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Symposium Speeches

Liability of Psychiatrists Under New York Law for Failing to Identify Dangerous Patients*

Scott Rogge, M.D., J.D.**

I have been asked to give a concise and comprehensive summary of the liability of therapists¹ under current New York

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1. "Therapists" and "clinicians" will herein include licensed mental health practitioners of various disciplines, including psychiatrists, psychologists, psychiatric social workers, or psychiatric nurse clinicians. The *Tarasoff* opinion uses the term "therapist." *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 340 n.2 (Cal. 1976). It has been noted that this is a "broad" term which has paved the way to arguments by analogy. See Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 98 n.6 (1994).

law for failing to identify dangerous patients. Due to time constraints, I will limit my discussion to a therapist's *Tarasoff* liability in New York.²

Tarasoff v. Board of Regents of the University of California is the landmark 1976 California Supreme Court case which fundamentally revised the previous law governing therapist responsibility to third-party victims of their violent patients.³ Prior to *Tarasoff*, clinicians were not held responsible for the violent acts of their patients unless they had a special relationship with the patient or the victim.⁴ This responsibility was generally limited to situations where the clinician had physical control or custody of the patient (such as with an inpatient), knew in advance of the patient's violent intentions, and failed to exercise appropriate control.⁵ In other words, clinicians previously risked liability for negligently allowing patients with violent histories and intentions to be released or to escape from their custody and control when those patients later caused harm to other people.

This traditional liability risk for clinicians was significantly expanded by the California Supreme Court in the *Tarasoff* case when the court ruled that when a therapist knows or should know that a patient represents a significant danger to an identifiable third party, the therapist should take reasonable steps to protect that third party from harm.⁶

2. Therapists are potentially liable in tort malpractice for failing to identify dangerous patients in a wide range of clinical circumstances. Examples include negligent diagnosis or treatment, monitoring or supervision, or discharge or escape of a dangerous patient. Potential *Tarasoff* liability only arises in one such clinical circumstance, when failure to identify a dangerous patient *who has threatened to harm a third party* results in *actual harm to the intended victim*. See *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976). See generally Ralph Slovenko, *Legal Duty of Therapists to Third Parties*, *PSYCHIATRIC TIMES*, Aug. 1999, at 51.

3. See *Tarasoff*, 551 P.2d at 335.

4. See *id.* at 343; see also *id.* at 354-56 (Clark, J., dissenting) (arguing that it is believed that placing a duty on therapists to disclose patients' threats to potential victims greatly impairs treatment); see also *People v. Burnick*, 535 P.2d 352, 365 (Cal. 1975) (en banc) (discussing that psychiatric predictions of violence are inherently unreliable).

5. See *Tarasoff*, 551 P.2d at 344 n.7.

6. See *id.* at 343.

Most of you are probably familiar with the facts of this case, so a brief summary will suffice.⁷ The *Tarasoff* case is essentially an unrequited love story run tragically amuck. Mr. Poddar was a foreign-born college student who developed a "crush" on another student, Ms. Tarasoff. She did not return his affections, and instead traveled abroad for a semester. Mr. Poddar became despondent and entered into therapy at the college counseling center. During a session, he made an overt threat to kill Ms. Tarasoff when she returned. The psychologist who was treating him became justifiably concerned and conferred with his supervising psychiatrist. The counseling center notified campus police by letter and instructed an officer to pick up Mr. Poddar and bring him to the hospital for involuntary commitment.

The campus police went to Mr. Poddar's house and interviewed him. He did not appear psychotic to them, and he denied that he had any intent to harm Ms. Tarasoff. Based on his reassurances, the police decided they had no grounds to bring him to the hospital. The counseling center took no further action. The medical director of the clinic, upon returning from vacation and learning of the events, instructed his staff to delete all records of the incident. The counseling center asked the campus police to return the commitment recommendation letter that it had sent and obliterated any reference to the events from the patient's chart.

Two months later Ms. Tarasoff returned from abroad. Mr. Poddar approached her, but she rejected him once again. In a fit of anger and confusion Mr. Poddar killed her, then immediately confessed and turned himself into the police.⁸ He was tried and convicted of second degree murder, but his criminal conviction was overturned on appeal on the grounds that the trial judge had given inadequate instructions to the jury concerning the defense of diminished capacity.⁹ He did, however, serve time for voluntary manslaughter.¹⁰ Upon release from prison, he returned to his homeland, married, and at last report

7. See *id.* See also factual recitations in *Tarasoff v. Regents of the Univ. of Cal.*, 33 Cal. App. 3d 275 (1973), *vacated* 529 P.2d 553 (Cal. 1974), *vacated* 551 P.2d 334 (Cal. 1976).

8. See *Poddar*, 518 P.2d 342, 345 (1974).

9. See *id.* at 350.

10. See Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safe-guard Society*, 90 HARV. L. REV. 358 (1976).

was living happily ever after.¹¹ The parents of Ms. Tarasoff did not live so happily ever after. They sued the university, the campus police, and the therapists involved in this tragedy.

The California Supreme Court actually heard the *Tarasoff* case twice. In its first decision, they narrowly and specifically defined the therapist's duty as a *duty to warn* in such cases.¹² After a rehearing *en banc*, the court rendered its second decision, in which the therapist's duty was redefined as the more vague *duty to protect* the intended victim.¹³

So what was new about the *Tarasoff* decision? First of all, it was not an inpatient discharge case. The violent patient was an *outpatient* and hence not in the clinician's custody or control at the time his threat was made. Second, the responsibility imposed upon the therapist by the court was not permissive or discretionary, allowing that the clinician *could* warn a potential victim of threatened violence. In effect, it was a *duty* which, if breached, was punishable in tort malpractice by civil monetary damages. Third, the new duty was rather vague and all encompassing. After all, what threats were sufficiently "serious and imminent"? If not specifically named, when was the threatened victim "identifiable"? And what were "reasonable steps" for the therapist to take to protect the party threatened?

Tarasoff-type duties have been recognized in over twenty-five states either by statute or by case law in the more than twenty years since the *Tarasoff* decision was handed down.¹⁴ Other jurisdictions have explicitly rejected or limited the application of the *Tarasoff* doctrine.¹⁵ Still other courts have distin-

11. See Stone, *supra* note 10, at 360-61.

12. See *Tarasoff*, 529 P.2d 553. This decision is commonly referred to as *Tarasoff I*.

13. See *Tarasoff*, 551 P.2d 334, 340. This decision is commonly referred to as *Tarasoff II*. Many legal experts attribute this to the "outraged reaction" to *Tarasoff I*. See, e.g., Vanessa Merton, *Confidentiality and the 'Dangerous' Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 294 (1982).

14. See *Bradley v. Ray*, 904 S.W.2d 302 (Mo. Ct. App. 1995) (containing an excellent discussion of the state of *Tarasoff* legal developments nationwide). See also *Hembree v. State*, 925 S.W.2d 513 (Tenn. 1996); *Estates of Morgan v. Fairfield Family Counseling Ctr.*, 673 N.E.2d 1311 (Ohio 1997), *reconsid. denied*, 676 N.E.2d 534 (Ohio 1997); *Almonte v. New York Med. College*, 851 F. Supp. 34 (D. Conn. 1994).

15. See, e.g., *Thapar v. Zezulka*, 994 S.W.2d 635 (Tex. 1999); *Green v. Ross*, 691 So.2d 542 (Fla. App.1997); *Nasser v. Parker*, 455 S.E.2d 502 (Va. 1995); *Lee v.*

guished *Tarasoff* in cases based on factual distinctions presented.¹⁶ Another line of cases has expanded *Tarasoff's* applications to new settings, new populations, and new classes of health providers and other defendants who may be held responsible for an individual's violent conduct.¹⁷

Statutory approaches have been similarly diverse as state confidentiality and malpractice laws have been amended to limit, permit, or mandate therapist disclosures in *Tarasoff*-type situations, often involving immunity from therapist failure-to-protect lawsuits in return.¹⁸ Several states have also enacted derivative statutes extending *Tarasoff*-type duties to new classes of professionals in new situations; for example, addressing a health care worker's duty to warn third party contacts of risks of exposure to a patient's transmissible disease (e.g., HIV/AIDS or active TB).¹⁹

Corregedore, 925 P.2d 324 (Haw.1996) (limiting the *Tarasoff* doctrine to cases involving potential victims of violent assault, while declining to extend it to risks of self-inflicted injury).

16. See, e.g., *Bishop v. South Carolina Dep't of Mental Health*, 473 S.E.2d 814 (S.C. App. 1996), *aff'd as modified*, 502 S.E.2d 78 (S.C. 1998) (victim had prior knowledge of patient's dangerousness); *Riley v. United Health Care of Harding, Inc.*, 165 F.3d 28 (6th Cir. 1998) (patient made non-specific threats); *Limon v. Gonzaba*, 940 S.W.2d 236 (Tex. App. 1997) (victims neither identifiable nor foreseeable).

17. See, e.g., *Garamella v. New York Med. College*, 23 F. Supp.2d 167 (D. Conn 1998) (psychiatric resident's supervisor sued for failing to notify resident's medical school that resident was a pedophile); *J.S. v. R.T.H.*, 714 A.2d 924 (N.J. 1998) (spouse had reason to know of her husband's sexually abusive behavior against neighbor's children); *Popple v. Rose*, 573 N.W.2d 765 (Neb. 1998) (babysitter's parents sued for failure to warn of their son's known dangerous sexual propensities); *Valentine v. On Target, Inc.*, 727 A.2d 947 (Md. 1999) (gun dealer sued); *Ludlow v. City of Clifton*, 702 A.2d 506 (N.J. Super. Ct. 1997) (school board and child study team sued); *Doe v. McKay*, 700 N.E.2d 1018 (Ill. 1998) (recovered memory case); *Cain v. Rijken*, 717 P.2d 140 (Or. 1986) (en banc) (driving case). See also James Beck, CONFIDENTIALITY VERSUS THE DUTY TO PROTECT: FORESEEABLE HARM IN THE PRACTICE OF PSYCHIATRY (James C. Beck ed., 1990); Leon VandeCreek & Samuel Knapp, TARASOFF AND BEYOND: LEGAL AND CLINICAL CONSIDERATIONS IN THE TREATMENT OF LIFE-ENDANGERING PATIENTS (rev. ed. 1993). See generally Michael L. Perlin, *Tarasoff at the Millenium: New Directions, New Defendants, New Dangers, New Dilemmas*, PSYCHIATRIC TIMES, Nov. 1999, at 20.

18. See, e.g., *Hutchinson v. Patel*, 637 So.2d 415 (La. 1994). See generally Michael R. Geske, Note, *Statutes Limiting Mental Health Professionals' Liability for the Violent Acts of Their Patients*, 64 IND. L.J. 391 (1989).

19. See Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy*

I am going to limit my discussion to New York's reaction to the *Tarasoff* decision. New York, like many other states, has responded to the case by passing a *Tarasoff* exception to its patient-therapist confidentiality laws.²⁰ This *Tarasoff* exception was passed in 1984 as an amendment to the section of the Mental Hygiene Law governing the confidentiality of clinical records. It appears to give clinicians permission to release relevant medical records, and presumably their contents, in *Tarasoff*-type situations without the risk of being sued for violating the state's confidentiality laws. In the words of the statute:

[I]nformation about patients or clients . . . reported to . . . [OMH licensed or operated facilities] shall not be released . . . except as follows: to an endangered individual and a law enforcement agency when a treating psychiatrist or psychologist has determined that a patient or client presents a serious and imminent danger to that individual. The reasons for any such disclosures shall be fully documented in the clinical record. Nothing in this paragraph shall be construed to impose an obligation upon a treating psychiatrist or psychologist to release information pursuant to this paragraph.²¹

But note these caveats. First, the confidentiality provision and its exception only expressly apply to New York State Office of Mental Health [OMH] operated or licensed facilities. Most psychiatric hospitals and clinics are in fact licensed by OMH. However, what about patients and therapists in non-OMH facilities, such as many substance abuse,²² Department of Corrections, or Office of Veteran Affairs ("VA") clinics? Does it apply to those in private practice?

Second, the *Tarasoff* exception to the confidentiality statute only expressly applies to treating psychiatrists and psychologists, but does not mention other psychotherapists. Does it in fact apply to other mental health providers treating patients more and more in the era of managed care, such as psychiatric

and *Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 41-44 (1998).

20. See N.Y. MENTAL HYG. LAW § 33.13(c)(6) (McKinney 1996).

21. *Id.*

22. Most substance abuse treatment facilities are licensed by the federal Office of Alcohol and Substance Abuse Services (OASAS).

social workers or nurse clinicians? What about non-treating clinicians, such as supervisors?

Third, the statutory provision gives permission for a *Tarasoff*-type disclosure by the therapist, but expressly imposes no obligation. In a *Tarasoff* case, would a New York court conclude that the legislature intended that there not be a mandatory *Tarasoff* duty on clinicians in New York based on this statute?

Fourth, the situation overriding the patient's confidentiality and justifying the disclosure of the threat by the clinician is very narrowly defined. The statutory exception applies only when the treating therapist has determined that the patient presents a "serious and imminent danger" to "an endangered individual." What happens in less imminent situations, or when threats are made to specific groups rather than individuals? Does strict confidentiality still prevail and prohibit disclosure?

The statute permits a *Tarasoff* warning to "an endangered individual" or "a law enforcement agency" such as the police in such situations. But what if the clinician feels that other protective steps are clinically preferable? Does the clinician in effect lose the protective effect of the statute?

And finally, in clinical situations arising outside the narrow limits of the statute, does any independent *Tarasoff* duty in tort exist, or does the statute preempt any common law duty on the therapist to issue a *Tarasoff* warning?

So far there is only one published decision that has been handed down in New York which has applied this *Tarasoff* statutory exception to a clinical situation, and it is not very helpful in answering these questions. *Oringer v. Rotkin*²³ is an Appellate Division case decided in 1990. The plaintiff had been a psychiatric patient at a state hospital outpatient clinic for five years, and was being treated by the defendant, a clinical psychologist. During a therapy session, the patient threatened to kill one of his son's schoolmates. The therapist took him quite seriously. He documented in the patient's chart that he considered this to be a serious and imminent threat. He then disclosed the patient's threat to the patient's wife in order to obtain

23. 556 N.Y.S.2d 67 (1st Dep't 1990).

the name of the threatened child. He relied upon the information given by the patient's wife and notified the parents of the threatened schoolmate.

The irate patient sued his therapist for breach of fiduciary duty of confidentiality in disclosing his threat to his wife.²⁴ In effect, then, *Oringer* was a reverse *Tarasoff* case. In *Tarasoff*, the threat was made and the therapist *did not* issue a warning. When the patient committed the act, the victim's family sued the therapist. In *Oringer*, the therapist *did* issue a warning and was then sued by the patient for issuing that warning.

The trial court in *Oringer* dismissed the suit for failure to state a cause of action. The Appellate Division reinstated the case only to grant summary judgment to the therapist anyway. It held that the therapist could not be held liable for breach of confidentiality as a matter of law under New York's *Tarasoff* statutory exception, noting in particular the therapist's compliance with the statutory requirements in the way he made and documented his disclosure.

While this case may make many therapists breathe a sigh of relief, it should be noted that the facts clearly fell within the very narrow bounds of the statutory exception. The therapist was a treating psychologist, and worked for an OMH operated facility. There was no dispute about the threat or its serious and imminent nature, and the therapist followed the statute to the letter and documented the basis for his disclosure. In fact, the only variance from the statute was that the therapist spoke to the patient's wife instead of to the police or the intended victim, and he only did that in order to ascertain the name of the intended victim. Thus, this case gives us little guidance in addressing the many unanswered questions raised by the statutory exception.

In conclusion, a fair summary of a therapist's *Tarasoff* liability under current New York law for the violent acts of their patients is that it remains uncertain over twenty years after the *Tarasoff* ruling. On the one hand, the good news for therapists is that there is no mandatory *Tarasoff* duty imposed on ther-

24. Plaintiff initially based her cause of action on a breach of CPLR 4507. This is a rule of evidence and does not give rise to a cause of action. The court stated that the facts alleged made out a cause of action for a breach of fiduciary duty of confidentiality. *See id.* at 68.

apists by statute or by case law in New York. Psychiatrists in OMH facilities are even protected by a specific statutory exception to the confidentiality laws from being held liable for a breach of confidentiality when confronting a *Tarasoff* situation, if they exercise professional discretion and issue a *Tarasoff* warning (at least where their patient presents a clearly serious and imminent danger to a specific individual).

On the other hand, the bad news is that the *Tarasoff* statutory exception offers no protection or guidance to therapists in the most common *Tarasoff* situations they face every day in their clinical work. One common situation of concern is when a therapist concludes, after evaluating a potentially violent patient, that there is a chronic longer-term risk of violence but no "serious and imminent" danger to others. If the therapist fails to issue a *Tarasoff* warning and violence occurs, the therapist may be sued for failure to warn or protect. Another common situation, perhaps of less concern, is where the therapist's assessment concludes that a serious and imminent danger exists and a warning is issued to a threatened victim, but a bad outcome results anyway. The therapist may still be sued for not making additional interventions to protect the victim.

Over two decades since the seminal and controversial *Tarasoff* decision, New York State clinicians still find themselves in a clinical and medicolegal quagmire in *Tarasoff* situations. During these twenty years, *Tarasoff* has been observed more and more commonly by therapists in clinical practice, to the point where it has arguably become the *de facto* standard of care in the mental health community in spite of the absence of clarifying statutory or case law. Hopefully the extent and limits of this potential new duty will be clearly elucidated in the years ahead so that therapists can proceed with more confidence and correctness in their work of helping patients avoid *Tarasoff*-type situations in the first place.