Central District of California, in 1982 found that Louisiana law (46) would not hold a psychiatrist to a duty to warn the victim where the patient never told the psychiatrist of his intent to kill the victim. In *White* v. *United States* (47), the United States Court of Appeals for the District of Columbia found no duty in the instant case but would accept Tarasoff-like liability if the specificity rule were satisfied.

More than any other case, the specificity rule is associated with *Brady* v. *Hopper* (48). Both the district court (48) and the United States Court of Appeals, Tenth Circuit for the District of Colorado (49), though not upholding liability in this case, accepted a therapist's duty to protect other persons if the patient makes a verbal threat directed against an identifiable person. In *Cooke* v. *Berlin* (50), the Court of Appeals, State of Arizona, citing Brady (48), similarly did not sustain the instant claims because there was no "specific threat to a specific victim" (50, p. 836). In *Williams* v. *Sun Valley Hospital* (51), the Texas Court of Appeals at El Paso, cited Brady (48) and Thompson (28) and found without "a threat or danger to a readily identifiable person" (51, p. 787), a liability should not be imposed upon treaters for the "unpredictable conduct" (51, p. 787) of their patients.

Also, in the eighties, ten state legislatures enacted laws to address the confidentiality versus public protection dilemma and this vague and fluid judicial jurisprudence: California, Colorado, Indiana, Kentucky, Louisiana, Michigan, Minnesota, Montana, New Hampshire, and Washington. In each of these statutes, the duty to warn/protect, if it exists, occurs only when the specificity rule is satisfied, i.e., when at least a threat of violence is made against an identifiable victim.

Like matroyshka dolls, the specificity rule fits into the identifiable victim rule which fits into the foreseeable victim rule which fits into the foreseeability rule, but the reverse order does not work. These rules are not coterminous.

Zone of Danger Rule

In tort litigation involving automobile accidents, the reckless driver's victims, though not identifiable to the driver, are foreseeable because they are in the "zone of danger," i.e., in the general direction in which the vehicle is headed. Though the analogy is not tight, in Hedlund (29), the violence to the targeted mother's five-year-old son was considered foreseeable by the court, because he could be expected to be near his mother and hence in the zone of danger. Thus, he need not be identified in a verbal threat to be a foreseeable victim.

In *Hamman* v. *County of Maricopa* (52), the Supreme Court of Arizona found that someone "subject to probable risks of the patient's violent conduct" (52, p. 1128) was in the zone of danger and the violence to this individual was, therefore, foreseeable. The court's definition is incomplete and vague (53), but from the facts of that case, one might surmise that people who live together with a potentially violent mental patient are in the zone of danger and their victimization may be foreseeable even without a verbal threat or other specific identifying information. Other courts explicitly rejected the notion that frequent social contact or co-habitation renders a group of people sufficiently identifiable as foreseeable victims (*Dunkle* v. *Food Service East Inc.* (54), *Leedy* v. *Hartnett* (39)).

Sovereign Immunity

In *Canon* v. *Thumudo* (55) the Michigan Supreme Court held that state employed psychiatrists are immune from claims concerning whether or not to hospitalize a potentially violent or dangerous patient, whether a relative should be warned of harm from a patient, and whether a patient is properly placed in an outpatient program. Such decisions are discretionary, not ministerial, and citing earlier court opinions, the Michigan Supreme Court stated "discretion implies the right to be wrong" (55, p. 691). The court did not address whether a duty to warn exists, apart from the sovereign immunity afforded state employed psychiatrists.

Professional Judgment

Some courts applied the traditional professional judgment rule to limit Tarasoff-like liability. For example, in *Sherrill* v. *Wilson* (56) in 1983, the Supreme Court of Missouri stated, "We conclude that the defendant physicians should not be held liable for even foreseeable damages simply because they might be found to have exercised negligent professional judgment in permitting [the patient] to leave the premises" (56, p. 666).

One approach to the professional judgment rule is to acknowledge that psychiatrists should bear no liability for an honest error in medical judgment but to insist that such judgment be based upon an adequate assessment of the patient. In *Clark* v. *State* (57), for example, the Supreme Court of New York, Appellate Division, Third Division, held that the psychiatrist's decision not to hospitalize a mental patient who attacked and injured a police officer was not based upon a "professional medical determination" (57, p. 170), because of insufficient examination of the patient, the medical record, and other available "vital information" (73, p. 172).

In contrast, especially to *Sherrill* v. *Wilson* (56), the Supreme Court of Ohio in *Littleton* v. *Good Samaritan Hospital* (58) established a formula for determining whether professional judgment was in fact exercised regarding decisions to extend hospitalization or discharge a potentially violent patient. Clinicians have a duty to apply professional judgment; and, if they do, they will not be liable for adverse outcomes. On the other hand, they will be held accountable if third persons are harmed because the physician failed to use professional judgment.

No Duty to Protect from a Dangerous Outpatient

Although not specifying under what conditions a special relationship would allow imposition of a protective duty on a psychiatrist, in *King* v. *Smith* (59), the Supreme Court of Alabama found that the psychiatrist's contacts with an outpatient were insufficient to establish a special relation exception to nonresponsibility. Hence, the psychiatrist had no duty to prevent his patient from killing his two daughters and then himself.

The United States District Court for the District of Maryland in its 1982 *Hasenei* v. *United States* (60) decision, rejected the Tarasoff analysis of common law and its resultant protective principle. The court stated that the psychiatrist had "neither the right nor the ability to control [the] veteran's conduct so as to give rise to [a] duty to warn others of [the] veteran's dangerousness" (60, p. 999). A special relation exception (Section 315, Restatement (Second) of Torts (11)) to the common law rule of nonresponsibility must involve control, such as the control afforded by hospitalization (Illustration under Section 319, cited in Footnote 10, p. 1009, (13)), before the psychiatrist can incur an obligation to protect other persons from the patient's potential violent conduct. A judicial seed in opposition to Tarasoff (which might be termed the Sections 315–319 rule) was thereby planted as early as 1982. Similar decisions would follow in the next decade.

Retreat from Tarasoff (1990–1999)

Similar interests and dynamics surrounding the duty to warn or protect continued into the last decade of the century. This includes the further developments and expansions of protective duties and applications of a Tarasoff-like principle favoring warnings over confidentiality concerning diverse issues, including informing a patient of her HIV seroconversion to prevent infection of a third person (61), informing a patient of the genetic heritability of a cancerous tumor to protect potential offspring (62), and compromised privilege (forcing testimony by therapists in the criminal prosecution of their patients) (63,64). However, with regard to the matter of protecting others from a patient's violent acts, the most substantial and salient trend has been a pronounced retreat from the Tarasoff principle. As will be discussed, courts retreated from the Tarasoff principle by "statutory containment," finding no duty to warn, finding no duty to control a voluntary patient, and where a duty to warn/protect is acknowledged, proactively sharply limiting its application beyond even the Thompson limitation imposed by the California Supreme Court. Because these recent cases, though very significant, have been little discussed compared with the earlier Tarasoff progeny cases, we will here recapitulate some notable facts given in several of these more recent court opinions. Before commensing our summary of how courts in the nineties have retreated from or rejected the Tarasoff principle, however, we must first acknowledge that not all jurisdictions demonstrated a judicial retreat from Tarasoff.

Adoption of Tarasoff

Connecticut—An example of where a court adopts and extends the application of the Tarasoff principle is *Almonte* v. *New York Medical College* (65). In this case, heard on appeal by the United States District Court for the District of Connecticut, the complaint alleged the foreseeable victims were future child patients of a physician in psychiatric and psychoanalytic training who allegedly told his psychoanalyst that he had a pedophiliac disorder. During the training rotation, the resident, Dr. Demasi, allegedly repeatedly sexually assaulted and threatened a 10-year-old patient in the hospital. Citing the United States Court of Appeals for the Second District in *Frazier* v. *United States* (66), the district court noted that the Court of Appeals did not reject the Tarasoff principle and indeed anticipated that the duty could extend to a "class of victims" (65, p. 40), as well as a particular victim. Subsequently, and after Almonte, the Supreme Court of Connecticut came to a remarkably consistent conclusion when addressing a duty to control in *Frazier* v. *United States* (1996) (67). The district court found that the plaintiffs stated a proper claim for "failure to exercise reasonable care to protect," because the psychiatrist and the college did not make an attempt to warn the rotational hospital or "otherwise protect future patients" (65, p. 41) such as the victim.

Missouri—Although pertaining to a case involving Missouri's state statutory requirement to report suspected child abuse, the Missouri Court of Appeals, Western District, in *Bradley* v. *Ray* (68), adopted the Tarasoff principle, at least to the extent that warnings are appropriate. This court followed the Tarasoff logic that the special relation alone (Section 315) provides an exception to the common law rule of nonresponsibility, and the Tarasoff-

Thompson rule that the protective duty arises only where the targeted victim is "foreseeable" and "readily identifiable." While establishing a Tarasoff-like duty to warn, this court distinguished its holding from that of the Missouri Supreme Court in Sherrill (56) which had previously found no duty to physically control the potentially violent patient.

Ohio—The Supreme Court of Ohio, having already formulated a professional judgment rule to assess Tarasoff-like liability regarding hospitalization errors involving inpatients who, after release, cause injury to others, has now applied a similar standard concerning outpatients in *Estates of Morgan* v. *Fairfield Family Counseling Center* (69). "When a psychotherapist knows or should know that his or her outpatient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her best professional judgment to prevent such harm from occurring" (69, p. 1313). This clearly brings the Tarasoff duty to protect from violence of outpatients to Ohio psychiatrists, where a duty to protect from inpatients already existed.

Tennessee—In 1997, the Supreme Court of Tennessee in *Turner* v. *Jordan* (70) acknowledged a Tarasoff-like duty to protect without the need for a specific threat, a specific victim, or involuntary hospitalization. Apparently, in a psychotic state, patient Tarry Williams was admitted to Hubbard Hospital. Curiously, because he was recognized to be violent, the treating psychiatrist, Dr. Harold Jordan, considered discharging Williams. On the evening following the day of admission, Williams severely assaulted a nurse, inflicting head injuries. In the ensuing lawsuit, the plaintiff's expert testified that Dr. Jordan failed "to medicate, restrain, seclude, or transfer Williams," thus, the standard of care was not satisfied. The high court of Tennessee concluded that the "psychiatrist owed a duty of care because he knew, or should have known, that his patient posed an unreasonable risk of harm to a foreseeable, readily identifiable third party" (70, 816).

Statutory Containment of Tarasoff

Louisiana—Several courts in the nineties allowed third party liability à la Tarasoff II, but only within the contours established by the state's protective disclosure law. Two appellate courts based their restriction of liability on Louisiana's protective disclosure law that applies a specificity rule (71). In *Hines* v. *Bick* (72), the Fourth Circuit, Court of Appeals of Louisiana, "granted an ex proprio moto a no right of action as to the hospital" (72, p. 455), and held that a mental patient had no right to recover damages from his hospital psychiatrist. Any duty of a psychiatrist to warn or protect a victim from a patient's violence occurs "only when a patient has communicated an immediate threat of physical violence against a clearly identified victim or victims" (72, p. 461).

Durapau v. *Jenkins* (73) concerned allegations that a patient stabbed the plaintiff about four months after release from the hospital. The Fifth Circuit, Court of Appeals of Louisiana, found no causal connection between the patient's release and his subsequent stabbing attack. Moreover, citing Louisiana's protective disclosure statute and *Hines* v. *Bick* (72), the court declared "before the duty of [a] psychiatrist to warn third parties about possible violent behavior of a patient even arises, the patient must have made a threat to a clearly identifiable victim" (67, p. 1069). In this case, then, the psychiatrist had no duty to warn or otherwise protect any potential victims and patient-therapist confidentiality prohibited disclosure.

Michigan—Similarly, the Court of Appeals of Michigan in its 1998 decision, *Swan* v. *Wedgwood Family Services* (74) found that a psychiatric treatment facility had no duty to warn or protect a 69-year-old man from a fatal attack by the 16-year-old patient. Any duty to provide treatment was owed to the patient, not to the victim. And, since Michigan's protective disclosure law (75) limits protective duties to situations satisfying a version of the specificity rule, no common law duty to warn or protect arose in this case.

No Duty to Warn

Florida—The District Court of Appeals for Florida, Third District, in *Boynton* v. *Burgess* (1991) (76), refused to impose on a psychiatrist a duty to protect an identifiable potential victim from a patient who had threatened to kill her. The court opined that such a duty would be unreasonable, unworkable, and harmful to the patient-therapist relationship. Also, reminiscent of the American Psychiatric Association's amicus brief to the Supreme Court of California regarding the Tarasoff I case, the court openly doubted a psychiatrist's ability to foresee harm with his "crystal ball." Moreover, the court put psychiatrists on notice that failure to honor confidentiality could be in violation of Florida law.

Without summarizing the facts of *Green* v. *Ross* (77), the Second District, Florida District Court of Appeal, also found no duty to warn. However, the Second District reasoned that the protective disclosure statute (78) was permissive and therefore did not create a legal duty to warn. Unlike the Third District, the Green opinion did not raise the specter of liability if a protective disclosure were made consistent with the permissive statutory law. Eschewing "judicial activism," the court explicitly left to the legislature the matter of deciding what, if any, new causes of action should be created.

Mississippi—In *Evans* v. *United States* (1995) (79), the United States District Court, Southern District of Mississippi, rejected a Tarasoff-like duty to warn. A Vietnam War veteran killed his daughter, Leslie, and then took his own life. The claim that the identifiable victim should have been warned was predicated on the Tarasoff ruling as well as the psychiatrist's assurances to the family that he would warn them if the patient's condition worsened and he posed a risk of violence. Applying Mississippi law, the court found no need for the psychiatrist to follow the Tarasoff principle which was in effect in California, but not Mississippi. The confidentiality law in effect in Mississippi (80) prevented protective disclosures; thus, even in the face of the doctor's alleged promise to issue a warning if need be, there was no protective duty.

Interestingly, the year after Evans killed his daughter and himself, the Mississippi legislature revised the confidentiality law by including a protective disclosure provision for treating physicians, psychologists, and social workers where a patient expresses "an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims . . ." (81). Although the wording is permissive, not obligatory, the court left open the question of whether a duty to warn identifiable victims could follow from this post hoc enacted exception to medical confidentiality.

Texas—After the Texas Court of Appeals at El Paso's Williams (51) decision in 1987, acknowledging a duty to warn or protect, four other Texas courts of appeals recognized protective duties to potential victims of a patient's violence. The Texas Court of Appeals at Austin in *Kerrville State Hospital* v. *Clark* (82), adopted the "zone of danger" rule from Hamman (52) to determine whether

the victim was foreseeable. The Texas Court of Appeals at Fort Worth in *Kehler* v. *Eudaly* (83) would have required that the victim be "readily identifiable" or the danger "foreseeable" for a duty to warn/protect to apply. In *Limon* v. *Gonzaba* (84), the Court of Appeals of Texas at San Antonio invoked the Tarasoff-Thompson rule to determine whether a duty existed.

Of the appellate courts that supported a Tarasoff-like duty to warn/protect, the Texas Court of Appeals at Houston, First Division, in *Zezulka* v. *Thapar* (85), was the only one in which the facts seemed to fit the specificity rule, even the narrowest formulation of the specificity rule. The patient, Lilly, reportedly hated his stepfather, Zezulka. He once slapped his stepfather in public and he told his psychiatrist, Dr. Thapar, that he wanted to kill his stepfather. Lilly's medical record stated that he was homicidal and wanted to kill his stepfather. One month after his discharge from the hospital, Lilly did just that. This court found that the psychiatrist indeed had a duty to warn the homicide victim.

Zezulka was appealed to the Supreme Court of Texas, *Thapar* v. *Zezulka* (86), which rendered its opinion in June of 1999. The Supreme Court of Texas rejected a Tarasoff-like duty to warn because the confidentiality statute governing mental health professionals prohibited such protective disclosures (86, p. 635). Actually, the law on privileged and confidential information explicitly allowed breach of confidentiality to notify medical or law enforcement officials if a patient presents a threat of violence (87). This confidentiality exception did not prevent the court from putting psychiatrists on notice, as the Florida court did in Boynton (76), that ". . . mental health professionals make disclosures at their peril" (86, p. 640); a worrisome play on Justice Tobriner's famous dictum in Tarasoff, "The protective privilege ends where the public peril begins" (7, p. 347).

No Duty to Control a Voluntary Patient

Florida—In the nineties, several courts held there is no duty to control a voluntary patient. In *Santa Cruz* v. *N.W. Dade Com. Health Ctr.,* (88), in 1991, the District Court of Appeals of Florida, Third District, citing Hasenei (60), Boynton (76), and *Paddock* v. *Chacko* (89), found no duty to protect victims from the violent acts of a voluntary patient. Here, Oscar Santa Cruz described as "violent and delusional" was committed to South Florida State Hospital. Before his transfer from Jackson Memorial Hospital, however, he managed to escape. Two weeks later, he returned to Northwest Dade Community Mental Health Center where he was treated as an outpatient. Within a few weeks of beginning outpatient treatment, he shot and injured Albert Declara, and his own brother, Osmani Santa Cruz. The Third District Court reasoned that the takes charge exception (Section 319) must be satisfied for a special relation exception (Section 315) to exist. Lacking a special relationship, no duty to protect third persons occurred in this case.

Kansas—By way of factual background for the Supreme Court of Kansas' *Boulanger* v. *Pol* (90), decision, in 1995, ten days after his discharge from an intermediate health care facility, Ron Hill nonfatally shot his uncle, Darrell W. Boulanger. Allegedly believing Boulanger to be the devil, Hill had assaulted Boulanger previously. In the court's opinion, it appears the intervening history, though quite detailed, did not create a strong case for the plaintiff, who was already frightened of Hill on the day of the shooting. The Supreme Court of Kansas found no duty to control a voluntary patient.

The Kansas decision could puzzle those who recall its *Durflinger* v. *Artiles* (91) decision in 1983. In Durflinger, the Kansas high court upheld a medical malpractice cause of action based on negligent discharge of a violent patient who reportedly had an antisocial personality disorder, but not mental illness, and who had been involuntarily committed.

The Kansas Supreme Court's finding of no duty to control a voluntary patient, in Boulanger (96), contrasts with its 1983 decision in Durflinger (91), wherein the court held there is a duty to control an involuntary patient. (The U.S. District Court's 1981 decision in Durflinger (32) was, incidentally, consistent with the state supreme court's opinion regarding the same case.) Because Boulanger was already fully aware that Hill presented a danger to him, there was no duty to warn Boulanger. No special relationship existed that would create a duty to warn the victim or to pursue involuntary hospitalization.

Maine—In *Rousey* v. *United States* (92), the United States Court of Appeals, Sixth Circuit, held that under Maine law, the psychiatric hospital had no duty to detain a voluntary inpatient who, in less than three weeks after discharge, shot and killed his estranged wife and three others and wounded two additional individuals. The plaintiff, Ann Rousey, was one of two survivors of the shooting. Using the Sections 319–315 formula, the court found no special relationship and hence no duty to detain. Additionally, any claim of negligent treatment pertains to a duty to the patient, not to third persons. And, there was no duty to warn, because the victims were not considered "reasonably foreseeable and readily identifiable victims" of the patient's violent acts (92, p. 399). (Even though allowing for the possibility of a Tarasoff duty to warn, the Sixth Circuit rejected the Tarasoff duty to hospitalize. The Tarasoff principle was a duty to protect; protective measures included both warnings and hospitalization. In the Tarasoff case the Supreme Court of California acknowledged California's statutory immunity against claims of failure to hospitalize but at the same time included hospitalization implicitly as one of the measures "reasonably necessary" for fulfilling the duty to protect.) Nonetheless, the sixth circuit court left open the possibility of a duty to warn if the victim is reasonably foreseeable and readily identifiable.

Mississippi—A Mississippi court similarly found no duty to protect other persons from a voluntary hospitalized patient in *Burchfield* v. *United States* (93). After escaping from an open ward at the Biloxi Veterans Administration Medical Center (VAMC), William Dyer, a 37-year-old man, assaulted Judy Burchfield, apparently a random victim, in her home. The U.S. District Court, Southern District of Mississippi, followed the logic of the District Court of Maryland in Hasenei (60) which declined to invoke Section 315 or 319 of the Restatement (Second) of Torts to establish a duty to control the patient. Because there is no recognized duty to control voluntary patients, including hospitalized patients, and because the attack against the randomly selected victim was unforeseeable, the court found no duty owed to the plaintiff and, therefore, no breach of a duty.

North Carolina—In *Moye* v. *United States* (94), the United States District Court, Eastern District for North Carolina, held that VA medical personnel had "no duty to control or commit a former patient" who shot and killed both of his parents (94, p. 179). The court additionally found no duty to warn, as the decedent parents were already aware of their son's potential for violence.

The Court of Appeals of North Carolina, in *King* v. *Durham County Mental Health* (95), similarly found no duty to control a voluntary patient. Mohammed Thompson, a 17-year-old youth

with a history of violent crime and drug abuse, was in residential treatment when he absconded from the facility and, together with an accomplice, attempted to rob a convenience store and shot and killed Sherri King White. Since no court order required Thompson to participate in the program, defendants in the ensuing lawsuit had neither the ability nor the right to control him.

However, in *Davis* v. *North Carolina Dept. of Human Res.* (96), the same court clarified that once a patient is hospitalized under civil commitment, the psychiatrist has a duty to protect others from harm. This duty is not limited to preventing escape and wrongful discharge; it also, as in this case, requires the psychiatrist to provide the court with appropriate information so the court can make an informed decision about whether to release the patient from civil commitment. This is consistent with earlier cases that sustained third party liability without requiring medical malpractice (97,98).

Virginia—By way of factual background for the Supreme Court of Virginia's 1995 *Nasser* v. *Parker* (99) decision, George Edwards had put a gun to the head of his rejecting girlfriend, Angela Lemon, and threatened to kill her. Five days after this incident, Dr. Parker, the psychiatrist who treated Edwards, arranged for Edward's voluntary hospitalization. Apparently feeling safe that Edwards was now safely hospitalized, Lemon, who had moved out, returned to her home. Not on a secure unit, Edwards left the hospital without authorization. Dr. Parker saw Edwards a few times as an outpatient and prescribed medication. Three days after his last doctor's appointment and eleven days after leaving the hospital, Edwards fatally shot Lemon and then himself.

The Supreme Court of Virginia rejected the Tarasoff interpretation of common law stating that the "special relation" exception is insufficient to support a duty to protect; rather the "takes charge" exception to the common law rule of nonresponsibility is required (99, p. 506). Voluntary hospitalization alone is insufficient legitimate control for the "takes charge" exception to apply (99, p. 506). Though not explicit on this point, the court left open the possibility that a duty to protect could exist if the patient were hospitalized under legal coercion, such as by civil commitment; but voluntary hospitalization and presumably outpatient treatment, too, provide insufficient legitimate control to permit a duty to protect others either through containment or warnings.

Although pertaining to release of a jail detainee, not a mental patient, in *Marshall* v. *Winston* (100) the Supreme Court of Virginia clarified that beyond legitimate control, the violence must have been foreseeable for the special relations Section 315 (a), via the takes charge Section 319 exception to nonresponsibility, to apply. Even though legal detention in jail provides legitimate control of the actor, the plaintiff failed to allege, let alone prove, that the defendants "knew or should have known that [the actor] was likely to cause bodily harm to others if not controlled" (100, p. 904).

In its 1997 *Sage* v. *United States* (101) decision, the United States District Court for the Eastern District of Virginia held that under Virginia law, the defendant hospitals "did not take charge of or exercise control over" a patient who went on a deadly shooting spree, "and thus [a] special relationship did not exist between [the] hospitals and patients such that [the] hospitals would have a duty to protect victims from wrongful acts of [the] patient" (101, p. 852). Dr. Jean Claude Pierre Hill, a psychiatric resident at Hahnemann University, allegedly double parked his car, exited, and then calmly shot four strange men. Two were seriously injured and Peter Foy died. Foy's executrix brought the law suit. The district court further held that the hospitals had no duty to prevent a wrongful act that was not foreseeable, or whose victims were not foreseeable.

To decide whether a duty existed, the district court turned to the relevant substantive Virginia law and the Nasser (99) decision of the Virginia Supreme Court in particular. As explained above, the Nasser court found there to be no duty to protect third persons as an exception to common law nonresponsibility unless a special relationship exists, Section 315, which in turn depends on the existence of the "takes charge" or control exception of Section 319. During Dr. Hill's treatment, military doctors never took charge of Dr. Hill; thus, there was no duty to protect victims from his violent behavior.

Acknowledgment of Circumscribed Duties to Warn or Protect

Illinois—The final approach to limiting Tarasoff-like duties and responsibilities is to acknowledge them but, at the same time, proactively circumscribe their application. This was the approach taken by two Illinois district courts and the Pennsylvania Supreme Court. An example of a court sharply restricting the contours of protective duties was the opinion of the Illinois Appellate Court, First District, Third Division, in *Charleston* v. *Larson* (102). Andrew Thaine was voluntarily admitted to CPC Streamwood Hospital on April 2, 1992. Early on May 3, he allegedly threatened Vita Charleston, a nurse in this facility, saying he would "break her neck" (102, p. 543). He assaulted her later that same day.

The appellate court held that the psychiatrist did not have a duty to protect Nurse Charleston, because the requisite special relationship, as defined in earlier Illinois case law, was lacking. Moreover, the patient's outburst was "unexpected and unpredictable" (i.e., unforeseeable) (102, p. 551).

Although not conforming to the facts of Charleston, the court identified two distinct protective duties and defined each most conservatively: the duty to warn and the duty to protect. Citing *Eckhart* v. *Kirts* (103), the court said a duty to warn arises if the patient expresses "specific threat(s) of violence . . . directed at a specific and identifiable victim," within a special relationship such as " 'direct physician-patient' or between the patient and the plaintiff" (98, p. 553, emphasis added).

The duty to protect in Charleston is not the Tarasoff concept that embodies various methods of protection from different types of warnings to hospitalization. Here the duty to protect is more closely akin to the duty to control through secure hospitalization. Citing *Estate of Johnson* v. *Condell Mem. Hosp.* (104), the court explained that this duty occurs only when a facility has "custody" of the patient authorized by a court adjudication that provides "actual control" over the patient. This concept of protection through the legitimate control of legally coerced hospitalization compares with the highly restricted protective duties suggested earlier, in 1982, by the Maryland court in Hasenei (60); and by the nearly contemporary decisions of the supreme courts of Kansas, in Boulanger (90), and Virginia, in Nasser (99).

Pennsylvania—Proactive circumscription of Tarasoff-like duties was also the approach taken by the Pennsylvania Supreme Court. The facts of the Pennsylvania case, *Emerich* v. *Philadelphia Center for Human Development* (105), are as follows: the assailant-patient had a history of verbally and physically abusing his homicide victim-girlfriend and had often threatened to kill her and his ex-wife. On the morning of the homicide, he reaffirmed to his counselor over the telephone his intention to kill his girlfriend, if she were to return to their apartment for her belongings. She, too, called the same counselor and told him she planned to return to the apartment to collect her items. The counselor advised her against

this but did not reiterate the specific threat. She went to the apartment, nonetheless, and was murdered.

The Pennsylvania Supreme Court held that, in this case, the counselor's admonition was warning enough, especially since the victim was presumably already aware of her boyfriend's violent potential based on his abusive treatment of her. The duty to warn arises only if a very limited formulation of the specificity rule is met, namely, only where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a "specifically identified or readily identifiable victim" (105, p. 1032). The court noted that third party liability had already been established in a previous decision by the same court (*Goryeb* v. *Commonwealth, Department of Public Welfare,* (1990) (106) for negligently discharging a dangerous patient (107, p. 1041), but the court was unclear whether a protective duty exists to hospitalize a forseeably violent outpatient.

Summary and Conclusion

In the third quarter of the twentieth century, even as the treatment of serious mental illness improved and moved from predominantly hospital to community based, confidentiality precluded protective disclosures and hospitalization was the principal means of protecting the public from potentially violent mental patients. Tarasoff announced that protective warnings could be not only desired, but legally compelled, and the outpatient clinic was not a haven from third party liability. Public protection was not to be put aside by the shift toward community treatment.

The confusing array of diverse rules in the nineteen eighties cast doubt on what clinicians should do, other than simply follow the law, regardless how capricious and inconsistent. Then, after over a decade of psychiatrists becoming indoctrinated with the Tarasoff principle and its various permutations, the nineties ushered in not only wholesale rejections of Tarasoff, but in several appellate court decisions, psychiatrists were warned that they could be in violation of confidentiality law if they issued protective warnings. A Georgia court recently awarded a patient police officer $151,470 in compensatory damages and $103,779 in legal fees, and his wife $25,000 for loss of consortium in a lawsuit against a psychologist who issued protective warnings that allegedly resulted in the officer's demotion and suspension at work (107). Mental health professionals in these jurisdictions must be re-indoctrinated if they wish to avoid liability of another kind.

The usual mantra, beyond proper diagnostic evaluation, risk assessment and treatment, is to follow the cognizant law. Even professional ethical codes provide paltry little guidance because they defer to the law which is inconsistent. If the professional's only concern is avoidance of liability, a mental health professional will handle a patient who presents a serious, specific threat of harm against a readily identifiable individual differently in different states. Liability is not a trivial concern; although the number and percentage of such third party liability suits is small, the monetary sums for adverse judgments can be staggering. In *Rotman* v. *Mirim,* a 1988 Massachusetts jury awarded the plaintiffs 4.5 million (108), though while on appeal, the parties settled the case for an unknown amount. In *Williamson* v. *Liptzin* (109) in 1997, the plaintiff was awarded one-half million dollars in damages, plus interest and costs. In *Buwa* v. *Smith* (110), a duty to warn case was settled, pretrial, for 2.8 million.

Concern about diverse and changing rules of liability can flummox and becloud one's judgment about what exactly is the right thing to do, a specific legal dictum, or lack thereof, notwithstanding. After all, we are talking about trying to save life and limb with a reasonable measure involving remarkably little effort. A simple algorithm has been offered to aid the clinician in making difficult dichotomous decisions about warnings and hospitalization (111); here, suffice it to say, the morally correct decision in balancing a potential victim's life against a patient's confidentiality is not invariably a legally defensible decision.

A rational ethical approach would recognize the importance of allowing protection to save life and limb, not to blindly adhere to the law. But the law itself, were it rational, would also recognize the possibility of gray areas where some judgment must be permitted between the rules of confidentiality and protective measures. Questions of adverse outcomes, especially wrongful death claims, should be examined for traditional malpractice issues such as improper or insufficient evaluation and treatment, including where the law allows, failure to control via hospitalization. Analyses should address whether the evaluation for dangerousness was sufficient and whether treatment planning appropriately took into account the question of danger potential where reason for such concern was evident. However, the matter of warnings, because of the high stakes, inexact science, and inconsistent, fluctuating jurisprudence, should allow for greater discretion by the clinician. Particularly where extreme violence is reasonably foreseeable, clinicians ought to be free to exercise discretion without fear of liability, much as judges are protected from liability when making tough decisions involving competing individual and societal interests. Rather than the clinician being forced into a position of facing the Scylla of a lawsuit for breach of confidentiality, or the Charybdis of a lawsuit for failure to warn, when these legal perils themselves shift positions like maelstroms in a stormy sea, there is a need for a liability free zone for discretionary warnings.

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