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Psychiatrists Have No Duty to Warn Third Parties of Patients' Threats: Tarasoff is Kicked Out of Texas... Finally!

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PSYCHIATRISTS HAVE NO DUTY TO WARN THIRD PARTIES OF PATIENTS' THREATS: *TARASOFF* IS KICKED OUT OF TEXAS . . . FINALLY![†]

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I. INTRODUCTION

On June 24, 1999, a unanimous Texas Supreme Court held that a mental health patient's threat to kill an identifiable person did not impose a duty on a psychiatrist to warn the intended victim.[1] In so holding, the court expressly declined to follow[2] the California Supreme Court's seminal decision in *Tarasoff v. Regents of the University of California*,[3] which held that a psychotherapist who determines, or reasonably should have determined, that a patient poses a serious danger of violence to a reasonably identifiable victim has a duty to warn that victim.[4] Although several jurisdictions have adopted the

† Dedicated to my father.
1. Thapar v. Zezulka, 994 S.W.2d 635, 636 (Tex. 1999).
2. *See id.* at 638.
3. 551 P.2d 334 (Cal. 1976).
4. *Id.* at 345. "Before *Tarasoff*, . . . no court had ever extended [the common law duty to control the conduct of another] principle to a psychiatrist's relationship with a

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Tarasoff doctrine,[5] either by statute or by case law, "[t]here can be no doubt about the controversy and confusion created by this controversial decision. Courts continue to struggle with its legacy over twenty years later, and despite intense, high-profile litigation, no national consensus has been reached."[6] The confusion stems from the fact that there are significant legal consequences to a psychiatrist's decision to disclose a patient's confidences. As one commentator succinctly put it:

> The dilemma is that if the psychiatrist reveals a confidence, the patient may register a complaint with the licensing board, and/or the patient may have the basis for a lawsuit based on a breach of confidentiality. On the other hand, if the psychiatrist does *not* reveal a confidence to protect a third person, and that person is harmed, then that third person may have the basis for a lawsuit for the injuries suffered.[7]

This Comment argues that the Texas Supreme Court was correct in declining to follow the *Tarasoff* doctrine, thereby excusing Texas psychiatrists from having to face this double-edged sword. The court is to be congratulated for finally putting an end to the ongoing debate of whether any duty to warn third parties should be imposed on Texas psychiatrists, regardless of whether those third parties are identifiable or not.[8]

Part II of this Comment outlines the facts and holding of the *Thapar* case. Part III analyzes the Texas confidentiality statute that was at issue in *Thapar* and will demonstrate that the Texas Supreme Court was correct in finding that psychiatrists are under no statutory duty to warn third parties. Part IV reviews and analyzes the common law immediately preceding *Thapar*, in Texas and in other states, and will conclude that the *Thapar* court was correct in refusing to recognize a common law duty to warn third parties of a patient's threats. Part V highlights some of the justifications of the *Thapar* holding in view of social and economic considerations. Finally, this Comment concludes in Part VI that while the *Thapar* court is to be applauded for its deferential approach to the legislature, the court is encouraged to also consider the Restatement of Torts, case law preceding *Thapar*,

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voluntary outpatient." Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 293 (1982).

5. Timothy E. Gammon & John K. Hulston, *The Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749, 751 (1995) (noting the states that have embraced *Tarasoff*).

6. *Divergent Opinions Regarding the* Tarasoff-*Type Duty – A Double Bind*, R_x FOR RISK, Winter 2000, at 1.

7. Michael J. Laub, Garamella, Conservator for the Estate of Denny Almonte v. New York Medical College - *Navigating the Murky Waters of a Psychiatrist's Duty to Protect Third Persons*, R_x FOR RISK, Winter 2000, at 1, 5.

8. Although referring mainly to psychiatrists, this Comment is also applicable to all professionals in the mental health field.

and public policy considerations in future cases, thus taking a stronger stand against *Tarasoff* and forced disclosure of mental health patients' confidential disclosures to their psychiatrists.

II. Statement of the Case

A. *Facts*

In *Thapar v. Zezulka*,[9] Thapar, a psychiatrist, had been treating Freddy Lilly, the victim's stepson, for approximately three years, mainly on an outpatient basis and always on a voluntary basis.[10] During his last session with Thapar, Lilly confided that he felt like killing his stepfather but had decided against it.[11] Thapar did not tell Lilly's family or law enforcement personnel of this and other similar threats.[12] One month later, Lilly shot his stepfather in the face at point-blank range, killing him instantly.[13] The wife of the victim brought a wrongful death action against Thapar, alleging, among other things, that Thapar was negligent in failing to warn the victim or his family that Lilly had threatened to kill his stepfather during one of Thapar's therapy sessions.[14]

B. *Holding*

The Texas Supreme Court held that the psychiatrist was prohibited by the confidentiality statute from disclosing to a victim that the patient had threatened to kill the victim during a therapy session; therefore, the psychiatrist had no *statutory* duty to warn third parties of this threat.[15] The court also held that a psychiatrist to whom a patient admitted a desire to kill an identifiable victim had no *common law* duty to warn that victim, the victim's family, or law enforcement.[16]

III. The Statutory Duty to Warn

Commentators have recognized that "[d]ue to the confusing and conflicting case law handed down over the years, 'a consensus is developing on the preference of [using] a legislative approach' to clarify the laws."[17] Allowing a state's legislature to define the elements and

9. 994 S.W.2d 635, 636 (Tex. 1999).
10. *See id.*
11. *See id.*
12. *See id.*
13. *See id.*
14. *Id.*
15. *Id.* at 639.
16. *Id.* at 636.
17. Allison L. Almason, *Personal Liability Implications of the Duty to Warn Are Hard Pills to Swallow: From* Tarasoff *to* Hutchinson v. Patel *and Beyond*, 13 J. CONTEMP. HEALTH L. & POL'Y 471, 481 (1997) (alteration in original) (quoting Alan R. Felthous, *The Ever Confusing Jurisprudence of the Psychotherapist's Duty to Protect*, 17 J. PSYCHIATRY & L. 575, 590 (1989)).

scope of a psychiatrist's duty leads to uniformity and predictability in case law. Moreover, the state's legislature *should* be the branch that defines the duty as its findings are arguably more reflective of a state's social policy than those of the judicial branch. The Texas Supreme Court has respectfully recognized that "the Legislature, by reason of its organization and investigating processes, is generally in a better position to establish such tests than are the judicial tribunals."[18] The judicial branch should not pompously assume that it is in a position to assert that public policy demands mandatory disclosure of patients' threats over the psychiatrist-patient confidentiality privilege.[19] The separation of powers doctrine is the cornerstone of our Constitution. For a democratic society to prevail, the judiciary should respect the legislative branch when deciding matters of public policy. Such deference was exhibited by the Texas Supreme Court in *Thapar* when it acknowledged, "We consider legislative enactments that evidence the adoption of a particular policy significant in determining whether to recognize a new common law duty."[20] While such deference to legislative enactment is to be encouraged, it is rendered useless if courts turn a blind eye to the actual language of the statutes themselves. Unlike courts of other jurisdictions, Texas courts have referred to the actual words of the state's confidentiality statute to determine the extent of the duty that a psychiatrist owes to third parties.

A. *The Texas Statute: Reviewing the Confidentiality Statute to Ascertain Whether the Duty to Warn Is Mandatory or Permissive*

Three years after the *Tarasoff* decision, the Texas Legislature enacted a statute governing the disclosure of communications between a mental health physician and his patient, a statute that strongly protects physician-patient confidentiality.[21] The statute prohibits a mental health professional from disclosing a client's communications to third parties subject to certain statutory exceptions.[22] The exception at issue in *Thapar* is found in section 611.004 of the Texas Health and Safety Code and provides that "[a] professional *may* disclose confidential information only . . . to medical or law enforcement person-

18. Praesel v. Johnson, 967 S.W.2d 391, 396 (Tex. 1998) (quoting Parrott v. Garcia, 436 S.W.2d 897, 899–900 (Tex. 1969)).

19. Such was the case in *Almonte v. New York Medical College*, 851 F. Supp. 34, 41 (D. Conn. 1994), in which a Connecticut district court held that "the Connecticut Supreme Court appears to have accepted 'the rule that a psychiatrist who knows or should know that a patient poses a threat to a particular victim or *class of victims* has a duty to warn such victims of the danger,'" despite the fact that the applicable Connecticut statute did not impose a mandatory duty on psychiatrists in such situations, but rather merely *permitted* disclosure of a patient's communications or records. *See* CONN. GEN. STAT. § 52-146F (1991) (second emphasis added).

20. *Thapar*, 994 S.W.2d at 639.

21. TEX. HEALTH & SAFETY CODE ANN. § 611.002(b) (Vernon Supp. 2001).

22. *Id.*

nel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is the probability of immediate mental or emotional injury to the patient."[23]

In defining the scope of this exception, a court should review the statute to ascertain if it *mandates* that psychiatrists warn third parties or merely *permits* them to do so. The consequences of this interpretation are significant. Fortunately, the Texas judicial branch has recognized that the words "may" and "allow," as opposed to "must" and "shall," are not accidental insertions and should not be blindly ignored in statutory interpretation.[24]

In Texas, the Code of Construction Act applies to any provision of the Texas Health and Safety Code enacted by the 60th Legislature or any subsequent legislature.[25] Because section 611.004 was enacted by the 66th Legislature,[26] the Code of Construction Act should be used when interpreting this section.

1. A Literal Interpretation of the Confidentiality Statute Indicates a Permissive Duty to Warn

Section 311.016 of the Code of Construction Act states that "unless the context in which the word . . . appears necessarily requires a different construction or unless a different construction is expressly provided for by statute . . . '[m]ay' creates discretionary authority or grants permission or a power."[27] Nothing in section 611.004 or the confidentiality statute indicates that the word "may" necessarily requires a different construction. Courts "must enforce the plain meaning of an unambiguous statute."[28] "The correct meaning of the word, 'may,' is that the [person to whom it applies] has discretion . . . ."[29] "That term generally creates a discretionary, not mandatory, function."[30] Consistent with this interpretation, no Texas court has ever

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23. *Id.* § 611.004(a)(2) (emphasis added).

24. *Thapar*, 994 S.W.2d at 639. *See also* Wright v. Ector County Indep. Sch. Dist., 867 S.W.2d 863, 868 (Tex. App.—El Paso 1993, no writ) (stating that "[t]he ordinary meaning of 'shall' or 'must' is of a mandatory effect, whereas the ordinary meaning of 'may' is merely permissive in nature").

25. TEX. GOV'T CODE ANN. § 311.002 (Vernon 1998).

26. *See* Act of May 9, 1979, 66th Leg., R.S., ch. 239, 1979 Tex. Gen. Laws 512 (amended 1991) (current version at TEX. HEALTH & SAFETY CODE ANN. § 611.004 (Vernon 2001)).

27. *See* TEX. GOV'T CODE ANN. § 311.016(1). *See also* J.R.W. v. State, 879 S.W.2d 254, 257 (Tex. App.—Dallas 1994, no writ) (stating that "[a] statute that uses the word 'may' is permissive rather than mandatory unless there is something in the statute to show a legislative intent that 'may' is mandatory").

28. Tune v. Tex. Dep't of Pub. Safety, 23 S.W.3d 358, 363 (Tex. 2000).

29. Bloom v. Tex. State Bd. of Exam'rs of Psychologists, 492 S.W.2d 460, 462 (Tex. 1973). *Accord* Womack v. Berry, 156 Tex. 44, 51, 291 S.W.2d 677, 683 (1956) (stating that "[t]he use of the permissive word 'may' imports the exercise of discretion").

30. *In re* Estate of Minnick, 653 S.W.2d 503, 508 (Tex. App.—Amarillo 1983, no writ).

interpreted the word "may" as mandating a psychiatrist to warn third parties. In fact, the word "may" has been held to denote a "permissive authorization" by the Texas Supreme Court.[31] The *Thapar* court held that section 611.004, through the use of the word "may," only *permits* a psychiatrist to disclose confidential information and does not *require* him to do so.[32] The court recognized the significance of the Texas Legislature's decision not to impose a mandatory duty when it reasoned that "[i]mposing a legal duty to warn third parties of patient's threats would conflict with the scheme adopted by the Legislature by making disclosure of such threats mandatory."[33]

The *Thapar* court's interpretation of the confidentiality statute is consistent with its holding the previous year in *Praesel v. Johnson*, where it interpreted a similar Texas statute as not imposing a mandatory duty on a treating physician to warn third parties of a patient's dangerous propensity.[34] In *Praesel*, an epileptic driver suffered a seizure and collided with a car driven by Terri Lynn Praesel, who died from the injuries she sustained.[35] Praesel's estate brought a wrongful death and survival action against the physicians who had treated the epileptic driver prior to the accident, alleging, among other things, that the physicians were negligent in failing to contact the state Medical Advisory Board regarding the patient's condition pursuant to a Texas Civil Statute.[36] That statute specifically provided that

> [a] physician who is licensed to practice medicine in Texas *may voluntarily* inform the [D]epartment [of Public Safety] or the board, orally or in writing, of the full name, date of birth, and address of a patient over the age of 15 years whom he or she has diagnosed as having a disorder or disability specified in the rules of the department. The release of such information by the physician to the board is an exception to the patient-physician privilege requirements of Section 5.08 of the Medical Practice Act.[37]

The court interpreted this section to mean that "[t]reating physicians are *permitted* by statute, but are *not required*," to disclose confidential information of a patient diagnosed with epilepsy.[38]

Moreover, section 611.004, the confidentiality statute, does not state that the psychiatrist may disclose to *any* third parties, including identi-

31. Thapar v. Zezulka, 994 S.W.2d 635, 639 (Tex. 1999).
32. *Id.* at 639 & n.22.
33. *Id.* at 639.
34. *See* 967 S.W.2d 391, 394 (Tex. 1998).
35. *Id.* at 392.
36. *See id.* at 392–93.
37. *Id.* at 394 n.2 (citing Act of May 15, 1989, 71st Leg., R.S., ch. 95, § 1, 1989 Tex. Gen. Laws 422, 423 (recodified 1995) (current version at TEX. HEALTH & SAFETY CODE ANN. § 12.096(a) (Vernon Supp. 2001 and indicating that recodification did not substantively change the pertinent law applicable to the case))) (emphasis added).
38. *Id.* (emphasis added).

fiable victims, but rather limits the scope of this exception to medical and law enforcement personnel.[39] Similarly, the statute at issue in *Praesel* limited the scope of those to whom confidential information may be disclosed to only the Medical Advisory Board or Department of Public Safety.[40] Thus, it would seem that the Texas Legislature has even limited the scope of a psychiatrist's *permissive* authorization to warn and that, in fact, a psychiatrist may be held civilly liable for warning an identifiable victim under the Texas statute.[41] Therefore, as acknowledged by the *Thapar* court, a literal interpretation of the exception shows that although Thapar was not obliged to disclose Lilly's threats, she could not have warned Lilly's family without breaching the confidentiality statute.[42]

2. Using Statutory Construction Aids to Interpret Section 611.004

Aside from a literal interpretation of section 611.004, the use of other statutory construction aids leads to a similar conclusion that there is no mandatory duty to warn. Section 311.023 of the Code of Construction Act provides that when construing a statute, regardless of whether or not the statute is considered ambiguous on its face, a court may consider construction aids. The Act lists seven non-exclusive aids, and an analysis of four of these aids indicates that section 611.004 does not dictate a duty to warn but rather provides psychiatrists with a "permissive authorization" to disclose confidential information.

Section 311.023(7) provides that courts may look to the title of a statute to aid them in statutory interpretation.[43] The title of section 611.004 reads, "*Authorized* Disclosure of Confidential Information Other than in Judicial or Administrative Proceeding."[44] "Authorized" implies that the Texas Legislature intended for the release of confidential information only in certain instances and certainly does not imply a mandatory duty to disclose. A logical reading of the title results in the conclusion that psychiatrists have discretion to disclose under the authority of the Legislature but are not obligated to do so.

Section 311.023(3) states that a court may consider the legislative history of a statute.[45] The "permissive" standard in section 611.004 was adopted from the original Act of 1979, which stated:

> Exceptions to the privilege of confidentiality, in other than court proceedings, *allowing* disclosure of confidential information by a

39. *See* TEX. HEALTH & SAFETY CODE ANN. § 611.004(a)(2) (Vernon Supp. 2001).
40. *Praesel*, 967 S.W.2d at 394.
41. *See* Tex. H.B. 1163 § 5, 66th Leg., R.S., 1979 Tex. Gen. Laws 239.
42. Thapar v. Zezulka, 994 S.W.2d 635, 639 (Tex. 1999).
43. TEX. GOV'T CODE ANN. § 311.023(7) (Vernon Supp. 2001).
44. TEX. HEALTH & SAFETY CODE ANN. § 611.004 (emphasis added).
45. TEX. GOV'T CODE ANN. § 311.023(3) (Vernon 1998).

> professional, exist only . . . to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient/client to himself or to others, or where there is the probability of immediate mental or emotional injury to the patient/client.[46]

The fact that this same permissive standard was adopted in the current legislation reinforces the conclusion that the Texas Legislature did not intend to impose on psychiatrists a mandatory duty to warn third parties. Had the legislature intended such a mandatory duty to be imposed, it seems that it would have taken the opportunity to do so when amending the 1979 Act in 1991 and 1999 or when codifying the Act in the Texas Health and Safety Code.

Section 311.023(4) states that courts may refer to common law or former statutory provisions, including laws on the same or similar subjects.[47] The *Thapar* court most often employed this construction aid. The court compared section 611.004 with section 261.101(a) of the Texas Family Code in order to ascertain the legislative intent behind the Texas confidentiality statute. Section 261.101(a) states that "[a] person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person *shall* immediately make a report as provided by this subchapter."[48] The court referred to an earlier case in which it found that the legislative scheme behind this statute was the "strongly avowed policy to protect children from abuse."[49] The court agreed that this policy was evidenced by the fact that the statute makes the reporting of child abuse mandatory and further provides that those who report child abuse in good faith are shielded from civil and criminal liability.[50] The court thus concluded that "imposing a common law duty to report was consistent with the legislative scheme governing child abuse."[51]

There is no similar "strongly avowed policy" to protect third parties found in section 611.004 of the Texas Health and Safety Code and its derivatives. As noted above, the Code does not demand mandatory reporting of threats, but merely permits disclosure in certain situations. Had the Legislature intended the need to protect third parties from dangerous patients to override the need of confidentiality between psychiatrists and patients, then surely it would have made the reporting of threats mandatory as it did in the Family Code. Furthermore, the Family Code imposes criminal penalties on those who fail to

46. Tex. H.B. 1163 § 4, 66th Leg., R.S., 1979 Tex. Gen. Laws 239 (emphasis added).
47. TEX. GOV'T CODE ANN. § 311.023(4).
48. TEX. FAM. CODE ANN. § 261.101(a) (Vernon Supp. 2001) (emphasis added).
49. Thapar v. Zezulka, 994 S.W.2d 635, 639 (Tex. 1999) (referring to Golden Spread Council, Inc. v. Akins, 926 S.W.2d 287, 291 (Tex. 1996)).
50. *See id.*
51. *Id.* at 640.

disclose child abuse, yet the Legislature chose not to impose civil or criminal penalties on psychiatrists who choose not to report a patient's threats.[52] Finally, unlike the Family Code, the Health and Safety Code does not shield psychiatrists from civil liability in situations where they make unwarranted disclosures in good faith.[53] Therefore, as the court in *Thapar* concluded:

> [I]f 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.[54]

It is clear that the Texas Legislature prioritizes physician-patient confidentiality over the protection of third parties in section 81.103(a) of the Health and Safety Code. This section provides that "[a] test result is confidential. A person that possesses or has knowledge of a test result may not release or disclose the test result or allow the test result to become known except as provided by this section."[55] The Code then lists only nine instances when test results can be disclosed.[56] Significantly, the Code does not allow disclosure of test results to a patient's family or sexual acquaintances[57] but rather only allows disclosure to a patient's spouse if the patient has tested positive for AIDS or HIV infection.[58] The implication of this statute is threefold. First, if a patient tests positive for a potentially fatal sexually transmitted disease other than AIDS, the physician cannot disclose the results of the test, not even to the patient's spouse. Second, if the patient tests positive for AIDS, the physician can only warn the patient's spouse, not a fiancé or lover. In Texas, same-sex marriage is not recognized; therefore, a homosexual's partner can never qualify as a "spouse."[59] Thus, a physician may find himself in a position where he knows that his patient has tested positive for AIDS or other fatal diseases and that the patient is not going to warn his sexual partner, yet a physician cannot disclose the test results to the partner. Third, the

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52. *Compare* TEX. FAM. CODE ANN. § 261.109 (Vernon 1996), *with* TEX. HEALTH & SAFETY CODE ANN. § 611.002 (Vernon Supp. 2001) (prohibiting disclosure of confidential information except as provided in the statute).

53. *See Thapar*, 994 S.W.2d at 640 (citing Act of Aug. 27, 1979, 66th Leg., R.S., ch. 239, §§ 4(b)-5, 1979 Tex. Gen. Laws 514 (current version at TEX. HEALTH & SAFETY CODE ANN. §§ 773.092, 773.094 (Vernon 1992))).

54. *Id.*

55. TEX. HEALTH & SAFETY CODE ANN. § 81.103(a) (Vernon 1992).

56. *Id.* § 81.103(b)(1)-(9).

57. *See id.*

58. *Id.* § 81.103(b)(7).

59. TEX. FAM. CODE ANN. § 2.001(b) (Vernon 1998) (stating that persons of the same sex may not obtain a marriage license). *See also id.* § 1.104 (prohibiting persons not married in accordance with Texas laws from contracting in the capacity of a spouse).

statute requires that the patient must first test positive before the physician can release the test results. Therefore, even if the physician suspects that a patient may be HIV positive, or if the patient has in fact told the physician that he is positive, the physician cannot disclose this information to the spouse. Recently, the Texas Supreme Court held that a health care provider has no duty under the Health and Safety Code to notify a wife of her husband's possible exposure to blood contaminated by the HIV virus.[60] To fortify the confidentiality requirement of section 81.103(a), the statute provides that anyone who discloses such information in violation of the statute is criminally liable.[61]

The likelihood that a third party will be harmed by nondisclosure of this confidential information outlined in the scenarios above is far greater than the likelihood that someone will be harmed by the nondisclosure of confidential information pertaining to a mental health patient's dangerous fantasies. Yet, Texas statutory law not only prevents a physician from disclosing such information but also imposes criminal liability on those who do disclose, even in good faith. Arguably, the Texas Legislature could not have intended psychiatrist-patient confidentiality to be any less inferior to the confidentiality between a patient and a person who has knowledge of his test results. There is no logical basis to distinguish between the two. Therefore, when compared with the Texas Family Code and Health and Safety Code, it is clear that the Texas Legislature could not have intended for the Texas confidentiality statute to impose upon psychiatrists a mandatory duty to warn.

Section 311.023(5) states that courts may look to the consequences of a particular statutory construction.[62] The Texas Supreme Court correctly resolved that the Texas Legislature did not intend to place psychiatrists in a double bind situation.[63] Whether one looks at the plain meaning of section 611.004 or uses construction aids to interpret its meaning, the conclusion should be the same: the Texas confidentiality statute does not mandate a duty to warn on the mental health profession.

60. *See* Santa Rosa Health Care Corp. v. Garcia, 964 S.W.2d 940, 943–44 (Tex. 1998).

61. *See* TEX. HEALTH & SAFETY CODE ANN. § 81.103(j) ("A person commits an offense if, with criminal negligence and in violation of this section, the person releases or discloses a test result or other information or allows a test result or other information to become known. An offense under this subsection is a Class A misdemeanor.").

62. TEX. GOV'T CODE ANN. § 311.023(5) (Vernon 1998).

63. *See supra* text accompanying note 54.

B. *Comparison of Section 611.004 with Statutory Provisions of Other Jurisdictions*

Numerous jurisdictions have adopted similar statutory rules imposing a duty on psychiatrists to warn third parties.[64] "Some statutes are permissive, allowing the psychiatrist to choose whether or not to warn. Other statutes impose a duty, leaving the psychiatrist no discretion."[65] Ideally, each of the statutes should be analyzed to ascertain whether this duty is mandatory or permissive. For example, the Nebraska statute is representative of one that could be interpreted as imposing a mandatory duty. It provides:

> No monetary liability and no cause of action shall arise against any psychologist for failing to warn of and protect from a client's or patient's threatened violent behavior or failing to predict and warn of and protect from a client's or patients violent behavior *except when* the client or patient has communicated to the psychologist a serious threat of physical violence against a reasonably identifiable victim or victims.[66]

The language of the Nebraska statute makes it clear that a physician will be liable if he fails to warn third parties in certain specified situations. The statutes at issue in *Thapar* and *Praesel* neither impose upon psychiatrists such a mandatory duty to warn nor penalize them for nondisclosure.

Significantly, such "mandatory" language is not found in the California confidentiality statute that was at issue in *Tarasoff*. In *Tarasoff*, a psychotherapist was held liable for failing to warn a victim that the victim's killer had confided his intention to kill her during a therapy session two months earlier.[67] The Supreme Court of California held that section 1024 of the Evidence Code created a statutory duty to warn the victim, constituting a "specific" exception to the physician-patient privilege.[68] However, as the dissent in *Tarasoff* correctly pointed out, the Evidence Code was the inappropriate statute to apply as the case did not involve an in-court disclosure by a psychiatrist.[69] Rather, the applicable statute in *Tarasoff* was the Lanterman Petris Short Act of 1969 (LPSA).[70] That Act provides, in part, that "[a]ll

64. Bradley v. Ray, 904 S.W.2d 302, 309 (Mo. Ct. App. 1995) (listing the jurisdictions that have adopted such statutes).

65. Jacqueline M. Melonas & Marynell Hinton, *Experts Share Advice on Reducing Risk When Treating Potentially Violent Patients*, PSYCHIATRIC NEWS, Oct. 2, 1998, http://www.psych.org/pnews/98-10-02/advice.html.

66. NEB. REV. STAT. § 71-1, 206.30 (1994) (emphasis added).

67. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 339–40 (Cal. 1976).

68. *See id.* at 347.

69. *Id.* at 456 (Clark, J., dissenting) ("Because they are necessary to the administration of justice, disclosures to the courts are excepted from the nondisclosure requirement by section 5328, subdivision (f). However, this case does not involve a court disclosure. Subdivision (f) and the Evidence Code sections relied on by the majority are clearly inapposite.").

70. CAL. WELF. & INST. CODE §§ 5000–5587 (West Supp. 2001).

information and records obtained in the course of providing services . . . shall be confidential."[71] When the *Tarasoff* decision was issued, the statute provided for only two exceptions to this confidentiality requirement, none of which were applicable to the case at bar.[72] Notably, the two exceptions were permissive, not mandatory, in nature.[73] An additional exception that would have been applicable in *Tarasoff*, but was enacted afterward, also involves non-mandatory language. That exception provides:

> [w]hen a patient, in the opinion of his or her psychiatrist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section *may* be released to that person or persons and to law enforcement agencies as the psychiatrist determines is needed for the protection of that person or persons.[74]

Therefore, it is evident that even after *Tarasoff*, the California Legislature did not intend to impose a mandatory duty to warn third parties upon psychiatrists; however, the California courts continue to impose such a duty.[75] In so doing, the California courts have forced psychiatrists into the following dilemma:

> The duty to warn recited in *Tarasoff* and the confidentiality provisions of LPSA hold a California psychiatrist, treating patients under LPSA, in an apparently inextricable dilemma. If the psychiatrist does not give the warning under the *Tarasoff* standard, then he may be liable for civil damages, or if he does give the warning, the patient whose confidence he has betrayed may sue him on the statutory basis of [the LPSA].[76]

Though it has been noted that numerous jurisdictions have adopted a statutory rule imposing a mandatory duty to warn in situations similar to that addressed in *Tarasoff*,[77] it is of equal significance that numerous jurisdictions have adopted statutes stipulating only a

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71. *Id.* § 5328.

72. *Tarasoff*, 551 P.2d at 356–57.

73. *See* CAL. WELF. & INST. CODE § 5328(g) (allowing disclosure to governmental agencies); *id.* § 5328.3(a) (specifying that a physician may inform a patient's family and governmental agencies of a patient's disappearance from a designated facility).

74. *Id.* § 5328(r) (emphasis added).

75. *See, e.g.*, Menendez v. Superior Court, 834 P.2d 786, 800 (Cal. 1992); People v. Wharton, 809 P.2d 290, 314 (Cal. 1991) (following *Tarasoff*). *See generally* Hoff v. Vacaville Unified Sch. Dist., 968 P.2d 522, 526–27 (Cal. 1998) (recognizing that in some instances the relationship of school personnel to students gives rise to a duty of care but holding otherwise to the facts presented).

76. Gammon & Hulston, *supra* note 5, at 787–88 (quoting Robert N. Cohen, Note, Tarasoff v. Regents of the University of California*: The Duty to Warn: Common Law and Statutory Problems for California Psychotherapists*, 14 CAL. W. L. REV. 153, 178 (1978)).

77. Bradley v. Ray, 904 S.W.2d 302 (Mo. Ct. App. 1995) (listing the jurisdictions that have adopted mandatory duty-to-warn statutes).

permissive duty to warn third parties.[78] However, courts in many states, not just California, are guilty of misinterpreting or simply ignoring the state's confidentiality statute.[79] Therefore, psychiatric guidelines in such states are forced to suggest:

> By their terms, these provisions are merely permissive authorizations that *allow* a psychiatrist to give a warning to an identified victim—they do not require that the psychiatrist provide such a warning. However, absent contrary case law, psychiatrists practicing in states that have such provisions should proceed on the assumption that state law does, in fact, impose such a duty to warn.[80]

Thanks to the Supreme Court's unanimous ruling in *Thapar*, Texas does not have conflicting case law, and a psychiatrist can be certain that Texas law does not impose a mandatory duty to warn. However, for those states whose judiciary has not clearly spelled out the law in this area, it is suggested that "[a] psychiatrist should not tread these murky waters alone. A lawyer should be contacted. The lawyer can analyze the situation in relation to the relevant statutory and case law."[81]

IV. Common Law Duty to Warn

Cases interpreting both the Restatement of Torts and Texas case law immediately preceding *Thapar* suggest that a psychiatrist is very rarely under a common law duty to warn third parties, even if they are readily identifiable, because the psychiatrist's relationship with the patient does not warrant such a duty.

A. *The Restatement*

While the general rule is that there is no duty to control the conduct of another[82] or to warn those endangered by such conduct,[83] section 315A of the Restatement of Torts provides for an exception to the general rule. The exception applies when "a special relation exists between the actor and the third person which imposes a duty upon the

78. *See* JoAnn E. Macbeth et al., Legal Risk Management Issues in the Practice of Psychiatry 4-11 to 4-12 (1994) (listing nine jurisdictions, including Texas, whose statutes refer to only a permissive breach of confidentiality).

79. *See, e.g.*, Almonte v. N.Y. Med. Coll., 851 F. Supp. 34 (D. Conn. 1994) (failing to consider confidentiality issues in deciding a psychiatrist had a duty to warn a third party of potential harm from a patient).

80. Macbeth et al., *supra* note 78, at 4-10. *See also* Confidentiality Versus the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry 19 (James C. Beck ed., 1990) (pointing out that "[i]f a patient seriously injures someone, and the patient's therapist failed to exercise due care, the courts will find a way to hold the therapist liable, statutes notwithstanding").

81. Laub, *supra* note 7, at 7.

82. Restatement (Second) of Torts § 315 (1965).

83. *See id.* § 314 cmt. c.

actor to control the third person's conduct."[84] The *Tarasoff* court held that a doctor-patient relationship or a hospital-patient relationship alone was sufficient to establish a special relationship under the meaning of the Restatement.[85] The court did not address the concept of a psychiatrist's "control" over his patient but merely assumed that such control existed by concluding that "[s]uch a relationship may support affirmative duties for the benefit of third persons."[86] However, a closer analysis of the Restatement indicates that the *Tarasoff* court misinterpreted the Restatement's provisions relating to the duty to control third persons. In fact, the scope of the "special relation" concept does not, and should not, extend so far as to cover situations where a patient has voluntarily sought help from a psychiatrist.

Comment c to section 315 states that "[t]he relations between an actor and a third person which require the actor to control the third person's conduct are stated in [sections] 316–319."[87] The applicable section, section 319, states that "[o]ne who *takes charge* of a third 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 third person to prevent him from doing such harm."[88] Implicit in this exception is the recognition that before a duty may be imposed on an actor, the actor must possess some degree of control over the third person. Logically, a psychiatrist cannot control a voluntary patient. The vast majority of "out-patients" and "in-patients" are voluntary patients.[89] In fact, only a small percentage of patients are involuntary patients, such as those committed by the State. Therefore, a psychiatrist will rarely find himself in a position where he has control over his patient.

An example of such a rare occasion appears in the recent federal case of *Garamella v. New York Medical College*.[90] This case concerned the relationship between a psychiatrist and a psychiatric resident at New York Medical College.[91] As part of residency training, Joseph DeMasi was required to undergo psychoanalysis conducted by Dr. Ingram, a faculty member, who was also a board-certified psychiatrist.[92] Dr. Ingram was obligated by his position to disclose to New

84. *Id.* § 315(a).

85. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 343 & nn.6–7 (Cal. 1976).

86. *Id.*

87. RESTATEMENT (SECOND) OF TORTS § 315 cmt. c.

88. *Id.* § 319 (emphasis added).

89. In fact, annual statistics from a local psychiatric hospital show that only seven percent of in-patients are involuntary and less than one percent of out-patients are involuntary. The out-patient statistic is drastically low primarily due to the fact that it is very difficult to enforce out-patient committals. Interview with Peggy Bailey, Chief Administrator, Springwood Psychiatric Hospital, Bedford, Texas (Jan. 29, 2000).

90. 23 F. Supp. 2d 167 (D. Conn. 1998).

91. *Id.* at 169.

92. *Id.*

York Medical College: (1) whether DeMasi was undergoing the required personal psychoanalysis; (2) whether DeMasi was ready to begin analyzing patients of his own; and (3) whether DeMasi was ready to be certified as a psychoanalyst.[93] During a training session, DeMasi told Dr. Ingram that he was a pedophile.[94] Subsequent to this disclosure, DeMasi had conducted a psychiatric rotation at a hospital, and during that rotation, he had sexually assaulted a ten-year-old boy.[95] The U.S. District Court for the District of Connecticut held that a jury could find the ten-year-old to be "within a foreseeable class of victims to whom Dr. Ingram might owe a duty of care arising from DeMasi's disclosures."[96] However, in so holding, the court specifically noted that "the relationship between Dr. Ingram and DeMasi cannot be characterized as strictly that of a psychiatrist-voluntary patient."[97] The court explained that this was because Dr. Ingram was DeMasi's instructor, as well as his analyst, and therefore, "he had a control mechanism over DeMasi that does not exist in the usual analyst-voluntary patient relationship."[98] In analyzing this degree of control, the court focused specifically on the question of how burdensome it would be for Dr. Ingram to control DeMasi and concluded that

> [e]ven without breaching the confidentiality of DeMasi's communications, *as an instructor*, Dr. Ingram was authorized to notify NYMC that: (1) DeMasi was not engaging in training analysis for certification, as required; (2) DeMasi had revealed information which made him unsuitable for psychoanalytic training; and (3) NYMC would be advised to review whether DeMasi should remain in the residency program practicing child psychiatry.[99]

Thus, the court made it clear that it is only in certain limited circumstances that a psychiatrist would be in a position to control a patient.

One commentator recognized that *Garamella* was a fact-specific decision, stating that "[t]he distinguishing factor in the decision was the element of control that Dr. Ingram retained over Dr. DeMasi, above and beyond the typical psychiatrist-patient relationship."[100] Clearly, certain factors must be present before a psychiatrist can be held to have a sufficient degree of control over his patient. For example, as in *Garamella*, a psychiatrist may have control over the patient's career or, as is usually the case with involuntary patients, may have control over a patient's actual liberty. Because most psychiatric patients are voluntary and have only a psychiatrist-patient relationship with their psychiatrist, these instances of control are extremely rare and fact-spe-

93. *Id.*
94. *See id.* at 170.
95. *See id.* at 170–73.
96. *Id.* at 174.
97. *Id.* at 173.
98. *Id.*
99. *Id.* at 174.
100. Laub, *supra* note 7, at 7.

cific. Consequently, a correct interpretation of the Restatement of Torts would reveal that psychiatrists are rarely in a special relationship with their patients sufficient to impose upon them a duty to warn.

In *Nasser v. Parker*, the Supreme Court of Virginia recognized the importance of the "takes charge" language of section 319 in determining whether a special relationship exists under section 315(a).[101] In *Nasser*, the father of a homicide victim brought an action for damages against the assailant's doctor and hospital for failing to warn the victim that her former boyfriend, who had threatened to kill her, had been released from the hospital.[102] The court expressly disagreed with *Tarasoff*'s holding that a doctor-patient or a hospital-patient relationship automatically qualifies as a "special relation" under Restatement section 315(a).[103] Rather, the court stated that

> [t]here is nothing special about the ordinary doctor-patient relationship or hospital-patient relationship. We think there must be added to those ordinary relationships the factor, required by § 319, of taking charge of the patient, meaning that the doctor or hospital must be vested with a higher degree of control over the patient than exists in an ordinary doctor-patient or hospital-patient relationship before a duty arises concerning the patient's conduct.[104]

The court concluded that because the patient was admitted to the psychiatric hospital on a "voluntary basis," the hospital and the treating psychiatrist were not under a duty to control his conduct.[105]

Likewise, the psychotherapist in *Tarasoff* never had legal control over her "dangerous patient," causing some commentators to characterize the decision as "unpersuasive" for failing to reference section 319 of the Restatement.[106] The *Tarasoff* plaintiffs alleged that the patient, Poddar, voluntarily sought counseling with Dr. Moore, a psychotherapist, and confided to Dr. Moore his intentions to kill Tarasoff, a girl with whom he had become obsessed.[107] The plaintiffs also alleged that at Dr. Moore's request, police briefly detained Poddar but released him because he appeared rational.[108] Furthermore, the plaintiffs alleged that Dr. Moore's superior ordered that no further action be taken, such that no one warned Tarasoff or her family of the threat.[109] Two months after Poddar allegedly confided his intentions to Dr. Moore, he killed Tarasoff.[110] The court held that

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101. 455 S.E.2d 502, 505 (Va. 1995).
102. *Id.* at 502–03.
103. *See id.* at 506.
104. *Id.*
105. *See id.*
106. Peter F. Lake, *Revisiting* Tarasoff, 58 ALB. L. REV. 97, 130 (1994).
107. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 339–41 (Cal. 1976).
108. *Id.* at 339–40.
109. *Id.* at 340.
110. *Id.* at 339.

> [w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger over violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending upon 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 danger, to notify police, or to take whatever other steps are reasonably necessary under the circumstances.[111]

Though the court referred to section 315 in arriving at its conclusion that there was a "special relationship" between Dr. Moore and Tatiana,[112] it did not proceed to the next step of analyzing the "special relation" factor under section 319, as was specifically directed by comment c of section 315.[113] If the court had referred to section 319, its illustrations, and comments, it would have realized that Dr. Moore had absolutely no legal control over Poddar and therefore should not have been held to be in a special relationship with him. In fact, the only people that possibly could have asserted legal control over Poddar were the campus police, who knew of Poddar's dangerous propensity towards the victim, yet chose to release him.[114] Though police have the immediate ability to restrain an individual's liberty upon probable cause[115] (which could have been Dr. Moore's statement to police that Poddar was dangerous and should be committed), the court, ironically, found that there was no special relationship between the police and Poddar or Tarasoff.[116] The court found that therapists have a special relationship with their patients because they can "control their dangerous patients through the exercise of both their statutory authority to initiate commitment proceedings and their therapeutic influence," yet the court found no such relationship between the police and these patients, despite the police's "express duty to assure public safety and their freedom from any obligation to preserve the confidentiality of [patients'] statements."[117] Such disparity in the court's treatment almost seems hypocritical. Why the *Tarasoff* court chose to ignore section 319 and make the inferential leap to arrive at the conclusion that a "special relationship" existed based simply upon entry into the relationship is not answerable on any legal grounds. Special relationships should not be so readily presumed. Instead, each case must be analyzed on its facts. There were no unique factors in *Tarasoff* that would give rise to a special relationship. In

111. *Id.* at 340.
112. *Id.* at 343.
113. *See generally* RESTATEMENT (SECOND) OF TORTS § 315 cmt. c (1965).
114. *Tarasoff*, 551 P.2d at 339–40.
115. Beck v. Ohio, 379 U.S. 89, 91 (1964).
116. *Tarasoff*, 551 P.2d at 341, 349.
117. Merton, *supra* note 4, at 296.

fact, there are very few situations where a psychiatrist might find himself in a special relationship with his patient.

The requirement that there be some degree of control before a duty is triggered has been recognized in Texas.[118] In *Kehler v. Eudaly*,[119] a Fort Worth appellate court pointed out that the only time the Texas Supreme Court recognizes duties to third parties is when there has been "a special relationship between the defendant and the actor that implicitly includes some right to control the action . . . or when the defendant who created or contributed to the actor's situation violated a statute . . . or when a duty is imposed to protect the general driving public."[120] The court then held that there was no relationship between a physician and patient that would provide the type of control necessary to impose upon the physician a duty to warn third parties.[121]

Although the Texas Supreme Court did not base the *Thapar* decision on common law, the facts indicate that the holding would have been the same had the court considered the degree of control that Thapar had over Lilly. Thapar almost always treated Lilly on an outpatient basis, and when she saw Lilly in the hospital, it was always on a voluntary basis.[122] Unlike the psychiatrist in *Garamella*, Thapar had no other connection with Lilly outside their psychiatrist-patient relationship; thus, Thapar never had legal control over Lilly. In the future, the Texas Supreme Court should refer to the *Kehler* decision and section 319 of the Restatement when dealing with the issue of characterizing a special relationship.

B. *Common Law*

The *Thapar* court declined to follow *Tarasoff* on the basis that the Texas confidentiality statute makes it unwise to recognize a common law duty to warn identifiable victims of a patient's threats. However, the court did not consider whether the common law alone recognizes such a duty[123] because the question had not previously arisen. Prior cases had simply held that physicians had no common law duty to warn unidentifiable victims.[124]

Aside from any reference to the Restatement, the *Thapar* court was correct in refusing to recognize a common law duty to warn, considering the court's holding one year earlier in *Van Horn v. Chambers*.[125] In *Van Horn*, the "[c]ourt held that a doctor who authorized the trans-

118. Kehler v. Eudaly, 933 S.W.2d 321 (Tex. App.—Fort Worth 1996, writ denied).
119. *Id.*
120. *Id.* at 332 (citations omitted).
121. *See id.*
122. Thapar v. Zezulka, 994 S.W.2d 635, 636 (Tex. 1999).
123. *See id.* at 638.
124. *See, e.g.*, Limon v. Gonzaba, 940 S.W.2d 236, 238–41 (Tex. App.—San Antonio 1997, writ denied) (holding that there is no duty when the third person is not specifically identifiable).
125. 970 S.W.2d 542 (Tex. 1998).

fer of a patient from a hospital critical care unit to a regular room without restraints did not have a duty to hospital employees who were injured in an attempt to restrain the patient after he assaulted a nurse."[126] The plaintiffs alleged that the doctor knew or should have known that the patient posed a danger to others and should have treated him accordingly (i.e., that he had negligently misdiagnosed the dangerousness of the patient), but the court concluded that it was only the patient to whom the doctor owed a duty not to misdiagnose.[127] Recall that the *Tarasoff* doctrine only imposes a duty to warn "once a therapist does in fact determine, or reasonably should have determined under applicable professional standards, that a patient poses a serious danger to others."[128] Therefore, jurisdictions that hold psychiatrists liable for failure to warn third parties are, in fact, holding psychiatrists liable for negligent misdiagnosis due to their failure to recognize that a patient was so mentally unstable that he was likely to act upon, as opposed to merely fantasize about, his homicidal threats made during therapy.

Given the court's holding in *Van Horn*, a learned author prophetically stated, just prior to the Texas Supreme Court's ruling in *Thapar*, that "it is unclear whether the Texas Supreme Court will adopt this [failure to warn identifiable victims] doctrine given its indication that doctors owe no duty to the public that depends on their proper diagnosis of their patients."[129] Though the plaintiffs in *Thapar* pled a separate claim of negligent misdiagnosis, which the court dismissed based on *Van Horn*,[130] it is clear that this action is inextricably intertwined with a failure to warn action in the psychiatric field. The psychiatrist in *Thapar* could not have been held liable for failure to warn a third party unless she was first held liable for misdiagnosing the dangerousness of her patient. Because Texas law has recognized that a psychiatrist cannot be liable to third parties for misdiagnosis of a patient,[131] Texas psychiatrists have no common law duty to warn identifiable third parties of patients' threats.

V. JUSTIFICATIONS FOR *THAPAR*

Dangerousness is not a medical disease, and there is simply no diagnostic test to measure it.[132] Thus, how can the courts justifiably expect psychiatrists to predict a patient's propensity for future violence? Even when patients make specific threats with respect to identifiable

126. 20 WILLIAM V. DORSANEO III ET AL., TEXAS LITIGATION GUIDE § 321.07[6] (2000).
127. *Van Horn*, 970 S.W.2d at 545.
128. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976).
129. 20 WILLIAM V. DORSANEO III ET AL., TEXAS LITIGATION GUIDE § 321.07[6] (1998).
130. *See* Thapar v. Zezulka, 994 S.W.2d 635, 638 & n.12 (Tex. 1999).
131. *See supra* text accompanying notes 126–27.
132. *See* Merton, *supra* note 4, at 299–300.

third parties, why is a member of the medical profession liable when such threats are carried out, yet other professionals and laymen are not? Such threats are made daily. No doubt, we have, at some point in our lives, made idle threats, such as "I'm going to kill 'X' if he does not leave me alone," or "I want to kill my parents!" While most of these threats are either mindless "venting" or mere fantasies, with no intention of being carried out, unfortunately, some are not. Even so, there is no sound ideological policy to hold psychiatrists liable for these unfortunate incidents simply because the profession attempts to treat those who may have a hidden violent propensity.

A. *Why Single Out the Mental Health Profession?*

There is no sound reason to impose upon the mental health profession a duty that is not imposed upon other professionals or friends. A clergy member is not liable for failing to disclose a confessor's sinful thoughts of future crime because the common law recognizes and respects this religious privilege.[133] A friend of the perpetrator is not liable for failing to warn an identifiable victim of possible danger because the common law refuses to impose such a duty. If neither a trusted member of the clergy nor a trusted friend has a duty to warn an identifiable victim, then why should that burden be placed on a trusted psychiatrist? The burden cannot be justified simply because the psychiatrist is paid to analyze the patient's thoughts. The *Tarasoff* court justified the extension of a psychiatrist's duty to third parties on the broad policy ground of "the public interest in safety from violent assault."[134] However, such an interest does not depend upon the professional relationship between the parties, for the priest and the friend, in the examples above, could just as easily protect the public from the ensuing violence. Under the *Tarasoff* court's rationale, there is no reason not to impose such a duty on everyone, whether professional or non-professional, in order to protect the public well-being. Even so, the court made the inferential leap of imposing this extenuated duty on psychiatrists, seemingly based on the fact that they are qualified professionals. The court stated:

> The role of the psychiatrist, who is indeed a practitioner of medicine . . . [is] like that of the physician who must conform to the standards of the profession and who must often make diagnoses and predictions based upon such evaluations. Thus the judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is compara-

133. *See, e.g.*, Terry Wuester Milne, Comment, *"Bless Me Father, for I am About to Sin . . .": Should Clergy Counselors Have a Duty to Protect Third Parties?*, 22 TULSA L.J. 139 (1986) (distinguishing the situation from that of *Tarasoff* by analyzing the "control" issue and the religious nature of clergy counseling).

134. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 346 (Cal. 1976).

> ble to the judgment which doctors and professionals must regularly render under accepted rules of responsibility.[135]

Comparing psychiatrists with "ordinary" physicians is fundamentally flawed. Indeed, a psychiatrist is a practitioner of medicine, not a clairvoyant. There is a sharp contrast between diagnosing a physical condition and diagnosing a psychiatric condition, especially when the diagnosis involves a duty to warn others against dangers emanating from the condition. For example, a physician can easily predict that foreseeable third parties may be harmed if he does not warn them that his patient has a communicable disease. However, it is much more difficult for a psychiatrist to predict that foreseeable, even identifiable, third parties will be harmed if he does not warn them of a patient's threats. "Unlike the 'infectiousness' of a disease, 'dangerousness' is not an objectively verifiable condition."[136] Rather, "dangerousness" requires psychiatrists to look into patients' minds and speculate on their "future response to a complex of variables, any one of which may or may not occur."[137] Neither psychiatry nor medicine is an exact science. Therefore, psychiatrists should not be held to a higher standard of care than physicians simply because the psychiatric profession strives to decipher the human mind.

While the *Tarasoff* court compared a psychiatrist's responsibility to that of other "professions," it is notable that the American Bar Association Model Code of Professional Responsibility, which has been adopted in some form by most states,[138] does not require attorneys to disclose confidential information obtained from their clients, even if disclosure may prevent imminent death or bodily injury.[139] A 1982 ABA House of Delegates proposal to reinstate a mandatory disclosure requirement was resoundingly defeated.[140] The drafters of the Code realized that "[i]t is very difficult for a lawyer to 'know' when such a heinous purpose will actually be carried out, for the client may have a change of mind."[141] The same holds true for psychiatrists. In fact, it is possible that a criminal defendant is more likely stating a determined intention to carry out the act than would a psychiatrist's patient, who in the majority of cases, is probably just airing a fantasy. "[O]ne of the best predictors of future violence is a past history of

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135. *Id.* at 345.

136. Merton, *supra* note 4, at 299.

137. *Id.* at 299–300.

138. *See* MORTIMER D. SCHWARTZ ET AL., PROBLEMS IN LEGAL ETHICS 40 (5th ed. 2001) (stating that "[r]oughly 40 states and other jurisdictions have adopted new legal ethics patterned on the ABA Model rules, but most of those have altered some of the important rules, such as those concerning confidentiality").

139. *See* MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(1) (1999) (using permissive language to show attorneys are not *required* to disclose information under the listed circumstances, even though they *may* do so).

140. Stuart Taylor, Jr., *Dishonesty in Law: A New Ethics Code Is Sought*, N.Y. TIMES, Aug. 17, 1982, at A23.

141. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 13 (1983).

violence,"[142] and it is asserted that a lawyer's client, especially a criminal defendant, is more likely to have a violent background than would a psychiatric patient. Moreover, a psychiatric patient presumably airs his fantasy in the hope of obtaining help from the psychiatrist. A defendant generally would have no such desire because his reason for making the threat is anything but that of seeking help. Consequently, it would be unjustifiable to penalize the psychiatrist who extracts the threat, attempting to help the patient, but not the attorney whose job will be finished, whether or not this threat is carried out.[143]

B. *A Moral Duty Should Suffice*

The absence of any general legal duty to warn and protect identifiable third parties does not mean that disclosure is never warranted. For example, as conceded in Part IV, a psychiatrist may be under a legal duty to control the patient if the psychiatrist possesses a certain degree of control over the patient.[144] Likewise, public policy may dictate that once a psychiatrist actually determines the patient's dangerousness, he is under a moral duty to warn and protect third parties. "The Canons of Ethics of physicians make it clear that there is a moral duty to breach a patient's confidence should it be necessary in order to protect the community."[145] When a profession has imposed an ethical or moral duty on a profession, judicial intrusion is unwarranted. Most, if not all, psychiatrists presumably will warn identifiable third parties if they firmly believe that they have accurately determined patients' potential dangerousness. To impose a mandatory legal duty upon psychiatrists would be self-defeating for it could lead to evaluations that are constantly second-guessed and evaluations that overpredict dangerousness in order to avoid civil liability.

C. *The Drastic Consequences of a Mandatory Duty*

The *Tarasoff* court stressed that requiring psychiatrists to warn a patient's victim would not entail the "drastic consequences" of involuntary commitment or other detention measures.[146] However, according to Dr. Cathal Grant, a Texas psychiatrist:

> If you think that a patient poses a threat to a third party that is so serious as to warrant you warning that third party of the threat, then your patient, under the standard level of care, is likely to be so seri-

142. Interview with Dr. Cathal Grant, M.D., Director of Psychiatry, H.E.B. Hospital, Bedford, Texas (Oct. 11, 1999).

143. This may explain why Texas has chosen not to adopt the exact wording of Model Rule 1.6(b)(1) but rather to impose a mandatory duty to warn on attorneys who have clearly established that a client is likely to commit a crime that may result in serious injury or death. *See* TEX. STATE BAR R. art. X, § 9, R. 1.05(e)–(f).

144. *See supra* Part IV.A.

145. Alan A. Stone, *The* Tarasoff *Decisions: Suing Psychiatrists to Safeguard Society*, 90 HARV. L. REV. 358, 374 (1976).

146. *See* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 346 (Cal. 1976).

> ously mentally ill as to warrant involuntary committal. To decide not to commit may put the psychiatrist at risk of a negligence suit. Thus, if you warn, you must commit. Warnings and committals are difficult to separate.[147]

Therefore, an increase in involuntary commitments is precisely the consequence likely to occur if such a duty is imposed.

Warning identifiable victims is not without unwelcome side effects. When a person is threatened, even via a warning, he will most likely experience fear and perhaps even paranoia. It has been recognized that "[w]arned individuals may themselves become so severely distressed that they become unwitting victims who are psychologically harmed by the duty to warn."[148] What should a warned individual do upon receiving the warning? Call the police? If the police do not feel that the patient is an immediate danger to himself or others, they cannot commit the patient, as was evidenced in *Tarasoff*.[149] "Notification of law enforcement officials may create only a temporary and prophylactic solution. *Tarasoff* amply demonstrates the limitations of the police in handling such situations."[150] Furthermore, the victim or the victim's family may attack the patient first, which "raises the question: Should the therapist be liable to his patient if the warning precipitates a violent assault upon the patient?"[151] If the judge or jury, with the benefit of hindsight, decides that a reasonable therapist would have found a patient's threats unfounded, then the therapist could be held civilly liable in a breach of confidentiality action for the injuries that the patient sustained.

The *Tarasoff* court held that "[t]he risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved."[152] However, an imposition of a mandatory duty to warn may seriously undermine the psychiatrist-patient relationship and may even lead to an increase in violent behavior. The confidentiality of this relationship puts patients at ease and gives them, in most instances, what may be their only chance to air their violent fantasies. As this is probably the only way that society can address these fantasies before they are acted out, it is important for the patient to feel comfortable in airing these fantasies. David Axelrad, President of the Texas Society of Psychiatric Physicians, believes that fantasy is a common experience.[153] "[A] patient can imagine killing a third party or family member and not act on impulse.

147. Interview with Dr. Cathal Grant, M.D., *supra* note 142.

148. ROBERT I. SIMON, CONCISE GUIDE TO PSYCHIATRY AND LAW FOR CLINICIANS 182 (2d ed. 1998).

149. *See Tarasoff*, 551 P.2d at 341.

150. Gammon & Hulston, *supra* note 5, at 780.

151. *Id.*

152. *Tarasoff*, 551 P.2d at 346.

153. Nathan Koppel, *Psychiatrists Have No Duty to Warn of Patients' Threats*, TEX. LAW., July 5, 1999, at 5.

With *Thapar* . . . psychiatrists can adequately address such fantasies without breaching their duty of confidentiality."[154] Without recourse to psychiatrists, mentally ill patients may be more likely to act upon their fantasies instead of seeking help.[155] Patients may be deterred from seeking help if they are aware of the possibility that their fantasies will be disclosed to those that they fear most.[156] As Doctor Grant opines:

> In eighteen years of practice, I have had several hundred patients that have expressed homicidal thoughts in my office. None have acted upon them. I would argue that had they been informed, prior to the session, that I would be obligated to disclose any homicidal threats, not one of these patients would have revealed these thoughts. I would also not hesitate to surmise that out of those several hundred patients, some may have acted upon their fantasies without psychiatric help.[157]

Thus, the risk of unnecessary warnings is not in fact a reasonable price to pay as it may well lead to an increase in violent behavior by these patients.

It has been argued that "[t]he *Tarasoff* exception to confidentiality is part of the same public policy exception requiring the reporting of contagious diseases, suspected child abuse, and gunshot wounds for the welfare of the patient and society."[158] However, in the case of a mental health patient who voluntarily seeks help from a psychiatrist, it is clear that such a situation cannot be justifiably grouped under the same public policy umbrellas as the above situations. When a mental health patient seeks help, he knows that part of the therapy entails confiding to the psychiatrist, and therefore, he is basically admitting that he needs help. Unlike the above scenarios, the harm has not yet occurred. The psychiatrist, with the aid of confidentiality, can attempt preventative therapy at this stage. Disclosure of confidential information by a psychiatrist has a much more deleterious effect on the psychiatric profession than would similar disclosure by any other professional. As one commentator recognized:

> To psychiatrists, this is to ignore a basic distinction between physical and psychiatric therapy: a gunshot wound or a venereal infection will respond to medication and care, whether or not it is reported, but revelation of the fantasy or wish embodied in a threat may undo whatever has already been accomplished in the therapeutic relationship.[159]

154. *Id.*
155. *See infra* note 157 and accompanying text.
156. *Id.*
157. Interview with Dr. Cathal Grant, M.D., *supra* note 142.
158. SIMON, *supra* note 148, at 184.
159. Merton, *supra* note 4, at 305.

In equating the psychiatric profession with the "non-psychiatric" medical profession, the *Tarasoff* court failed to recognize this crucial distinction.

VI. CONCLUSION

The deference to the legislature shown in the *Thapar* decision is condoned and should set an example for other states to follow because legislative bodies are in a better position than judicial bodies to decide upon matters of social policy. Judicial bodies may be prejudiced by hindsight, or they may not have enough knowledge of the world of psychiatry. If the medical profession, educated in such matters, cannot agree on bright line criteria for predicting dangerousness, then how much more troublesome would a similar decision be for the judiciary? With the benefit of voluminous statistics and endless hours of reasoned debate, the Texas legislature has clearly established that psychiatrists have discretion to warn identifiable third parties. If a plain reading of the statue concludes that there is no mandatory duty to warn, then the discussion should end at this point. Unfortunately, such is not always the case. Therefore, it is disappointing that the Texas Supreme Court grounded its decision primarily upon the confidentiality statute. Had the court been required to decide the case purely on common law grounds, it is opined that the Restatement of Torts and the preceding Texas case law on negligent misdiagnosis would have led the court to the same conclusion. Should the court face such a task in the future, it is encouraged to follow the national trend of focusing on the degree of control over a patient and, additionally, to refer to the doctrine of negligent misdiagnosis before finding a duty to warn.

Public policy considerations also confirm that psychiatrists should have discretion in disclosure of their patients' confidences. Under the *Tarasoff* doctrine, a psychiatrist may be held liable for not distinguishing between those fantasies that are likely to be acted upon and those that are not, but ultimately, "the judgment of whether or not the psychiatrist's decision was right or wrong will be made by members of a disciplinary board, a judge, or a jury, all of whom will have the benefit of 20/20 hindsight."[160] After *Thapar*, a psychiatrist in Texas will not be judged by those who may be prejudiced by hindsight. Moreover, the concept that a mandatory duty to warn is needed to protect public safety is unfounded and self-defeating as it may cause an increase in violent behavior. A psychiatrist's moral duty provides an adequate balance between protecting the public and preventing unnecessary committals of mentally ill patients. The *Thapar* holding will prevent needless committals that could occur if a mandatory duty to warn were imposed on psychiatrists, yet still protect both the general public

160. *See* Laub, *supra* note 7, at 5.

and the patient. The Texas Supreme Court has inadvertently recognized what the *Tarasoff* court failed to—that public safety will be better protected by letting psychotherapists perform the duties of their profession to the best of their human capabilities, not by threatening these professionals with a double-edged sword.

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