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CONFIDENTIALITY AND THE "DANGEROUS" PATIENT: IMPLICATIONS OF *TARASOFF* FOR PSYCHIATRISTS AND LAWYERS

by
Vanessa Merton*

You may find lawyers defining the range of treatments that you are allowed to use in specified circumstances. Lawyers may prescribe the criteria by which you are to choose among the allowable treatments. Lawyers may specify the priorities you must assign to different patients. Lawyers may require you to keep detailed records to establish at all times that you are in full compliance. Lawyers may punish you unless you can refute beyond a reasonable doubt their presumption that your failures result from not following all of their regulations and requirements.

The lawyers have you outnumbered, but on the average they are no match for you in intelligence or dedication. Just don't let them ambush you while you are absorbed in caring for the sick.**

I. INTERPROFESSIONAL CONFLICT

A. *Lawyers and Doctors: The Guerrilla War Goes On*

The rancor and contempt felt by most physicians for that stock villain "the lawyer" has become a standard theme in the sociology of the professions. The epigraph above may be a gem of its kind

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Much of the research for this article was done under the auspices of the National Endowment for the Humanities, through its sponsorship of the Postdoctoral Fellowship Program at the Hastings Center Institute of Society, Ethics and Life Sciences. The Center is a superlative setting for research of this sort, not so much because of its (relatively modest) resources, but because of the extraordinary people who are associated with it. Jonas Robitscher was one of the original Fellows of the Hastings Center and until his death was a regular and valued participant in its work. The loss of his support and friendship is keenly felt by all at the Center. See 11 HASTINGS CENTER REPORT 14 (June 1981).

** Commencement Address by Chancellor W. Allen Wallis, University of Rochester School of Medicine and Dentistry, quoted in Schwartz, *Will Medicine Be Strangled in the Law?* N.Y. Times, Feb. 25, 1975, at 35, col. 2.

and perhaps atypically vehement, but the intensity of feeling it captures is not exaggerated. The atmosphere encountered by lawyers who venture into the health-care setting in a professional capacity is much like that in a village controlled by indigenous forces when the government troops drop by.¹

For a lawyer to ask why such antipathy exists would be disingenuous; the reasons are legion, many of them valid, some no doubt misinformed. Lawyers may be able to refute them, but to what end? We are dealing not, or not solely, with the sort of cognitive

¹ A number of lawyers over the past decade have participated in the health-care system in a different way and for different reasons than ever before. Neither hospital counsel nor health-care administrators, not adversarial or representative in the usual sense, these lawyers do not engage in institutional management, patient protection, or staff defense. Instead, their role is advisory, educational, and supportive; their objective is to work with health-care providers as members of the health-care team. As is true of the "ethicists" who also have become integral to the operation of several hospitals, see Kahn, *Philosophers Prime Physicians for Ethical Dilemmas*, HOSPITALS, Sept. 16, 1982, at 162; Lippert, *The Medical Philosophers*, 14 HEALTH 12 (1982); *Hospitals Turning to Philosophers for Advice on Life-and-Death Decisions*, N.Y. Times, Mar. 19, 1982, at A1, col. 3, this new breed of hospital based lawyer has been brought into the institution initially via the academic superstructure found in most major medical centers. While these lawyers do a good bit of teaching and lecturing, they also go on rounds, sit in on "morning report," participate in mortality and morbidity conferences, join institutional review boards, and consult with troubled health-care providers on individual cases. Their mission is not to "define . . . prescribe. . . specify. . . require. . . and punish," as Chancellor Wallis put it, but rather to enable health-care providers to deliver the best services possible. Their professional responsibility is first to the health-care personnel with whom they work, and ultimately to the patients for whose benefit all work. They are, in Geoffrey Hazard's classic phrase, "lawyers for the situation." See G. HAZARD, *ETHICS IN THE PRACTICE OF LAW* 58 (1978).

Very gradually, despite considerable resistance, these lawyers seems to be making inroads on the physician's stereotyped image of the mercenary attorney. Clinicians are discovering that these lawyers, who themselves often have had clients, can understand what it is to struggle with difficult decisions under constraint of limited time and resources and inadequate information. Some genuine progress towards acknowledging the problems and values common to both professions has been made. It is this kind of exchange and shared experience which might eventually alter the attitudes of health-care professionals toward lawyers and the law.

Not to be unduly optimistic: most of this has been happening on "soft money"—special grants from government agencies or private foundations. These funds are evaporating and it is not at all clear that as a class these programs have generated sufficient enthusiasm to insure their survival. A few may survive, with correspondingly minimal impact on the deeply-rooted distrust of lawyers still epidemic in the medical sphere. The typical encounter of lawyer and physician, other than as patient or as client, is likely to remain a bristling bout of barely suppressed hostility and suspicion in which each takes more or less disguised delight in surpassing the other's jargon.

belief that is subject to modification by skillful persuasion and better evidence. We are dealing with what both street parlance and social science would deem an "attitude," a view of the world which has crystallized from an amalgam of experience, psychological need, and plausible folklore. One indication of this is that physicians' ire seems to focus in personal terms on lawyers, rather than on the abstract obduracy of our complex legal system and its tedious processes.

As every lawyer who has ever tried a case to a jury should know even without benefit of the technical literature on attitude formation,² changing someone's attitude requires more than verbal facility and sound argument. An article such as this one, in the highly unlikely event that it is read by a practicing clinician, cannot be expected to greatly affect that clinician's attitude toward lawyers. (The clinician who reads this piece probably would be an unusually benign specimen to begin with). What an article like this *can* try to do is trace the connection between a particular recent development of the law, one which most clinicians consider stupid and unfair, and their own previous actions. The point is not to avoid blame but to help clinicians appreciate just how much control they can exercise over their legal destinies through the medium of professional self-regulation.

This essay examines the role conflict of the professional whose patient or client may be "dangerous" to others, and the ways in which professional standards of ethics and practice, incorporated by judicial ruling, contribute to that role conflict. The paper's focus is on the plight of the psychiatrist,³ but it also addresses the strain felt by the lawyer who either represents such a client or is asked to advise a psychiatrist who has such a patient. It suggests that health-care providers are not altogether justified in assigning

² See, e.g., *Zimbardo, The Tactics and Ethics of Persuasion*, in *ATTITUDES, CONFLICT AND SOCIAL CHANGE* 81 (1972).

³ Jonas Robitscher correctly maintained that the word "psychiatrist" often should be read to denote an array of practitioners—not only physicians, clinical psychologists, and psychoanalysts, but also the "social workers, registered nurses, counselors, pastoral counselors, ex-addicts and ex-alcoholics and other indigenous workers, and a large category we term 'mental health technicians' who in some settings . . . enjoy psychiatric authority and . . . make psychiatric decisions." J. ROBITSCHER, *THE POWERS OF PSYCHIATRY* 8 (1980).

sole responsibility for some of their professional difficulties to the law's incursions on clinical autonomy. Contrary to the assertions of Chancellor Wallis, the criteria by which the law evaluates the conduct of medical professionals continue almost exclusively to be defined by the self-set standards of customary and prudent practice, and that state of affairs is unlikely to change.⁴ For so long as it

⁴ See generally A. HOLDER, *MEDICAL MALPRACTICE LAW* (2d ed. 1978); W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 32 (4th ed. 1971); *RESTATEMENT (SECOND) OF TORTS*, § 299A (1965); Annot., 81 A.L.R.2d 597 (later case service 1979 & Supp. 1982) (overwhelming weight of authority supports view that expert evidence to support malpractice action is essential). Despite the protests of those who find anomalous the medical profession's ability to define unilaterally its legal and ethical responsibilities, see, e.g., R. VEATCH, *A THEORY OF MEDICAL ETHICS* 82-107 (1981), very few courts have imposed an "objective," nonprofessionally defined, standard of care on physicians, and then only with regard to the nontechnical issue of informed consent. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) (physician must disclose all risks a reasonable person would consider, as opposed to what other physicians would consider, significant). But see *Note on the Aftermath of Canterbury in the District of Columbia*, in *LAW AND MEDICINE: CASES AND MATERIALS* 202-03 (D. Sharpe, S. Fiscina, & M. Head eds. 1978) (explaining why *Canterbury* may not be good law even in the District of Columbia). See also *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (physicians have a duty to advise patients of all material risks of refusal to undergo recommended diagnostic tests; material risks are those that physicians know or should know would be regarded by a reasonably prudent person as significant) (relying on *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972)); *Sard v. Hardy*, 34 Md. App. 217, 367 A.2d 525 (1976) (physician's duty to disclose may be determined by nonprofessional standard if trial court decides specific facts of case justify failure to present expert opinion); *Cornfeldt v. Tongen*, 262 N.W.2d 684 (Minn. 1977) (physician can be held liable for failure to disclose risks according to jury standard, without reference to established custom of medical community); *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971) (standard of practice in informed consent cases distinguished from that of normal malpractice suit, in which issue is whether physician failed to conform to accepted medical practice); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) (evidence of professional standards on disclosure of relevant risks not required to maintain action); Annot., 52 A.L.R.3d 1084 (1973 & Supp. 1982) (traditional view in effect in most jurisdictions still is that duty is measured by professional medical standard: either custom of local community of physicians or what a reasonable physician would do under similar circumstances). For an exhaustive state-by-state analysis of the legislative response to judicial innovation in the area of informed consent, see generally Meisel & Kabruck, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980).

The cases most often cited for the proposition that standards of practice are gradually becoming defined by legal rather than by expert medical standards are Washington decisions. See *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979) (compliance with standard of profession of ophthalmology insufficient to defeat claim of malpractice for failure to conduct additional simple, inexpensive, risk-free, diagnostic tests when initial test inconclusive). Accord *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974) (same holding when

obtains, lawyers will be tempted to respond to complaints about unjust or unworkable standards with "Physician, heal thyself." Of course, the argument that clinicians can control their exposure to legal liability through concerted professional action is not meant to imply that their moral dilemmas can be as easily resolved. For most practitioners those questions undoubtedly are far more troubling.

B. *Psychiatrists and Lawyers: A More Subliminal Conflict*

Of all health-care providers, psychiatrists traditionally have been the least intolerant of lawyers. Despite the utter opposition of their philosophies—the rigid determinism of psychoanalytic theory, behavioral science, and psychopharmacology matched by the idealistic insistence on "free will" of the law—psychiatrists and lawyers seem to have enjoyed an uneasy detente akin more to sibling rivalry than to guerrilla war. For one reason, psychiatrists have been the object of relatively few malpractice actions (it is harder to prove negligent failure to resolve an adjustment reaction to adult life than careless reduction of a fractured leg) other than as the indemnified and defended representatives of mental health institutions.⁵ Too, lawyers and psychiatrists share a peculiar problem: along with their reputedly high social status and income, both receive considerable public ridicule and obloquy.⁶ Perhaps because

claim for failure to perform *any* diagnostic procedure because not indicated by professional standards). *But see* *Meeks v. Marx*, 15 Wash. App. 571, 550 P.2d 1158 (1976) (restricting *Helling* to its unique facts); WASH. REV. CODE § 4.24.290 (Supp. 1975) (legislative nullification of the *Helling* rule). For a critical analysis of these decisions and for argument that "the law's tradition of allowing the medical profession to set its own standards of care must be scrupulously upheld except when those standards are patently unreasonable," see Peters, *The Application of Reasonable Prudence to Medical Malpractice Litigation: The Precursor of Strict Liability?* 9 L. MED. & HEALTH CARE 21, 24 (Dec. 1981).

⁵ See Fishalow, *The Tort Liability of the Psychiatrist*, 4 BULL. AM. ACAD. PSYCHIATRY & L. 191, 191 (1976), and authorities cited therein at 217 n.5.

⁶ The shamanistic "shrink" and the shyster "mouthpiece" both are derided for the arbitrariness and absurdities of their doctrines. Lawyers seem almost to take a perverse delight in recounting examples of the abuse heaped on them. See D. MELLINKOFF, *THE CONSCIENCE OF A LAWYER* 1-15 (1973) for a particularly thorough collection, ranging from Jesus' "Woe unto you also, ye lawyers!" through Shakespeare's: "The first thing we do, let's kill all the lawyers," to the proverb about St. Ives: "Advocatus et non latro; Res miranda populo" (translated by Mellinkoff as "A lawyer and not a thief; A thing almost beyond belief"). Mellinkoff sums up public opinion of lawyers as follows: "Sure the law is the third oldest

the accelerating application of forensic psychiatry in every aspect of civil and criminal practice has resulted in more frequent and more sustained professional contact between lawyers and psychiatrists, however, the mutual misunderstanding characteristic of relationships between lawyers and the generic class of health-care providers seems increasingly to prevail between lawyers and psychiatrists.

No wonder we sorely miss Jonas Robitscher. As a master of both professions who succeeded in melding their respective insights into an integrated perspective, Dr. Robitscher was well equipped to identify the excesses of each. His intolerance for rigid ideology of

profession all right, in close order after whoring and pimping." *Id.* at 1. Lawyers may take some consolation in the fact that it was Adolph Hitler who said: "Every lawyer must be regarded as a man deficient by nature or else deformed by usage." Willig, *The Bar in the Third Reich*, 20 A.J. LEGAL HIST. 1, 1 (1976).

For an example of community attitudes toward psychotherapy, see the extensive account in R. SLOVENKO & G. USDIN, *PSYCHOTHERAPY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION* 44-46 (1966), discussing an illustrative comment by Vladimir Nabokov:

Our grandsons will no doubt regard today's psychoanalysis with the same amused contempt as we do astrology and phrenology. I cannot conceive how anybody in his right mind should go to a psychoanalyst, but of course if one's mind is deranged one might try anything: after all, quacks and cranks, shamans and holy men, kings and hypnotists have cured people.

Id. at 45.

In part such attitudes may be explained by the fact that lawyers and psychiatrists generally are called upon to intervene in circumstances of intense conflict, internal or interpersonal. These interventions often directly affect persons other than the client or patient in ways that the ministrations of other professionals do not. Regardless of the conflict's outcome, the psychic distress it engenders will linger. Psychologists tell us that distress can foster the need to attribute blame to someone else—a means of feeling able to control and avert further distress. Of those involved in the conflict, the professional, who after all is making a living from it, is the easiest to blame. Lawyer and psychiatrist thus may acquire a kind of guilt by association. See Chaikin & Darley, *Victim or Perpetrator: Defensive Attribution of Responsibility and the Need for Order and Justice*, 25 J. PERSONALITY & SOC. PSYCHOLOGY 268 (1973) (people need to attribute blame for misfortune to something other than chance in order to feel in control). Fritz Heider's work on the external and internal determinants of perceptions of causation remains the basic model for social psychological analyses of the attribution of responsibility. See F. HEIDER, *THE PSYCHOLOGY OF INTERPERSONAL RELATIONS* 79, 112-24, 167-74, 212-14, 246-51, 255-65 (1958). Heider points out that a person may be "held responsible for each effect that is in any way connected with him or seems in any way to belong to him" —guilt by association. *Id.* at 113. For an interesting interpolation of the Heiderian model with theories of legal liability, see Hamilton, *Who is Responsible? Toward A Social Psychology of Responsibility Attribution*, 41 Soc. PSYCHOLOGY 316 (1978).

any stripe, together with his critical eye, led him to diagnose the occasional lunacy of the law and the apparent anomie of psychiatry with equal candor and accuracy. Thoroughly skeptical of the Guttmacher-Weihofen model of a "psychiatrized" legal system in which judges and penal authorities would rely on the scientific assessment of "impartial" experts, Dr. Robitscher was likewise unpersuaded by the Szaszian claim that just about any utilization of psychiatric expertise in legal decision-making is inherently corrupt and collusive.⁷ At the same time he appreciated the partial truths of both positions, which he incorporated into his own more complex prescriptions.

Jonas Robitscher saw no reason to conclude that law and psychiatry, either as intellectual disciplines or as practical professions, are inherently incompatible. The title of his first book reflects his longstanding commitment to forging their rapprochement. His lucid exposition of the sources and consequences of the friction between the two professions, *In Pursuit of Agreement: Psychiatry and the Law*, still stands as the exemplar of what has become an impressive body of literature.⁸ Only Dr. Robitscher's last work, *The Powers of Psychiatry*, surpasses it. In both books, Dr. Robitscher reviewed the contexts in which the interaction of psychiatrists and lawyers has been more problematic than productive, and suggested several reasons: the at times slavish adherence of lawyers to absolutist logic and outdated precedent; the annoyingly mutable

⁷ See J. ROBITSCHER, *THE POWERS OF PSYCHIATRY* 52, 113 (1980). See also M. GUTTMACHER & H. WEIHOFEN, *PSYCHIATRY AND THE LAW* 10-11 (1952); Szasz, *Psychiatric Expert Testimony: Its Overt Meaning and Social Function*, 20 *PSYCHIATRY* 313 (1957).

⁸ See, e.g., S.J. BRAKEL & R.S. ROCK, *THE MENTALLY DISABLED AND THE LAW* (rev. ed. 1971); W. BROMBERG, *THE USES OF PSYCHIATRY IN THE LAW: A CLINICAL VIEW OF FORENSIC PSYCHIATRY* (1979); A. BROOKS, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* (1974); T.G. GUTHEIL & P.S. APPLEBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* (1982); M. GUTTMACHER, *THE ROLE OF PSYCHIATRY IN LAW* (1968); S. HALLECK, *LAW IN THE PRACTICE OF PSYCHIATRY: A HANDBOOK FOR CLINICIANS* (1980); H. HUCKABEE, *LAWYERS, PSYCHIATRISTS AND CRIMINAL LAW: COOPERATION OR CHAOS?* (1981); J. KATZ, J. GOLDSTEIN, & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* (1967); *LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY* (C.K. Hofling ed. 1981) [hereinafter cited as *LAW & ETHICS*]; J.W. POLIER, *THE RULE OF LAW AND THE ROLE OF PSYCHIATRY* (1968); *PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS AND DEBATE* (R. Bonnie ed. 1977); R. SLOVENKO, *LAW AND PSYCHIATRY* (1973); A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* (1975); D. WEXLER, *MENTAL HEALTH LAW: MAJOR ISSUES* (1981).

nosology and inflated scientism of psychiatrists; and, most importantly, the failure of both lawyers and psychiatrists to approach one another's work with open minds, respect, and the will to understand.

II. INTRAPROFESSIONAL CONFLICT: DIVIDED LOYALTIES

A. *Uncertainty and Ambivalence in Professional Work*

Like members of the other "helping professions," lawyers and psychiatrists elicit ambivalent responses from those they try to help. Resentment, mistrust, and envy often mingle with whatever gratitude is felt by recipients of professional service and care.⁹

The ambivalence of patients and clients is mirrored in the contradictory impulses experienced by professionals when the needs of an individual patient or client clash with the interests of society or of another individual. Under a variety of titles—"divided loyalties," "double agent," "conflict of interest,"—this problem has assumed a central role in the study of professional ethics. Like the related issue of the inherent limitations of professional ability,¹⁰ it

⁹ For two of the early sociological accounts of this phenomenon, see Goffman, *The Medical Model and Mental Hospitalization: Some Notes on the Vicissitudes of the Tinkering Trades* in *ASYLUMS* 321, 345-47, 358-59 (1961); Merton & Barber, *Sociological Ambivalence*, reprinted in *SOCIOLOGICAL AMBIVALENCE AND OTHER ESSAYS* 3 (R.K. Merton ed. 1976). See also Toulmin, *The Meaning of Professionalism: Doctors' Ethics and Biomedical Science* in *KNOWLEDGE, VALUE AND BELIEF* 254, 259-61 (H.T. Engelhardt, Jr. & D. Callahan eds. 1977) (despite the title, Professor Toulmin devotes substantial portions of his analysis to the legal profession). Finally, see Merton, Merton, & Barber, *Client Ambivalence in Professional Relationships: The Problem of Seeking Help from Strangers*, in 2 *NEW DIRECTIONS IN HELPING* (B.M. DePaulo, A. Nadler, & J.D. Fisher eds. in press).

¹⁰ Because of the (not necessarily conscious) belief that they need, as much as technical prowess, the power to inspire clients and patients with trust in the practitioner and faith in the practice, professionals are tempted to minimize factors that might undermine that faith and trust. The line between appropriate reassurance and deceptive advertising is not always easy to negotiate. It is axiomatic, but hard to admit (either to oneself or to the patient or client) that the adroitly conducted cross-examination may not discredit the witness, that the perfectly executed surgery may not save the patient. Ironically, the quack or hack often *will* offer guaranteed results. The probabilistic nature of professional practice has been thoroughly investigated only with respect to medicine, see generally H. BURSZTAJN, R. FEINBLOOM, R. HAMM, & A. BRODSKY, *MEDICAL CHOICES, MEDICAL CHANCES: HOW PATIENTS, FAMILIES AND PHYSICIANS CAN COPE WITH UNCERTAINTY* (1981); A. ELSTEIN, L.S. SHULMAN, & S.A. SPRAFKA, *MEDICAL PROBLEM SOLVING: AN ANALYSIS OF CLINICAL REASONING* (1978), but the uncertainty principle clearly obtains in other professions as well. For the first systematic

is a difficult problem for most professionals to face.

It seems reasonable to suggest, as many critics of the professions have, that in the course of gaining informed consent to treatment or representation, professionals ought to discuss topics such as the limits of their expertise and the potential for divided loyalties. An honest interchange in which the client's or patient's own unconscious or unspoken fears are voiced could diffuse those fears. While it is not easy, and not invariably appropriate, to explain to an anxious patient or client that one's very best may fail and that one's loyalty is subject to compromise, continuing denial of these critical aspects of the professional role can only exacerbate the problem. Paradoxically, open admission of the potential for failure and betrayal may allow a deeper trust to develop in the professional relationship.¹¹

sociological account of the impact of uncertainty in medical practice, see T. PARSONS, *THE SOCIAL SYSTEM* 466-69 (1951). See also C. BOSK, *FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE* (1979); R. FOX & J. SWAZEY, *THE COURAGE TO FAIL* (1974); ARROW, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Davis, *Uncertainty in Medical Prognosis, Clinical and Functional*, 66 AM. J. SOC. 41 (1960); Fox, *Training for Uncertainty*, in *THE STUDENT-PHYSICIAN* 207-41 (R.K. Merton, G. Reader, & P.C. Kendall eds. 1957). The best recent treatment of the perceived need to assert control over sources of uncertainty in professional practice is Light, *Uncertainty and Control in Professional Training*, 20 J. HEALTH & SOC. BEHAV. 310 (1979).

Conscientious professionals increasingly find it liberating to divest themselves of their airs of authority and to require clients and patients to acknowledge the uncertainty inherent in the professional encounter, despite the difficulties such a policy can cause. The classic work on the difficulty of making important decisions under conditions of uncertainty is *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* (D. Kahneman, P. Slovic, & A. Tversky eds. 1982). In coping with the inevitable uncertainties, however, both the patient or client and the professional still need the comforting sensation of *being in the presence of power*. The trick is to forge a therapeutic alliance, a fiduciary compact that can create that sense of power and, in a positive version of the self-fulfilling prophecy, enable the work to proceed without the false support of an illusion of certitude.

¹¹ See Brody, *The Patient's Role in Clinical Decision-Making*, 93 ANNALS INTERNAL MED. 718 (1980); Burt, *Conflict and Trust Between Attorney and Client*, 69 GEO. L.J. 1015, 1045-46 (1981); Katz, *Disclosure and Consent in Psychiatric Practice: Mission Impossible?* in *LAW & ETHICS*, *supra* note 8, at 91, 102-03, 115. See also D. ROSENTHAL, *LAWYER AND CLIENT: WHO'S IN CHARGE* 38-61, 168-70 (2d ed. 1977) ("participatory" model of professional-client relationship, involving client's access to complete information, initial definition of goals, periodic evaluation of professional's performance, and continuing communication with professional may result in more effective collaboration and more genuine client-professional relationship); Martyn, *Informed Consent in the Practice of Law*, 48 GEO. WASH. L. REV., 307, 313-18 (1980) (full disclosure to client has positive utilitarian consequences as

B. Patient Welfare and Society's Protection: The Role Conflict of Psychiatrists

Jonas Robitscher was among the first to describe the divided loyalties of psychiatrists and the need to protect patients from becoming victims of the varied pressures on their doctors.¹² Chilling reports of abuses in Soviet psychiatry¹³ have led other knowledgeable commentators to become concerned with this problem.

One such observer is David Bazelon, the jurist who presided over the D.C. Circuit Court of Appeals during the decades of its innovative jurisprudence in the field of forensic psychiatry and mental-health policy.¹⁴ Now Senior Circuit Judge, Bazelon continues an unrelenting campaign not only against the "perils of wizardry"¹⁵—undue reliance on technical expertise, psychiatric and otherwise

well as moral implications). *But see* Ackerman, *Why Doctors Should Intervene*, 12 HASTINGS CENTER REPORT 14 (Aug. 1982) (goal of restoring patient autonomy ill-served by mechanical application of legalistic rules such as truth-telling); Moore & Tumin, *Some Social Functions of Ignorance*, 14 AM. SOC. REV. 787 (1949) (client trust in unvarying professional competence and certainty of favorable outcome necessary for effective relationship).

¹² See J. ROBITSCHER, IN PURSUIT OF AGREEMENT: PSYCHIATRY AND THE LAW 203-21 (1966).

¹³ For a description of Soviet psychiatrists' use of diagnostic labels such as "reformist delusion" and "litigation mania" to "deprive [political dissidents] of freedom for an unlimited length of time, keep them isolated and drugged, and discredit their ideas and actions," see V. BUKOVSKY & S. GLUZMAN, A MANUAL ON PSYCHIATRY FOR DISSIDENTS 1, 7-8 (1974). See generally S. BLOCH & P. REDDAWAY, PSYCHIATRIC TERROR: HOW SOVIET PSYCHIATRY IS USED TO SUPPRESS DISSENT (1977). A letter from dissident psychiatrist Anatoly Koryagin, which was smuggled out of the Soviet Union, indicates that world reaction to accounts of these practices has not deterred their continuation. Koryagin's disclosures and protests bought him twelve years of imprisonment and exile. See *Letter from A. Koryagin, Appeal to Psychiatrists*, 1981 LANCET 1121 (Nov. 14, 1981). Koryagin was elected an honorary member of the American Psychiatric Association.

¹⁴ See generally *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) ("beyond reasonable doubt" standard of proof of mental illness and dangerousness imposed in involuntary civil commitment proceedings); *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972) (*Durham* test rejected in favor of A.L.I. "substantial capacity" test for insanity defense); *Washington v. United States*, 390 F.2d 444 (D.C. Cir. 1967) (expert witnesses' use of technical psychiatric terms limited and explanatory instructions regarding role of psychiatric witnesses required); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966) (involuntary mental patient's constitutional right to treatment upheld); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966) (inquiry into least restrictive alternative course of treatment for mental patient required); *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954) (new test of criminal responsibility adopted under which accused is not responsible if act is produced by mental disease or defect).

¹⁵ Bazelon, *The Perils of Wizardry*, 131 AM. J. PSYCHIATRY 1317 (1974).

—but also against the enlistment of psychiatrists into “service to the political and social status quo.”¹⁶ Echoing that theme, a major conference, “In the Service of the State: The Psychiatrist as Double Agent,” was cosponsored in 1977 by the American Psychiatric Association and the Hastings Center.¹⁷ Dr. Seymour Halleck, a forensic psychiatrist and author of a handbook for clinicians on law and mental health, also has explored the ethical implications of the psychiatrist’s role of “double agent.”¹⁸ Dr. Alfred Freedman, chairman of the department of psychiatry at New York Medical College and past president of the American Psychiatric Association, made the divided allegiance of psychiatrists the subject of his address to the plenary session of the First World Congress of Psychiatry. (The Congress later adopted the Declaration of Hawaii, international psychiatry’s code of ethics.¹⁹) The Chief of the Center for Studies of Crime and Delinquency at the National Institute of Mental Health, Dr. Saleem Shah, has repeatedly decried the practice of confusing therapeutic objectives with obligations of social control.²⁰

1. *In and Out of the Institutional Setting*

Those who have expressed concern about the divided loyalties of psychiatrists intimate that clarification and differentiation of the psychiatrist’s professional role is most urgently required in institutional settings such as hospitals, prisons, schools, and the armed services. The patient’s ability to withdraw from the psychiatrist’s care, which can serve to check potential abuse, is limited within

¹⁶ Bazelon, *The Law, The Psychiatrist and The Patient*, 5 *MAN & MEDICINE* 77, 78 (1980).

¹⁷ See *In the Service of the State; The Psychiatrist As Double Agent*, 8 *HASTINGS CENTER REPORT* (Special Supp. 1978). See also Callahan & Gaylin, *The Psychiatrist As Double Agent*, 4 *HASTINGS CENTER REPORT* 12 (1974).

¹⁸ See Halleck, *Privacy and Social Control* in *THE POLITICS OF THERAPY* 119 (1971).

¹⁹ See Freedman, *Ethics in Psychiatry: A Question of Allegiance*, 8 *PSYCHIATRIC ANNALS* 5, 14 (1978). See also *WORLD PSYCHIATRIC ASSOCIATION, DECLARATION OF HAWAII* (1977), reprinted in *DICTIONARY OF MEDICAL ETHICS* 138-40 (A.S. Duncan, G.R. Dunstan, & R.B. Welbourn eds., rev. & enlarged ed. 1981).

²⁰ See Shah, *Dangerousness and Mental Illness: Some Conceptual, Prediction and Policy Dilemmas*, in *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* (C. Frederick ed. 1978) [hereinafter cited as Shah, *Dangerousness*]; Shah, *Foreword to A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* at x (1975).

such institutions, and the independence of the psychiatrist's clinical judgment is likely to be compromised by a sense of responsibility to institutional goals and priorities. Ties to other professionals and ambitions for advancement in the institutional hierarchy also may have significant effects.

Concern about the pressure on psychiatrists who practice in institutions is well founded. To some extent, that concern is shared by institutional administrators. In many psychiatric hospitals, elaborate structural arrangements have been devised to separate responsibility for clinical administration and ward management from responsibility for the therapeutic regimen. The therapist who works on the patient's inner conflicts does not decide whether to give the patient a day's pass or how to respond to the patient's "acting out" on the ward.²¹ But measures intended to insulate the therapeutic mission of institutions from their purpose of social control and societal protection can never wholly resolve the role conflict of psychiatrists. Patients associated with institutions constitute only a fraction of those whose behavior psychiatrists are expected to control. Psychiatrists in private practice routinely are called upon, and choose, to function as agents of social order and family authority, despite the protests of their patients. In the process of trying to carry out this mandate, some psychiatrists may experience what Bateson *et al.* describe as a "double bind": a situation in which no matter what one does, one "can't win" and will feel that one has failed to satisfy a legitimate obligation.²²

²¹ See, e.g., R.L. COSER, TRAINING IN AMBIGUITY: LEARNING THROUGH DOING IN A MENTAL HOSPITAL 35-61 (1979).

²² See Bateson, Jackson, Haley, & Weakland, *Toward a Theory of Schizophrenia*, reprinted in STEPS TO AN ECOLOGY OF MIND 201 (G. Bateson ed. 1972). It is important to note that many psychiatrists claim to feel no such conflict, or consider it an extremely rare occurrence. To them, the responsibility of assuring that their patients do not harm themselves or others seems entirely commensurate with their primary professional function of helping and healing—indeed, it is identical to that function. (While to therapists this may seem an obvious point, I am indebted to Dr. Willard Gaylin, psychiatrist and President of the Hastings Center, for clarifying it for me.) The position of these psychiatrists is unabashedly paternalistic; that is, they will act in what they judge to be the best interests of their patients, even when those actions are completely contrary to their patients' express wishes. In hospitalizing, medicating, or revealing the confidence of a patient who is disruptive on the job, problematic for family, or dangerous to the public, such psychiatrists see themselves as advancing, not compromising, the patient's interest. Lawyers frequently are confused by this

2. *An Example: The Tarasoff Problem*

A prime example of conflict between loyalty to a patient and responsibility to others is the *Tarasoff* problem, so called after the controversial and unprecedented decision of the Supreme Court of California in the case of *Tarasoff v. Regents of the University of California*.²³ In that decision the court recognized a limited duty on the part of psychotherapists to protect third parties from patients whom they consider "dangerous," if necessary by violating that fundamental tenet of the profession's ethic, the promise of confidentiality. All psychiatrists, indeed all psychotherapists of whatever persuasion, regardless of institutional affiliation or its absence, are charged with this duty. Although *Tarasoff* arose in the context of an institution, there is no reason to anticipate that the court's holding will be confined to such situations. Subsequent cases involving both private and institutionally based therapists have not even alluded to the issue of institutional affiliation. *Tarasoff* and its progeny provide substantial grounds for the thesis that the professional role conflict of psychiatrists is not generated solely by the pressures of practice in institutions.

The *Tarasoff* decision galvanized the psychiatric profession into efforts to educate courts and legislatures about the limits of psychiatrists' capacity to assure public safety, but these disclaimers have had little effect on the spread of the *Tarasoff* doctrine to other jurisdictions. Psychiatrists condemn the doctrine as yet an-

rationale and tend to view the psychiatrist who acts in accord with it not as paternalistic but as actively preferring, to the detriment of the patient, the convenience, comfort, and safety of others. The conflict between lawyers and psychiatrists is often characterized as the clash of two commitments, one to patient autonomy and the other to patient welfare. See, e.g., Plotkin, *Limiting the Therapeutic Ory: Mental Patients' Right to Refuse Treatment*, 72 Nw. U.L. Rev. 461, 462-63 (1978) (state has delegated psychiatrists too much naked authority; "liberty" includes the freedom to decide about one's own health; external regulation of modes of psychiatric treatment prevailing in state mental health hospitals an absolute necessity); Treffert, *Letter to the Editor: Dying With Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1973) (persons who could not be civilly committed under revised procedures designed to protect constitutional rights have suffered serious injury as a result of lack of supervision and treatment). To many lawyers, however, the conflict appears as one between *patient* welfare, of which autonomy is a significant but not necessarily overriding component, and the welfare of *others*, to whom the psychiatrist does not owe the same loyalty. Thus, lawyers and psychiatrists contrive to talk past one another.

²³ 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

other unnecessary stricture inflicted on them by an uncomprehending judicial system. Their anxiety and antagonism are entirely understandable. The *Tarasoff* ruling did not *create* the role conflict they are experiencing, however; it merely embodied and perhaps reinforced a conflict that has long existed.

Tarasoff seems to have brought home to many psychiatrists the double-bind quality of their professional obligations. Dissolution of that bind will depend on more than individual response. It may require psychiatrists to act collectively, to develop a professional consensus that simply will not permit certain practices—such as predicting the lifelong course of a defendant's behavior at a sentencing proceeding. As psychiatrists generally recognize, bringing the dimensions of a schizophrenogenic conflict into conscious awareness, in and of itself, rarely is all that is needed to resolve the problem.

C. *Public Interest and Client Representation: The Role Conflict of Lawyers*

Lawyers too have been made painfully aware that loyalty to their clients often comes into conflict with the responsibilities imposed on them in their role as "officers of the court." This role conflict is also not a byproduct of institutional affiliation or of government support for legal services; it is encountered in the practice of every member of the profession and does not lend itself to easy "administrative" solution.²⁴ For a lawyer, the role conflict may be

²⁴ For an early discussion of "the defense lawyer as double agent" in the context of plea bargaining, see Blumberg, *The Practice of Law as Confidence Game: Organizational Cooptation of a Profession*, 1 L. & Soc'y Rev. 15, 20, 28 (1967) (analyzing the effects of "close and continuing relations with the prosecuting office and the court itself" on defense lawyers, "whether privately retained or of the legal-aid, public defender variety.")

Legal scholars and leaders of the bar gradually have abandoned the fallacy that the profession's ethical code, detailed and labored over as it may be, can ever constitute a dispositive hierarchy of principle, an ethical algorithm that will yield the correct course of action for the lawyer in each particular case. See, e.g., M. FREEDMAN, *LAWYER'S ETHICS IN AN ADVERSARY SYSTEM* vii (1975); G. HAZARD, *ETHICS IN THE PRACTICE OF LAW* 56-57 (1978); Callan & David, *Professional Responsibility and the Duty of Confidentiality: Disclosure of Client Misconduct in an Adversary System*, 29 RUTGERS L. REV. 332, 335-36 (1976); Kutak, *The Next Step in Legal Ethics: Some Observations About the Proposed Model Rules of Professional Conduct*, 30 CATH. U.L. REV. 1, 6 (1980); Glenn, Book Review, 57 TEX. L. REV. 307, 319 (1979) (reviewing G. HAZARD, *ETHICS IN THE PRACTICE OF LAW* (1978) and J. LIEBERMAN,

even more distressing than it is for a psychiatrist; the lawyer's sense of primary loyalty to the client is remarkably strong.²⁵ It is

CRISIS AT THE BAR: LAWYERS' UNETHICAL ETHICS AND WHAT TO DO ABOUT IT (1978)). See also Comment, *ABA Code of Professional Responsibility: Void for Vagueness?* 57 N.C.L. REV. 671 (1979); Discussion by Participants and Panel of Address of J. Ferren, *The Corporate Lawyer's Obligation to the Public Interest*, 33 BUS. LAW. 1253, 1279 (1978).

The American Bar Association's MODEL CODE OF PROFESSIONAL RESPONSIBILITY [hereinafter cited as ABA CODE], promulgated in 1969, has been adopted in some form, albeit with significant deletions and modifications, by the courts or legislatures of every state and the District of Columbia (even California's idiosyncratic Rules of Professional Conduct bear substantial resemblance; see CAL. BUS. & PROF. CODE § 6076 Rules 1-23 (West 1974 & Supp. 1980). Dissatisfaction with the ABA CODE's ambiguity, inconsistency, and failure to acknowledge the conflict among the lawyer's several roles provided the impetus for the appointment in 1977 of a blue-ribbon panel charged to undertake a "comprehensive rethinking of the ethical premises and problems of the profession of law." American Bar Association Commission on Evaluation of Professional Standards [hereinafter cited as Kutak Commission], *Chairman's Introduction*, MODEL RULES OF PROFESSIONAL CONDUCT at i (Proposed Final Draft 1981) [hereinafter cited as PROPOSED MODEL RULES]. The release in January, 1980, of an entirely reworked ethical code entitled "Discussion Draft," definitely accomplished its purpose of provoking debate throughout the profession. See Burt, *supra* note 11, at 1017 n.15; see also *Review Symposium: The Model Rules of Professional Conduct*, 1980 AM. B. FOUND. RESEARCH J. 923 (1980).

The Discussion Draft provision on the confidentiality of client communications garnered particularly strong reaction, and apparently prompted another professional organization, the American Trial Lawyers of America, to issue a rival code. See Burke, *ATLA-ABA Tiff Looms Over Altering Ethics Code*, NAT'L L.J., May 19, 1980, at 10. See also R. POUND-AMERICAN TRIAL LAWYER'S FOUNDATION COMMISSION ON PROFESSIONAL RESPONSIBILITY, THE AMERICAN LAWYER'S CODE OF CONDUCT (Public Discussion Draft 1980) [hereinafter cited as ATLA CODE]. The ATLA CODE's position on confidentiality is notably stricter than that of the American Bar Association both in its present Code or in its Proposed Model Rules. It would all but prohibit disclosure of client confidences under almost any circumstances. See ATLA CODE Rule 1.2-1.4 alternative B; Subin, *War Over Client Confidentiality: In Defense of the Kutak Approach*, NAT'L L.J., Jan. 19, 1981, at 22-23. However, the ATLA CODE has received little endorsement within the profession other than from its proponents.

The May 1981 Final Draft of the PROPOSED MODEL RULES appears to be less of a departure from the traditional model of professional behavior, at least with respect to issues of confidentiality. (However, some critics continue to caution that Proposed Rules 1.6, 1.13, and 3.3 are more supportive of lawyer disclosure than they seem. Panel Presentation of Professor Monroe Freedman to New York City Bar Association (Apr. 14, 1982). For further discussion, see text accompanying note 184 *infra*. The American Bar Association House of Delegates was unable to reach a firm decision about the PROPOSED MODEL RULES at its August, 1982 convention, see Taylor, *Dishonesty in Law: A New Ethics Code Is Sought*, N.Y. Times, Aug. 17, 1982, at A3, col. 1, and finally voted to defer further consideration. Regardless of the eventual decision, complaints about the inadequacies of the bar's attempts to reduce its ethical precepts to writing doubtless will continue unabated. Of course, it is much easier to criticize proposed solutions than to formulate them.

²⁵ For an enlightening and much-cited discussion of the tensions created by lawyers' role-differentiated behavior, see Wasserstrom, *Lawyers as Professionals: Some Moral Is-*

not uncommon for the lawyer to feel a genuine identification with the client and the client's cause, especially in a relationship of some duration. Even when the advocate's "warm zeal" is entirely feigned, the distinctive dimension of *representation*—of acting *for* and speaking *for* clients as well as to and about them—commands an almost irreducible residue of allegiance.²⁶ The traditional role of champion, or for those who prefer less honorific terms "hired gun," cannot easily comport with any act of betrayal, however public-spirited it may be.

Lawyers are almost obsessively preoccupied with preserving the

sues, 5 HUM. RTS. 1 (1975). The definitive statement of the lawyer's sense of loyalty to client is the even more frequently cited passage from Lord Brougham's defense of Queen Caroline against George IV's bill for divorce in the House of Lords. It is repeated here for the sake of those few readers who have escaped previous exposure:

[A]n advocate, in the discharge of his duty, knows but one person in all the world, and that person is his client. To save that client by all means and expedients, and at all hazards and costs to other persons, and, among them, to himself, is his first and only duty; and in performing this duty he must not regard the alarm, the torments, the destruction which he may bring upon others. Separating the duty of a patriot from that of an advocate, he must go on reckless of consequences, though it should be his unhappy fate to involve his country in confusion.

2 TRIAL OF QUEEN CAROLINE 8 (J. Nightingale ed. 1821). Lord Brougham, of course, was engaged at the time in calculated political maneuvers, not in meditation on the theme of the advocate's professional responsibility. For an excellent analysis of the impact of this bromide and other classics of the legal-ethics literature on contemporary thinking about the lawyer's role, see Patterson, *Legal Ethics and the Lawyer's Duty of Loyalty*, 29 EMORY L.J. 909 (1980). Our current Chief Justice, Warren Burger, presented an interesting and a quite different view of the optimal resolution of an advocate's role conflict in a concurring opinion written while he still sat on the D.C. Circuit Court of Appeals:

The advocate's role and duty . . . is not to "win" or set his client free, but to see that the case is tried and reviewed in accordance with a set of rules When the advocate has done that, he has done his duty. He should not be asked to do more and he ought not to do less.

Johnson v. United States, 360 F.2d 844, 847 (D.C. Cir. 1966).

This comment was preceded by the observation:

Few courts have stated this basic ethical duty more cogently than the Supreme Court of Nebraska: An attorney owes his first duty to the court. He assumed his obligations toward it before he ever had a client. His oath requires him to be absolutely honest even though his client's interests may seem to require a contrary course.

Id. at 846 n.2 (quoting *In re Integration of Neb. State Bar Ass'n*, 133 Neb. 283, 289, 275 N.W. 265, 268 (1937)). The decision Justice Burger so heartily endorsed went on to declare: "The lawyer cannot serve two masters; and the one [he has] undertaken to serve primarily is the court." 133 Neb. at 289, 275 N.W. at 268.

²⁶ See Wasserstrom, *supra* note 25, at 14.

sanctity of client communications. Perhaps that is why they are afforded potent protection by an attorney-client privilege in every jurisdiction, state and federal.²⁷ Geoffrey Hazard, Reporter for the American Bar Association Commission on Evaluation of Professional Standards, calls the attorney-client privilege the "pivotal element of the modern American lawyer's professional function."²⁸ Is it the fact that almost everything lawyers do involves communication, either *with* clients or *on behalf* of clients, that makes lawyers so unnerved by the prospect of mandatory disclosure? In the words of one federal judge:

The broad commitment of the lawyer to respect confidences reposed in him is his talisman. Touching the very soul of lawyering, it rests upon a "privilege" which is that of the client, not that of the lawyer. Inaccurately described as the "lawyer's privilege against testifying," the privilege of clients to bind their lawyers to secrecy is universally honored and enforced as productive of social values more important than the search for truth. Canon 4 [the ethical mandate to preserve client confidences] is designed to preserve the trust of the client in his lawyer, without which the practice of law, whatever else it might become, would cease to be a profession.²⁹

²⁷ See the exhaustive table of authorities in Callan & David, *supra* note 24, at 338 n.31. For a classic definition of the elements of the privilege, see *United States v. United Shoe Mach. Co.*, 89 F. Supp. 357, 358-59 (D. Mass. 1950). The importance of the privilege to "sound legal advice or advocacy" has been reaffirmed by the Supreme Court in a pair of recent cases, see *Upjohn Co. v. United States*, 449 U.S. 383 (1981) (proper representation possible only when client need not apprehend disclosure); *Trammel v. United States*, 445 U.S. 40, 51 (1980) (attorney-client privilege rooted in imperative need for confidence and trust between lawyer and client).

²⁸ Hazard, *An Historical Perspective on the Attorney-Client Privilege*, 66 CALIF. L. REV. 1061, 1061 (1978).

²⁹ *Fred Weber, Inc. v. Shell Oil Co.*, 566 F.2d 602, 607 (8th Cir. 1977), *cert. denied*, 436 U.S. 905 (1978). See also the concurring opinion of Judge Mountain in *In re Callan*, 66 N.J. 401, 331 A.2d 612 (1975):

In some substantial degree, the effectiveness of the representation an attorney affords his client will depend upon the quality of the relationship that exists between them. And only if that relationship is one of utter trust and confidence on the part of the client will he communicate with his attorney in a completely candid and uninhibited manner. Of perhaps paramount importance in inducing this kind of relationship and trust is a conviction on the part of the client that his communications will not be revealed to others. It would be difficult to exaggerate the importance of this factor.

Outsiders are scarcely sympathetic when lawyers place the preservation of client confidences above the arguably more compelling interest of preventing harm to other identifiable individuals. We need only recall the notorious "where the bodies are buried" case.³⁰ To many lawyers, the refusal of Robert Garrow's attorneys to divulge his secrets, despite the plea by the father of one of Garrow's victims to know whether his daughter was alive or dead, was the only ethical choice. To most onlookers, the attorneys' behavior appeared not merely unheroic but downright inhuman.³¹ The eventual dismissal of the indictment lodged against them³² and the bar association's vindication of their position³³ could not have altogether assuaged the revilement they suffered.

Lawyers have been subjected to more than criticism for failing to disclose confidential information about their clients. They have been held in contempt of court and ordered to jail,³⁴ suspended

Id. at 408-09, 331 A.2d at 617.

³⁰ See *People v. Belge*, 83 Misc. 2d 186, 372 N.Y.S.2d 798 (Onondaga Cty. Ct.), *aff'd*, 50 A.D.2d 1088, 376 N.Y.S.2d 771 (4th Dep't 1975), *aff'd*, 41 N.Y.2d 60, 359 N.E.2d 377, 390 N.Y.S.2d 867 (1976). See also M. FREEDMAN, *supra* note 24, at 1.

³¹ *People v. Belge*, 83 Misc. 2d at 189, 372 N.Y.S.2d at 801 ("Public indignation reached a fever pitch . . . a hue and a cry went up from the press and other news media . . ."); see Freedman, *Where the Bodies Are Buried: The Adversary System and the Obligation of Confidentiality*, 10 CRIM. L. BULL. 979, 979 (1974) ("Members of the public were shocked at the apparent callousness of these lawyers, whose conduct was seen as typifying the unhealthy lack of concern of most lawyers with the public interest and with simple decency."). See also the catalogue of public outcry in Chamberlain, *Legal Ethics, Confidentiality and the Case of Robert Garrow's Lawyers*, 25 BUFFALO L. REV. 211, 221-22 n.64 (1975). For the reaction of a psychiatrist, see M. PESZKE, *INVOLUNTARY TREATMENT OF THE MENTALLY ILL* 140 (1975) ("The recent case from New York State in which attorneys knew about a murder but did not inform the authorities and kept the parents of the murdered child in suspense is accepted and condoned by canon ethics, but revolting to the moral and common sense attitude of most citizens!"). Those who judged Garrow's attorneys with such severity presumably did not ask themselves whether they would want to be represented by a lawyer whose loyalty was less single-minded. Somehow, it is usually the other fellow's lawyer who ought to have been more concerned about the public.

³² *People v. Belge*, 83 Misc. 2d at 191, 372 N.Y.S.2d at 803.

³³ New York State Bar Ass'n Comm. on Professional Ethics, Op. 479 (1978).

³⁴ See, e.g., *In re Grand Jury Proceedings (United States v. Lawson)*, 600 F.2d 215 (9th Cir. 1979) (refusal to provide names of clients to grand jury); *In re January 1976 Grand Jury*, 534 F.2d 719 (7th Cir. 1976) (refusal to comply with subpoena to produce money received from clients suspected of bank robbery); *In re Kozlov*, 156 N.J. Super. 316, 383 A.2d 1158 (1978) (refusal to reveal name of client who was source of information about prejudiced juror), *rev'd*, 79 N.J. 232, 398 A.2d 882 (1979); *In re Callan*, 122 N.J. Super. 479, 300 A.2d

from practice,³⁵ and prosecuted for aiding and abetting their clients in violating the law.³⁶ The courts, administrative agencies and disciplinary committees that imposed these penalties were unmoved by the argument that lawyers cannot function without the complete trust of their clients. Since clients are not entitled to legal assistance in the planning or commission of a crime or tort,³⁷ encouraging them to rely on the lawyer's fidelity in the context of ongoing or anticipated misconduct is seen as serving no valid purpose. However, trying to determine whether client confidences are in the sacrosanct category of past offenses, in which case a lawyer should risk incarceration to protect them,³⁸ or whether they consti-

868 (Ch. Div.), *aff'd*, 126 N.J. Super. 103, 312 A.2d 881 (App. Div. 1973), *rev'd*, 66 N.J. 401, 331 A.2d 612 (1975) (failure to disclose client violation of court order); *Waldmann v. Waldmann*, 48 Ohio St. 2d 176, 358 N.E.2d 521 (1976) (refusal to disclose client's address). *See also State ex rel. Sowers v. Olwell*, 64 Wash. 2d 828, 394 P.2d 681 (1964) (refusal to produce knife allegedly used in murder by client).

³⁵ *In re Ryder*, 263 F. Supp. 360 (E.D. Va.), *aff'd per curiam*, 381 F.2d 713 (4th Cir. 1967) (attorney hid proceeds of and weapons used during bank robbery); *In re Carter*, [1981 Transfer Binder] FED. SEC. L. REP. (CCH) ¶ 82,847 (Feb. 28, 1981) (corporate counsel failed to disclose fraudulent scheme of management; suspension from practice before the SEC reversed because unambiguous standards of professional conduct covering their activity did not exist at time; held, prospectively, that attorneys aware of client's failure to satisfy disclosure requirements must take "prompt steps"). *See also In re Carroll*, 244 S.W.2d 474 (Ct. App. Ky. 1951) (attorney suspended for failure to correct client's statement during hearing which attorney knew to be false).

³⁶ *SEC v. National Student Mktg. Corp.*, 457 F. Supp. 682, 713-15 (D.D.C. 1978) (failure to try to prevent closing of corporate merger and to disclose to shareholders and to SEC confidential information received from client's auditor constitutes aiding and abetting violation of securities laws; injunctive relief denied). For a list of other opinions filed in connection with this much-litigated case, and reference to the lengthy bibliography it generated, see *Proceedings of the Forty-First Annual Judicial Conference for the District of Columbia Circuit*, 89 F.R.D. 169, 223, n.2 (1980).

³⁷ *See, e.g., Clark v. United States*, 289 U.S. 1 (1933); *United States v. Calvert*, 523 F.2d 895, 909-10 (8th Cir. 1975); *United States v. Friedman*, 445 F.2d 1076, 1086 (9th Cir.), *cert. denied*, 404 U.S. 958 (1971); *Union Camp Corp. v. Lewis*, 385 F.2d 143, 144 (4th Cir. 1967); and other authorities enumerated in PROPOSED MODEL RULES, *supra* note 24, Rule 1.6, Note on Exceptions to Confidentiality at 44. *See generally* UNIF. R. EVID. 502(d)(1) (1953); MODEL CODE OF EVIDENCE Rule 212 (1942); Note, *The Future Crime or Tort Exception to Communications Privileges*, 77 HARV. L. REV. 730 (1964), and authorities cited therein.

³⁸ *See People v. Kor*, 129 Cal. App. 2d 436, 447, 277 P.2d 94, 101 (1954) ("Attorney should have chosen to go to jail and take his chances of release by a higher court."); ABA Comm. on Professional Ethics, Informal Op. 312 (unpublished) *cited in* Callan & David, *supra* note 24, at 345 n.53 (attorney should refuse to disclose privileged communication "though the court [may] send him to jail"). *See also* New York State Bar Ass'n Comm. on Professional Ethics, Op. 528 (1981) (lawyer need not comply immediately with court order

tute potential threats or reveal continuing wrongdoing, in which case a lawyer probably should report them to the appropriate authorities,³⁹ has proven an elusive task and a perilous enterprise. The range and diversity of professional ethical opinion on almost any single issue is extraordinary.⁴⁰ Judge Skelly Wright calls these

to disclose client confidence which is subject to reversal or modification on appeal, even if faced with risk of being held in contempt).

³⁹ See ABA CODE, *supra* note 24, DR 7-102(B)(1) (lawyer should reveal client fraud on tribunal, committed in course of lawyer's representation; in some jurisdictions, not applicable if information considered a client confidence or secret); ABA Comm. on Professional Ethics and Grievances, Informal Op. 155 (1936) (lawyer should reveal future unlawful act or continuing wrong); ABA STANDING COMMITTEE ON ASSOCIATION STANDARDS FOR CRIMINAL JUSTICE, STANDARDS FOR CRIMINAL JUSTICE—THE DEFENSE FUNCTION, Standard 4-3.7(d) (2d ed. 1980) [hereinafter cited as ABA STANDARDS] (lawyer must reveal expressed intention of client to commit crime and information required to prevent crime that would seriously endanger life or safety of person or corrupt processes of courts). (The ABA STANDARDS are purely hortatory in that they are not the law of any jurisdiction, nor are they enforced by the disciplinary structure of the profession.) *But see* ABA Comm. on Professional Ethics and Grievances, Formal Op. 287 (1953) (lawyer must advise court not to rely on lawyer's silence to corroborate client's lack of prior criminal record, but cannot reveal client's past perjury); ABA Comm. on Ethics and Professional Responsibility, Informal Op. 1314 (1975) (confidential privilege must be upheld over obligation to notify court of client's fraud on tribunal).

⁴⁰ For example, on the relatively discrete issue of revealing a fugitive client's whereabouts, *compare* ABA Comm. on Professional Ethics and Grievances, Formal Op. 23 (1930) (no duty to disclose generally) *with* ABA Comm. on Professional Ethics and Grievances, Formal Op. 155 (1936) (duty to disclose when client has fled jurisdiction) *and* ABA Comm. on Professional Ethics, Informal Op. 1141 (1970) (depending on whether fugitive seeks advice concerning "rights" or concerning how he can "best remain a fugitive," lawyer either *cannot* disclose or, if fugitive refuses to surrender, *must* disclose whereabouts) *and* Arizona State Bar Comm. On Professional Ethics, Op. 65 (1960), *reprinted in* 6 ARIZ. BAR J. 15 (1970) (no ethical obligation of disclosure prior to arrest) *and* Michigan State Bar Comm. on Professional and Judicial Ethics, Op. 163 (1954), *reprinted in* 38 MICH. BAR J. 216 (1959) (no duty to disclose generally) *and* New York State Bar Ass'n Comm. on Professional Ethics, Op. 528 (1981) (client's whereabouts clearly confidential and need not be disclosed) *and* New York State Bar Ass'n Comm. on Professional Ethics, Op. 529 (1981) (lawyer not required to withdraw from representation of fugitive who refuses to surrender) *overruling* New York State Bar Ass'n Comm. on Professional Ethics, Op. 405 (1975). *Compare also* New York County Lawyer's Ass'n Comm. on Professional Ethics, Op. 462 (1958) (no duty to disclose) *and* New York City Bar Ass'n Comm. on Professional Ethics, Op. 81-13 (1981, as amended 1982) (attorney has option, but no duty to disclose), *reprinted in* N.Y.L.J., Mar. 5, 1982, at 26; Dec. 31, 1981, at 2, *and* North Carolina Bar Council on Professional Ethics, Op. 385 (1962), *reprinted in* 9 N.C. BAR J. 14 (1962) (duty to disclose arises when client practices fraud or deception). *See also* Matter of Jacqueline F., 94 Misc. 2d 96, 404 N.Y.S.2d 790 (Bronx Cty. Surr. Ct. 1978), *aff'd*, 65 A.D.2d 545, 409 N.Y.S.2d 704 (1st Dept. 1978), *aff'd*, 47 N.Y.2d 215, 391 N.E.2d 967, 417 N.Y.S.2d 884 (1979) (depending upon circumstances of case, address of client may or may not be privileged; attorney could be compelled on pain of

questions "as uncharted as they are fundamental."⁴¹

D. *Role Conflict in Law and in Psychiatry*

1. *Similarities*

Lawyers, then, are no strangers to the kind of role conflict that psychiatrists feel was imposed on them by the *Tarasoff* ruling. Like psychiatrists, lawyers have reacted to efforts to moderate their loyalty to clients by conjuring up the image of professional colleagues in the Eastern Bloc. Horror stories of Cuban and Bulgarian lawyers who, instead of defending their clients, more or less acquiesce in their execution⁴² are reminiscent of the tocsin sounded about the role of Soviet psychiatry in suppressing dissidence. In each instance, the profession has countered a perceived threat to its autonomous self-regulation with the slippery-slope argument that "it could happen here."

It is disconcerting for a lawyer trained in our adversary system to read statements such as those of Ma Rongjie, a prominent criminal defense lawyer from the People's Republic of China. Speaking of his defense of Jiang Qing, the widow of Mao Zedong and one of the Gang of Four, Mr. Ma explained that there never was any reason for him to meet his client because "the police and the prosecutors worked on the case a long time, and the evidence they found which wasn't true they threw away."⁴³ In China, said Mr. Ma, lawyers are "servants of the state" and their role is limited to pleading mitigating circumstances for clients whose guilt is largely predetermined.⁴⁴ Yet even under such a system, some vestige of the lawyer's professional responsibility to suppress emotions contradictory to the needs of the client can be detected. During the Cultural

contempt to disclose, notwithstanding privilege claim); *Richards v. Richards*, 64 Misc. 285, 119 N.Y.S. 81, *aff'd*, 143 A.D. 906, 127 N.Y.S. 1141 (1st Dept. 1911) (address of client is unprivileged). *But see* *Waldmann v. Waldmann*, 48 Ohio St. 2d 176, 358 N.E.2d 521 (1976) (client's address held privileged when it relates to the business and interest of client).

⁴¹ *United States v. Wright*, 489 F.2d 1181, 1188 (D.C. Cir. 1973).

⁴² *See, e.g.,* M. FREEDMAN, *supra* note 24, at 2; Fried, *The Lawyer as Friend: The Moral Foundations of the Lawyer-Client Relation*, 85 YALE L.J. 1060, 1060-61 n.1 (1976).

⁴³ Margolick, *Defense Lawyer for the Gang of Four Retains His Faith in China*, N.Y. Times, Jan. 6, 1982, at B5, col. 1.

⁴⁴ *Id.*

Revolution, Mr. Ma had spent eight years in prison or at hard labor. As he put it, "the Gang of Four has caused me a lot of trouble." "But," he went on, "I am a lawyer. Even if I hated them I had to help them."⁴⁵ Many American lawyers might say exactly the same thing.

2. *And a Difference*

In view of the parallel trends in law and in psychiatry toward increasing emphasis on the professional's duty to people other than the client or patient, it is hardly surprising that after *Tarasoff* a movement began to impose a mandatory obligation, as opposed to a discretionary power, on attorneys to disclose client confidences when the consequences of not doing so might place the life or safety of a third party in jeopardy. That movement seems to have stalled temporarily, and the previous understanding that lawyers should exercise professional judgment in determining when, if ever, to resort to disclosure of client confidences seems to have been reinstated. As this paper tries to show, the analogy between a psychiatrist caught in a *Tarasoff* bind and the lawyer in a similar situation has superficial appeal but ultimately is unconvincing. Because of the unique status of psychiatrists in our society, the psychiatrist-patient relationship must be distinguished from all others, and its limits differently defined.

E. *The Power of Psychiatrists*

The historical development of psychiatrists' power to influence a broad array of legal rights has been exhaustively documented, and need not be reiterated here. In his final book, Dr. Robitscher provided a comprehensive summary of the dimensions of this power.⁴⁶ To mention only a few: psychiatric opinions of mental competence are usually conclusive, whether they focus on the general ability to manage affairs or on a specific capacity, such as the capacity to assist in one's defense at a criminal trial. Psychiatric findings of prior incompetence can void a will, a contract, or a marriage. Psy-

⁴⁵ *Id.* at B1, col. 4.

⁴⁶ J. ROBITSCHER, *Fifty-One Ways Psychiatrists Exercise Authority*, in *THE POWERS OF PSYCHIATRY* 401 (1980).

chiatrists could enable a man to avoid the draft or a woman to get an abortion, when those were crucial issues (as soon they may be again). Psychiatric evaluations are often required in the processing of an application for a "sensitive" job in private industry as well as in the military or government. Psychiatric testimony frequently will decide the question of child custody. And since the time of Benjamin Rush and Phillipe Pinel, physicians of the mind have been able to excuse the criminally accused from moral responsibility and legal guilt.

Psychiatrists make the plausible point that these so-called "powers" are illusory, since their expert opinions may be rejected in their entirety by the judges and juries who hear them. Dr. Robitscher discounted that point as theoretically valid but of minimal significance in actual practice. "The argument of psychiatrists that decisions are made by courts, not psychiatrists, does not stand up. In fact, courts do not understand psychiatry; they rely on psychiatrists to interpret psychiatric issues in legal terms, and in very many cases they accept psychiatric testimony uncritically."⁴⁷

The most dramatic illustration of the effect of psychiatric expertise on legal rights has always been its use to deprive people of their liberty, either temporarily and directly through an emergency commitment order, or indefinitely and indirectly through testimony supportive of judicial commitment.⁴⁸ It was this power to

⁴⁷ *Id.* at 27. See also Settle & Oppgaard, *The Pre-Trial Examination of Federal Defendants*, 35 F.R.D. 475, 479-80 (1965) (courts tend to rely "almost 100%" on the results of psychiatric evaluations in determining competence to stand trial); Vann & Morganroth, *The Psychiatrist as Judge: A Second Look at Competence to Stand Trial*, 43 U. DET. L.J. 1, 9 (1965) (psychiatric determinations of competency are rarely questioned; "judges tend to follow recommendations of psychiatrists"). This may be particularly true with respect to civil commitment proceedings. See Monahan, *Empirical Analysis of Civil Commitment: Critique and Context*, 11 L. & Soc'y REV. 619, 622-23 (1977) (reporting on clinical investigations that found judges ordering commitments based on psychiatric recommendations despite explicit findings of no supporting evidence); Wexler, *The Administration of Psychiatric Justice*, in MENTAL HEALTH LAW: MAJOR ISSUES 71,101 (1981) ("The judge who signs the commitment order is the most significant figure in the commitment process by only a small margin. The physician's recommendation is probably the most important single factor in the commitment decision.").

⁴⁸ Every jurisdiction, either by statute or through common law, permits the immediate detention for medical evaluation of persons alleged to be mentally ill and "dangerous" to themselves, to others, or to property. Most states provide for long-term confinement of indi-

commit that Dr. Robitscher called "a basic underpinning of psychiatric authority" which "sets psychiatrists apart from others in our society."⁴⁹ In the last decade, however, death penalty statutes that require an assessment of the probability that a given defen-

viduals certified as "in need of care and treatment." State statutory schemes vary enormously in terms of the specific conditions for their invocation, the procedural safeguards associated with them, and the qualifications of those licensed to initiate such proceedings (ranging from "next friend" through "peace officer" to "physician") See Brakel & Rock, *Involuntary Hospitalization*, in *THE MENTALLY DISABLED AND THE LAW* (rev. ed. 1971). However, the element of mental illness, albeit under a host of different titles, is an indispensable predicate of all these schemes, see, e.g., Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions*, 23 J. LEGAL EDUC. 24, 32 (1970); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1202 (1974), and ultimately the participation of a psychiatrist is required to confirm a diagnosis of mental illness.

The ferment in this area of the law has spawned an immense forensic literature and a complex jurisprudence on the criteria and processes by which involuntary civil commitment may be authorized. See, e.g., *Parham v. J.R.*, 442 U.S. 584 (1979) (commitment of minor at parent's request requires inquiry by neutral fact finder; requirement may be satisfied by thorough psychiatric investigation and review); *Addington v. Texas*, 441 U.S. 418 (1979) (clear and convincing evidence standard for involuntary civil commitment required by 14th Amendment); *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (state cannot constitutionally confine a nondangerous person capable of surviving safely in freedom); *Baxstrom v. Herold*, 383 U.S. 107 (1966) (judicial determination of dangerousness and mental illness required to "recommit" prisoner whose sentence expired); *In re Ballay*, 482 F.2d 648 (D.C.Cir. 1973) (burden of proof of mental illness and dangerousness in involuntary civil commitment proceeding must be beyond reasonable doubt); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972) (constitutional right to individual treatment if involuntarily committed), *aff'd in part, rev'd in part, sub. nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976) (due process safeguard of a preliminary hearing is required prior to an involuntary commitment); *Dixon v. Attorney Gen.*, 325 F. Supp. 966 (M.D. Pa. 1971) (formal hearing required to "recommit" mentally disabled). See also Elliot, *Procedures for Involuntary Commitment on the Basis of Alleged Mental Illness*, 42 U. COLO. L. REV. 231 (1970) (recent trend toward giving greater weight to psychiatric judgment concerning involuntary hospitalization); Livermore, Malmquist, & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968) (ease with which one is classified as mentally ill should raise doubt as to the validity of sole reliance on psychiatric evaluation); Robitscher, *Legal Standards and Their Implications Regarding Civil Commitment Procedures*, in *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* 61 (C. Frederick ed. 1978); Roth, Dayley, & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA L. REV. 400 (1973) (court commitment hearings place a barrier between unfettered psychiatric discretion and the patient); Shuman, *The Road to Bedlam: Evidentiary Guardposts in Civil Commitment Proceedings*, 55 NOTRE DAME LAW. 53 (1979) (state statutes employ traditional due process protections in civil commitment).

⁴⁹ Robitscher, *The Limits of Psychiatric Authority*, 1 INT'L J.L. & PSYCHIATRY 183, 188 (1978).

dant will pose a "continuing threat to society"⁵⁰ have provided psychiatrists with the opportunity to dispense not just liberty but life.

A Texas psychiatrist, James Grigson, has not hesitated to conclude from a 90-minute "mental status examination" that the defendant he examined was a "sociopath" who could not be treated or rehabilitated and who would commit further acts of violence.⁵¹ Dr. Grigson apparently has yet to meet a defendant whom he does *not* think dangerous. His testimony for the prosecution in dozens of cases has resulted in a long list of capital sentences, earning the psychiatrist the ghastly sobriquet of "Dr. Death."⁵² Only within the past year has the Supreme Court prohibited the practice of compelling defendants in custody to submit to such examination without notice to their counsel and warnings about the purpose of the interview.⁵³ The Court refused, however, to exclude from sentencing proceedings psychiatric testimony on the propensity of a defendant to commit violence, thereby tacitly endorsing the claim that psychiatrists can make such predictions.⁵⁴

⁵⁰ See, e.g., IDAHO CODE § 19-2515(f)(8) (1979); TEX. STAT. ANN. art. 37.071(b)(2) (Vernon 1981); WASH. REV. CODE ANN. § 10.94.020 (repealed 1981). See also Bonnie, *Foreword, Psychiatry and the Death Penalty: Emerging Problems in Virginia*, 66 VA. L. REV. 167, 177-78 (1980) ("Since courts will not ordinarily possess the clinical sophistication to determine whether an opinion rests on an accepted theoretical foundation, we must depend on clinicians themselves, as a matter of professional ethics, to be sensitive to the limits of their own expertise and to qualify their opinions accordingly."); Dix, *Participation by Mental Health Professionals in Capital Murder Sentencing*, 1 INT'L J. L. & PSYCHIATRY 283 (1978) (the extent to which testimony by mental health professionals is relied upon in the imposition of the death penalty varies from state to state); Dix, *The Death Penalty, "Dangerousness," Psychiatric Testimony and Professional Ethics*, 5 AM. J. CRIM. L. 151 (1977) (psychiatric testimony is relied upon in determining an individual's dangerousness to society).

⁵¹ *Estelle v. Smith*, 451 U.S. 454, 457-60 (1981).

⁵² See Tierney, *Doctor, Is This Man Dangerous?* 3 SCR. 82 at 28 (June 1982). See also J. ROBITSCHER, *supra* note 7, at 199-204.

⁵³ *Estelle v. Smith*, 451 U.S. 454 (1981).

⁵⁴ *Id.* at 472-73. But cf. *People v. Murtishaw*, 29 Cal. 3d 733, 767, 631 P.2d 446, 466, 175 Cal. Rptr. 738, 759 (1981) (court reversed first degree homicide conviction because of admission at penalty phase of trial of testimony of psychopharmacologist who predicted defendant would probably "engage in future violence"; court noted "[e]xpert predictions that persons will commit future acts of violence are unreliable, and frequently erroneous; . . . such forecasts, despite their unreliability and doubtful relevance, may be extremely prejudicial.").

It may well be that these extraordinary powers were more or less thrust upon the psychiatric profession by a society anxious to seize upon some "scientific" basis for their exercise. Until quite recently, however, psychiatrists have not sought in any organized fashion to disavow either this authority or its underlying rationale: their supposed ability to determine from a clinical evaluation that an individual is "dangerous." Even though the American Psychiatric Association authorized and filed an *amicus* brief in *Estelle v. Smith* challenging Grigson's testimony,⁵⁵ only a few mental health professionals have deplored Dr. Grigson's role in Texas courts. It was the profession's willingness to accept attribution of a peculiar expertise in predicting future conduct that landed psychiatrists in the *Tarasoff* quandary.

III. THE *Tarasoff* DECISION

A. *The Facts of Tarasoff*⁵⁶

Prosenjit Poddar was a Bengali of the Harijan (untouchable) caste who had worked his way up through the Indian educational system. He was sent to study naval architecture at the Berkeley campus of the University of California in the fall of 1967. A year later, he met a young woman, Tatiana Tarasoff, whose variable responses to his attentions he evidently misinterpreted. After her final rejection of him, Poddar became inconsolably dejected and began to exhibit symptoms of clinical depression: eating and sleeping irregularly, failing to keep up with his studies or his job, and listening endlessly to tape recordings he had secretly made of his conversations with the girl. In June of 1969, at the urging of a

⁵⁵ Brief *Amicus Curiae* for the American Psychiatric Association at 11, *Estelle v. Smith*, 451 U.S. 454 (1981) (urging a limited prohibition on testimony as to *long-term* predictions of violence by psychiatrists).

⁵⁶ The statement of *Tarasoff's* facts in this section derives from numerous sources, principally the following: *People v. Poddar*, 10 Cal. 3d 750, 518 P.2d 342, 111 Cal. Rptr. 910 (1974); Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976); Winslade, *Psychotherapeutic Discretion and Judicial Decision: A Case of Enigmatic Justice*, in *THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION* 139 (H.T. Engelhardt, J. Healey, & S. Spicker eds. 1981). There are at least a score of other articles about this celebrated case in the academic legal literature alone. See the list in Note, *Discovery of Psychotherapist-Patient Communications after Tarasoff*, 15 SAN DIEGO L. REV. 265, 266 n.8 (1978).

friend, Poddar agreed to become a voluntary outpatient at the student health service. Diagnosed as an acute paranoid schizophrenic, Poddar was placed under the care of a clinical psychologist.

In late August, after a total of nine therapy sessions, Poddar confided to his therapist that he intended to kill Tatiana when she returned from summer vacation. (Although he did not identify the subject of his threats by name, there was apparently no contention that her identity was not easily ascertainable.) In addition, the friend who had originally persuaded Poddar to seek professional help had reported to the therapist that Poddar planned to buy a gun. When the therapist asked his patient to promise not to harm Tatiana, Poddar left in a huff. The therapist, after consulting with two psychiatrists, decided to commit Poddar for observation and requested assistance from the campus police.⁵⁷ Within three days, several officers took Poddar into custody and searched his rooms. They released him after he managed to convince them that he was rational and that he would stay away from Tatiana.

Poddar never returned to therapy and no subsequent effort was made either to commit him or to contact Tatiana or her family. Instead, the clinic director specifically ordered that all records of the commitment attempt be destroyed, which in fact was not done, and that no further action be taken, supposedly because he did not

⁵⁷ The therapist's letter to William Beall, Chief of Campus Police, dated August 20, 1969, read as follows:

Dear Chief Beall:

Mr. Poddar was first seen at Cowell Hospital by Dr. Stuart Gold, June 5, 1969, on an emergency basis. After receiving medication he was referred to the outpatient psychiatry clinic for psychotherapy. Since then I have seen him here seven times.

His mental status varies considerably. At times he appears to be quite rational, at other times he appears quite psychotic. It is my impression that currently the appropriate diagnosis for him is paranoid schizophrenic reaction, acute and severe. He is at this point a danger to the welfare of other people and himself. That is, he had been threatening to kill an unnamed girl who he feels has betrayed him and violated his honor. He has told a friend of his (Farrokhq Mistree, also of International House) that he intends to go to San Francisco to buy a gun and that he plans to kill the girl. He has been somewhat more cryptic with me, but he has alluded strongly to the compulsion to "get even with," and "hurt" the girl.

I have discussed this matter with Dr. Gold and we concur in the opinion that Mr. Poddar should be committed for observation in a mental hospital. I request the assistance of your department in this matter. [Signed] Lawrence Moore, Ph.D. Clinical Psychologist. Department of Psychiatry (on file with the author).

want the judgment of the campus police called into question. Meanwhile, Poddar had developed a friendship with Tatiana's brother Alex and had become his roommate. Alex knew that Poddar had threatened his sister, but, for whatever reasons, did not take the threat seriously.

After Tatiana's return to campus that fall, Poddar plagued the girl, constantly trying to see and speak with her. She rebuffed him unequivocally. Poddar's obsession peaked in late October. He fought with Alex, who warned him that if Poddar did not leave Tatiana alone, he would suffer at the hands of her father. That did not keep Poddar from repeatedly going to the Tarasoff home and demanding to see Tatiana. Finally, on the evening of October 27, 1969, Poddar found Tatiana home alone. She allowed him to come in, but soon asked him to leave. He shot her with a pellet gun and stabbed her repeatedly until she was dead. He then called the police and surrendered.

During a seventeen day trial, Poddar's attorney raised both an insanity and a diminished capacity defense. The jury found him sane and his capacity for specific intent unimpaired, and convicted him of second-degree murder. On appeal, the conviction was reversed due to a flaw in the jury instructions. Since it appeared unlikely that a retrial held more than five years after the first would result in a conviction, the State agreed to release Poddar on condition that he immediately return to India, where he is now married to a lawyer—it is said, happily so.

Tatiana's parents sued the psychologist, the psychiatrists, the campus police, and the University of California for \$200,000 in damages, citing two causes of action: the failure to warn them or Tatiana of the impending danger, and the negligent failure to bring about Poddar's commitment. It seemed evident that statutory governmental immunity shielded all the defendants from liability for erroneous decisions in the commitment process, so that the only remaining foundation for the suit was what the plaintiffs dubbed a "duty to warn."

B. *Rationale and Analysis*

1. *The Duty To Warn*

In the absence of a specific statutory provision to the contrary, there generally is no affirmative duty to control the behavior of another, nor to warn a third person of another's threat.⁵⁸ In other words, as one commentator on *Tarasoff* notes,⁵⁹ had Poddar confided his homicidal intention to a neighbor or the local barkeep, that individual would bear no legal responsibility for failing to disclose the danger or prevent the tragedy, despite the absence of any legal or ethical obligation to preserve confidentiality. Before *Tarasoff* the only exceptions to this general proposition were two situations: when a special relationship, usually custodial but always controlling, existed between the party considered responsible and a person whose dangerousness had, or should have, been recognized; and when there had been an express undertaking by the party considered responsible to protect or warn a foreseeable victim.⁶⁰

For example, cases in many jurisdictions have imposed liability on psychiatric hospitals for injuries resulting from negligent supervision or release of a dangerous inpatient and, in one instance, even for injury due to negligent failure to admit a patient who presented himself for care.⁶¹ Damages have also been assessed

⁵⁸ See RESTATEMENT (SECOND) OF TORTS § 315 (1965); W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 356 (4th ed. 1971); Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886 (1934).

⁵⁹ See Note, *Torts—Duty to Act for Protection of Another—Liability of Psychotherapist for Failure to Warn of Homicide Threatened by Patient*, 28 VAND. L. REV. 631, 639 (1975).

⁶⁰ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 435, 551 P.2d 334, 343, 131 Cal. Rptr. 14, 23 (1976). See generally RESTATEMENT (SECOND) OF TORTS §§ 315-20 (1965).

⁶¹ See *Greenberg v. Barbour*, 322 F. Supp. 745 (E.D. Pa. 1971). See also *Semler v. Psychiatric Inst.*, 538 F.2d 121 (4th Cir.) (negligent release of dangerous patient in violation of court order), *cert. denied*, 429 U.S. 827 (1976); *Hicks v. United States*, 511 F.2d 407 (D.C. Cir. 1975) (negligent failure to disclose records to court resulting in release of dangerous patient); *Underwood v. United States*, 356 F.2d 92 (5th Cir. 1966) (negligent failure to transfer records to new psychiatrist resulting in release of dangerous patient); *Smith v. United States*, 437 F. Supp. 1004 (E.D. Pa. 1977) (negligent transfer of suicidal patient to open facility), *rev'd on other grounds*, 587 F.2d 1013 (3d Cir. 1978); *Merchants Nat'l Bank & Trust Co. v. United States*, 272 F. Supp. 409 (D.N.D. 1967) (negligent failure of veterans administration hospital to warn employer of furloughed patient of his "dangerousness" enabled patient to escape supervision and kill his wife); Department of Health & Rehabilitative

against guardians for failure to warn a temporary caretaker of the violent disposition of a minor ward.⁶² Agencies of the state have been held responsible for failing to warn foreseeable victims that a prisoner was about to be paroled, but only when there had been a prior promise to do so.⁶³ Finally, returning to a medical context, physicians have been required to compensate those infected as a result of their failure to diagnose and to warn others about a patient's contagious condition.⁶⁴ In most of these cases, however, the

Servs. v. McDougall, 359 So. 2d 528 (Fla. Dist. Ct. App. 1978) (negligent supervision by hospital personnel resulted in escape of dangerous inmate). *But cf.* *Centeno v. New York*, 48 A.D.2d 812, 369 N.Y.S.2d 710 (1st Dep't 1975), *aff'd*, 40 N.Y.2d 932 (1976):

Although another physician might disagree as to the form and period of treatment to be followed, a liability would not arise; nor would it arise if the professional judgment to discharge him was in fact erroneous. The prediction of the future course of a mental illness is a professional judgment of high responsibility and in some instances it involves a measure of calculated risk. If a liability were imposed on the physician or the State each time the prediction of future course of mental disease was wrong, few releases would ever be made and the hope of recovery and rehabilitation of a vast number of patients would be impeded and frustrated. This is one of the medical and public risks which must be taken on balance, even though it may sometimes result in injury to the patient or others.

Id. at 813, 369 N.Y.S.2d at 711 (1st Dep't 1975), *aff'd*, 40 N.Y.2d 932 (1976).

⁶² See, e.g., *Johnson v. State*, 69 Cal. 2d 782, 447 P.2d 352, 73 Cal. Rptr. 240 (1968) (parole authority held responsible for not warning foster parents that ward placed in their care was dangerous); *Ellis v. D'Angelo*, 116 Cal. App. 2d 310, 253 P.2d 675 (1953) (parents held responsible for failing to warn babysitter that child was "dangerous"). See generally *RESTATEMENT (SECOND) OF TORTS* § 316 (1965).

⁶³ See, e.g., *Morgan v. County of Yuba*, 230 Cal. App. 2d 938, 41 Cal. Rptr. 508 (1964) (county liable for sheriff's failure to warn decedent of release of dangerous prisoner after promising to do so). *But cf.* *Williams v. State*, 308 N.Y. 548, 127 N.E.2d 545 (1955) (as a matter of public policy, state would not be liable for death caused by escaped convict, even if negligently permitted to escape; state's duty with respect to psychiatric patients greater than with respect to prisoners). The decision in *Thompson v. County of Alameda*, 88 Cal. App. 3d 936, 152 Cal. Rptr. 226 (1979), a post-*Tarasoff* case indicating that liability could attach to a state agency responsible for releasing a dangerous ward without warning those foreseeably endangered, even in the absence of a prior promise to do so, was reversed by the California Supreme Court. 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980) (en banc).

⁶⁴ See, e.g., *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (physician can be held liable for negligent failure to advise nurses and parents of risk from child with typhoid fever); *Hofmann v. Blackmon*, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (holding physician owes duty to minor child living with parent suffering contagious disease to inform those charged with minor's care of disease and steps necessary to prevent child's exposure), *cert. denied*, 245 So. 2d 257 (Fla. 1971); *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (physician's duty to notify public officials and parents of danger from child with scarlet fever); *Wojcik v. Aluminum Co. of America*, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup. Ct. 1959) (failure to advise wife of husband's tuberculosis held actionable); *Jones v. Stanko*, 118

physician had not complied with an explicit statutory mandate to report every case of a particular infectious disease.⁶⁵

These decisions reflect the policy judgment that, in some situations, the person most likely to foresee an injury should bear the risk of its occurrence and the burden of taking steps to prevent it. Before *Tarasoff*, however, no court had ever extended this principle to a psychotherapist's relationship with a voluntary outpatient. In addition, the California statute under which Poddar's emergency detention could have been authorized seems clearly to prohibit disclosure of confidential information, except to the patient's relatives or to law enforcement agencies.⁶⁶ In asking the campus police for assistance, the Berkeley therapists had adhered to the exact course of action prescribed by the statute.

The trial judge felt constrained to dismiss the case since there was no direct precedent for the claim. The plaintiffs appealed the dismissal of their case to California's Supreme Court. In *Tarasoff v. Regents of the University of California*,⁶⁷ that court reversed the dismissal and reinstated the claims against both the police and the therapists. This meant that the plaintiffs would be permitted to try to prove their allegations at a trial, and if successful, could collect damages attributable to the failure of the police and the therapists to warn them of Poddar's threat. The court focused its attention on the abortive effort to commit Poddar, characterizing it as a "Good Samaritan" act—a step that need not be attempted but that once undertaken must be carried out in a non-negligent fashion.⁶⁸

Ohio St. 147, 160 N.E. 456 (1928) (failure to notify public officials and "persons in proximity" to smallpox victim of contagious nature of disease can constitute negligence). See generally Annot., 5 A.L.R. 926 (1920); 70 C.J.S. *Physicians and Surgeons* § 48(j) (1951 & Supp. 1981); 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 245-46 (1981).

⁶⁵ See, e.g., N.Y. PUB. HEALTH LAW §§ 2101, 2225-2226, 2300 (McKinney 1977 & Supp. 1981).

⁶⁶ CAL. WELF. & INST. CODE § 5328.3 (West 1972).

⁶⁷ 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974) [hereinafter cited as *Tarasoff* I].

⁶⁸ On the duty of a "Good Samaritan" to proceed non-negligently, see generally Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247, 276 nn.113-15 (1980). Most states, however, protect physicians and other medical personnel from liability for consequences of even negligent acts committed while gratuitously aiding people in emergencies.

2. *A Special Relationship*

The psychiatric profession's outraged reaction to *Tarasoff I*⁶⁹ led the California Supreme Court to take the unusual step of granting a petition for rehearing. This time, the defendants were assisted by the filing of several *amicus curiae* briefs on behalf of the American Psychiatric Association and other professional organizations.⁷⁰ Eighteen months after the original ruling, a final decision was rendered.

Again, the Supreme Court reversed the lower court's dismissal and reinstituted the suit, holding:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious threat of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending 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 the police, or to take whatever other steps are reasonably necessary under the circumstances.⁷¹

At the same time the court cautioned:

We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express

See generally G. ANNAS, L. GLANTZ, & B. KATZ, *THE RIGHTS OF DOCTORS, NURSES AND ALLIED HEALTH PROFESSIONALS* 106-07 (1981); Zaremski, *Good Samaritan Statutes: Do They Protect the Emergency Care Provider?* 7 *MEDICOLEGAL NEWS* 5 (1979).

⁶⁹ For example: "To make a law of this understanding puts psychiatrists in a position where they have to respond even to idle threats." *Therapists and Threats*, *TIME*, Jan. 20, 1975, at 56 (statement of Dr. Alfred Freedman, past president of the American Psychiatric Association); "The soundest practice is to try to defuse a person's homicidal urges through treatment. The minute you report them, they drop out of therapy. . . . If you locked up everybody who made a threat there wouldn't be enough room in the hospitals." *California Court Limits Doctor-Patient Privilege*, *N.Y. Times*, Dec. 25, 1974, at 15, col. 1 (statement of Dr. Morris Grossman, Stanford University Professor Emeritus of Psychiatry).

⁷⁰ Other organizations included the California State Psychiatric Association, the San Francisco Psychoanalytic Institute, the National Association of Social Workers, and the California Hospital Association.

⁷¹ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 431, 551 P.2d 334, 340, 131 Cal. Rptr. 14, 20 (1976).

threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.⁷²

The hardship for therapists of trying to negotiate a safe passage between the Scylla of unjustified disclosure and the Charybdis of failure to warn was somewhat mitigated by the court's ruling that their judgment need not be "perfect," but merely must evince "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [their profession] under similar circumstances."⁷³ While the court did not limit the therapist's obligation to act to cases in which the identity of the victim was known, it did recognize that a therapist could not be required to "interrogate" the patient, or to "conduct an independent investigation" in order to discover the victim's identity.⁷⁴ The case never actually went to trial, but was settled on terms "within the range for wrongful death of a college girl"⁷⁵ on July 1, 1977—one year to the day after the second *Tarasoff* opinion.

⁷² *Id.* at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

⁷³ *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (citations omitted).

⁷⁴ *Id.* at 439 n.11, 551 P.2d at 335 n.11, 131 Cal. Rptr. at 25 n.11. The California Supreme Court has since made it absolutely clear that a nonspecific threat directed at the general population cannot be the predicate for *Tarasoff* liability, even when it might be reasonable to expect the therapist to recognize that a patient poses danger to the community at large. The potential victim of the patient has to be "readily identifiable" in order to trigger a *Tarasoff* duty. See *Thompson v. County of Alameda*, 27 Cal. 3d 741, 754, 614 P.2d 728, 735, 167 Cal. Rptr. 70, 76 (1980). See also *Hooks v. Southern Cal. Permanente Medical Group*, 107 Cal. App. 3d 435, 165 Cal. Rptr. 741 (1980) (duty to warn when foreseeable risk of harm to foreseeable victim exists); *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980), discussed in text accompanying notes 152-56 *infra*. The reasoning in *Hooks* has also been adopted by a federal district court. See *Leedy v. Hartnett*, 510 F. Supp. 1125 (M.D. Pa. 1981), discussed in text accompanying notes 178-81 *infra*.

⁷⁵ Personal communication from George Alexander McKray, Esq., counsel for the Tarasoffs, on June 28, 1979.

The major difference between the initial opinion and the decision after rehearing is the responsibility placed on the police. In the second opinion, neither a "duty to warn" nor a duty to take special steps to protect the victim was imposed on the police, despite their express duty to assure public safety and their freedom from any obligation to preserve the confidentiality of Poddar's statements. If a therapist's responsibility in these circumstances can be met by communicating the perceived danger to law enforcement authorities, as *Tarasoff* clearly says, why should such authorities—whose power to restrain the liberty of the "dangerous" person exceeds that of any therapist—themselves be exonerated from liability for failing to warn the victim or prevent the harm? The California Supreme Court's only stated reason for upholding the dismissal of the suit against the police was the absence of a "special relationship," such as that of psychotherapist and patient, between the police and Poddar. The *Tarasoff* ruling centers on this concept of a "special relationship," and on the posited ability of therapists⁷⁶ to anticipate potential violence in patients. Analogizing the relationship to other "controlling" relationships, the court suggested that therapists can control their dangerous patients through the exercise of both their statutory authority to initiate commitment proceedings and their therapeutic influence.

IV. *Tarasoff's* CONSEQUENCES FOR PSYCHIATRIC PRACTICE

A. *The Limits of Psychiatric Expertise*

1. *Diagnosing Dangerousness and Predicting Behavior*

It has been asserted, reasonably enough, that the *Tarasoff* court hoist psychiatrists with their own petard. Having failed to correct

⁷⁶ In its discussion of the duty to disclose, the *Tarasoff* court did not distinguish psychiatrists from other professionals engaged in treating the mentally ill or emotionally disturbed, and used the comprehensive term "psychotherapist". Nothing in the *Tarasoff* opinion or in subsequent decisions limits the applicability of the duty to Board-certified psychiatrists or even to physicians. See *People v. Murtishaw*, 29 Cal. 3d 733, 768-69 n.31, 631 P.2d 446, 467 n.31, 175 Cal. Rptr. 738, 759 n.31 (1981) (judicial notice taken of studies showing unreliability of psychiatrists' attempts to forecast violence; such studies held likely to apply to psychologists' forecasts as well). For a discussion of the applicability of *Tarasoff* to psychiatric nurses, see Kjervik, *The Psychiatric Nurse's Duty to Warn Potential Victims of Homicidal Psychotherapy Outpatients*, 9 L. MED. & HEALTH CARE 11 (1981).

the perception of judges, correctional authorities, legislators, and the public that they are capable of detecting "dangerousness," and having acquired in large part the power to determine society's reaction to the "dangerous" individual,⁷⁷ psychiatrists now arguably are confronted with the logical implications of that power.

Individual members of the profession, as well as commentators from other fields, have long concurred that, in the legal arena, psychiatrists are induced to exceed the bounds of their genuine competence and too often allow themselves to render extraordinarily complex and difficult value judgments in the guise of "scientific" opinion.⁷⁸ Jonas Robitscher, for one, devoted a significant portion of his career to exposing and combatting such malpractice.⁷⁹ But on the whole, prior to *Tarasoff*, this concern had not been embraced, nor had evidence of its potential for abuse been marshalled, by broad-based and representative groups within the profession. It is somewhat ironic that only six months before the decision in *Tarasoff I* a prestigious task force of the American Psychiatric Association concluded that "neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.' Neither has any special psychiatric expertise in this area been established."⁸⁰

On the rehearing of *Tarasoff I*, the attorneys for the American Psychiatric Association and other professional organizations as *amici curiae* cited that report and contended that the imposition of a duty to take reasonable measures to protect the potential victim of a dangerous patient was unfair, because psychiatrists simply

⁷⁷ "If a sociologist predicted that a person was 80 percent likely to commit a felonious act, no law would permit his confinement. On the other hand, if a psychiatrist testified that a person was mentally ill and 80 percent likely to commit a dangerous act, the patient would be committed." Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1290 (1966).

⁷⁸ See, e.g., Bazelon, *supra* note 15; Dershowitz, *supra* note 48; Halleck, *A Critique of Current Psychiatric Roles in the Legal Process*, 1966 WIS. L. REV. 379; Suarez, *A Critique of the Psychiatrist's Role as Expert Witness*, 12 J. FORENSIC SCI. 172 (1967). See generally B. ENNIS, PRISONERS OF PSYCHIATRY (1972); T. SZASZ, IDEOLOGY AND INSANITY (1972); T. SZASZ, LAW, LIBERTY AND PSYCHIATRY (1963).

⁷⁹ See, e.g., Robitscher, *supra* note 49.

⁸⁰ A.P.A. TASK FORCE ON CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL, REPORT 8: CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 28 (1974).

cannot accurately foresee violent behavior in their patients, and was unwise, because of the disastrous impact of such a duty on the practice of psychotherapy. They brought to the court's attention numerous articles and studies purporting to demonstrate that, in the current state of the art, psychiatrists consistently overpredict violent behavior—that their predictions may well be no more reliable than those arrived at by the toss of a coin.⁸¹

A storm of criticism from psychiatrists followed in the wake of the second *Tarasoff* opinion, echoing the contentions advanced by the *amici*.⁸² Conceding the low reliability and questionable validity of psychiatric diagnoses—what detractors have called psychiatric “labels”—some psychiatrists maintain that susceptibility to error is even more pronounced in their prognoses, and most problematic of all when their task is the prediction of violent behavior.⁸³ A vio-

⁸¹ See, e.g., A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 33 (1975). Stone states:

It can easily be stated flatly on the basis of my own review of the published material on the prediction of dangerous acts that neither objective actuarial tables nor psychiatric intuition, diagnosis, and psychological testing can claim predictive success. . . . The mental health professionals . . . simply have no demonstrated capacity to generate even a cutting line that will confine more true than false positives.

See also J. MONAHAN, *The Prevention of Violence*, in *COMMUNITY MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM* (1976); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1974); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974); Steadman & Keveles, *The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70*, 129 AM. J. PSYCHIATRY 304 (1972).

⁸² See, e.g., Gurevitz, *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289, 291 (1977); McDonald, *The “Warning” Decision—Further Complications*, PSYCHIATRIC NEWS, Jan. 21, 1977, at 33; Shah, *Dangerousness—A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOLOGIST 224 (1978); Skodol & Karasu, *Emergency Psychiatry and the Assaultive Patient*, 135 AM. J. PSYCHIATRY 202 (1978). The *Tarasoff* decision poses an impossible dilemma for clinicians, according to the Recommended Position Statement on the *Tarasoff* Decision of the American Psychiatric Association Committee on Confidentiality, quoted in Beigler, *Privacy and Confidentiality*, in *LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY* at 69, 82-83 (C.K. Hofling ed. 1981).

⁸³ “Psychiatrists can predict dangerousness about as well as the corner butcher.” Statement of Dr. Stanley Portnow, Associate Professor, N.Y.U. Medical School, N.Y. Times, Dec. 16, 1979, at E7; “Psychiatrists don’t have the capacity to predict dangerousness. Every empirical study demonstrates that they cannot. Just because the legal system says you can, doesn’t make it so.” Statement of Dr. Alan Stone, President of the American Psychiatric Association (1979-80) and Professor, Harvard Law School, in Saxbe, *Must Psychotherapists*

lent assault on another person is a peculiarly difficult phenomenon to predict accurately, because it is such a comparatively rare event. The prediction of violence, like that of many other low base-rate behaviors, is subject to a substantial risk of resulting in "false positives"—that is, of identifying as "dangerous" many persons who will never engage in violent conduct.⁸⁴

Psychiatrists quite properly denounce the term "dangerousness" as a legal construct, not a medical one, and an ill-defined, ambiguous construct at that.⁸⁵ Unlike the "infectiousness" of a disease, "dangerousness" is not an objectively verifiable condition. Nor can it accurately be considered a personal attribute, or a character trait. Rather, like other behavioral-science concepts, it is a way of describing the probable outcome of interaction between a person and the environment or social situation in which that person functions. To predict violent behavior is to speculate about someone's future response to a complex of variables, any one of which may or

Warn About Released Patients? N.Y. Times, Feb. 12, 1980, at C3, col.2.

The recent highly publicized trial of John W. Hinckley, accused of attempting to assassinate President Reagan, has once again heightened the controversy over the role of mental health professionals in the legal system. While most of the media attention has focused on the unexpected verdict of not guilty by reason of mental disease or defect, and subsequent calls for reform or abolition of the insanity defense, the validity of psychiatric predictions of long-term "dangerousness" also has come to the fore in connection with the need to assess Hinckley's present mental state and eligibility for release from custody. The general attitude of mental health professionals seems to have undergone radical change since the pre-*Tarasoff* era. In one news report, the emphatic declaration of leading forensic psychiatrist Dr. Loren Roth, "Can clinicians say which person will be dangerous in nine months, one year or five years? No!" is cited as expressing an opinion generally held in the psychiatric profession. See Pines, *Violence Termed Hard to Foretell: Mental Experts Say Profession is Not Equipped to Predict How Hinckley May Act*, N.Y. Times, June 27, 1982, at 25, col. 1.

⁸⁴ J. MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* 33 (1981) (citing Meehl & Rosen, *Antecedent Probability and the Efficacy of Psychometric Signs, Patterns or Cutting Scores*, 52 *PSYCHIATRIC BULL.* 194 (1955), and quoting Livermore, Malmquist, & Meehl, *supra* note 48, at 84).

⁸⁵ See Brooks, *Notes on Defining the "Dangerousness" of the Mentally Ill*, in *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* at 37 (C. Frederick ed. 1978); Shah, *Dangerousness*, *supra* note 20, at 156. For a critique and review of the use of the term in the context of civil commitment, see Weissbourd, *Involuntary Commitment: The Move Toward Dangerousness*, 15 *J. MAR. L. REV.* 83 (1982) (courts have tried to resolve conflict of legal and psychiatric concerns by emphasis on largely legal concept of dangerousness). See also Dershowitz, *supra* note 48, at 24.

may not occur.⁸⁶ Although actuarial correlates with violent behavior have been observed,⁸⁷ there appears to be little agreement among practitioners, either in terms of theoretical analysis or empirical research, as to what, other than prior acts of violence, constitutes a *clinical* indicator of "dangerousness." Even an expressed violent intention, such as that of Prosenjit Poddar, may reflect only the harmless discharge of repressed emotion, common in the therapeutic process. There are no courses in medical schools and psychoanalytic institutes and no definitive texts which explain the technique and criteria by which an assessment of "dangerousness" can be made.⁸⁸ Therefore, psychiatrists argue, there is no "standard of the profession" for determining when a patient "presents a serious danger of violence to another,"⁸⁹ and the failure to forestall or forewarn of such a contingency can never fairly be evaluated by the hindsight of judge and jury.

The profession's shocked and defensive reaction to this new responsibility was particularly understandable since the very same California court, during the interim between the two *Tarasoff* decisions, had decided that the standard of proof required in sex-offender commitment proceedings based on psychiatric recommendation must be "beyond a reasonable doubt," noting:

⁸⁶ See generally Bem and Funder, *Predicting More of the People More of the Time: Assessing the Personality of Situations*, 85 PSYCHOLOGY REV. 485 (1978); Bowers, *Situationism in Psychology: An Analysis and Critique*, 80 PSYCHOLOGY REV. 307 (1973); Cohen, Groth, & Siegel, *The Clinical Prediction of Dangerousness*, 1978 CRIME & DELINQ. 28, 33 (1978); Lewin, Lippett, & White, *Patterns of Aggressive Behavior in Experimentally Created "Social Climates"*, 10 J. Soc. PSYCHOLOGY 271 (1939). On the importance of viewing "dangerousness" as a "probabilistic" assessment, the consequences of which are dictated by social policy and political judgment rather than "objective" science, see Monahan & Wexler, *A Definite Maybe: Proof and Probability in Civil Commitment*, 2 L. & HUM. BEHAV. 37 (1978); Morse, *Crazy Behavior, Morals, and Science: An Analysis of the Mental Health Law*, 51 SO. CALIF. L. REV. 527, 593-94 (1978).

⁸⁷ See J. MONAHAN, *supra* note 84, at 71. For an extraordinarily lucid explanation of the distinction between clinical and actuarial or statistical predictive methods and their relative benefits and disadvantages, see Underwood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment*, 88 YALE L.J. 1408 (1979).

⁸⁸ See Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976).

⁸⁹ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 431, 551 P.2d 334, 340, 131 Cal. Rptr. 14, 20 (1976).

Perhaps the psychiatrist is an expert at deciding whether a person is mentally ill, but is he an expert at predicting which of the persons so diagnosed are dangerous? Sane people too are dangerous, and it may legitimately be inquired whether there is anything in the education, training, or experience of psychiatrists which renders them particularly adept at predicting dangerous behavior. Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate, and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals.⁹⁰

Such an assessment of the validity of psychiatric opinion must indeed come as a revelation to the tens of thousands who are involuntarily hospitalized each year because a psychiatrist has found them "dangerous," and to the defendants in Texas and Virginia who have received death sentences predicated on psychiatric testimony of "continuing dangerousness."⁹¹ Dr. Lee Coleman, a California psychiatrist whose studies were cited in the A.P.A. *amicus* brief, was moved to comment, after the rehearing of *Tarasoff I* had been granted:

It is hard for me to understand how the psychiatric community can ask to have it both ways—to be free of an obligation to warn, on the basis of *inability* to predict dangerousness, and yet to have the authority to incarcerate patients on the basis of an *ability* to predict dangerousness.⁹²

2. The "Draconian Dilemma"

Not only have psychiatrists found *Tarasoff* an opportune reason to publicize the limits of their expertise, they have also been impelled by the decision to acknowledge the role conflict precipitated

⁹⁰ *People v. Burnick*, 14 Cal. 3d 306, 326, 535 P.2d 352, 365, 121 Cal. Rptr. 488, 501 (1975) (quoting *Murel v. Baltimore City Criminal Court*, 407 U.S. 355, 364-65 n.2 (1972) (Douglas, J., dissenting)).

⁹¹ See Shah, *supra* note 82, at 225-26; Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCHIVES GEN. PSYCHIATRY 397 (1972). See also notes 47-55 *supra*.

⁹² Ayres & Halbrook, *Law, Psychotherapy and the Duty to Warn: A Tragic Trilogy?* 27 BAYLOR L. REV. 677, 686 (1975).

by their willingness to serve as agents of social control. As the *Tarasoff* dissent observed, therapists are confronted with a "Draconian dilemma."⁹³ The obligation of confidentiality in a therapeutic relationship is not merely a premise of professional ethics⁹⁴ but a legally enforceable imperative. Although the duty is qualified,⁹⁵ its violation may be compensated by damages for breach of privacy, breach of fiduciary duty, breach of implied contract, defama-

⁹³ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 457, 551 P.2d 334, 358, 131 Cal. Rptr. 14, 38 (1976).

⁹⁴ See, e.g., AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1957), reprinted in 4 ENCYCLOPEDIA OF BIOETHICS at 1751 (W.T. Reich ed. 1978); PRINCIPLES OF MEDICAL ETHICS iv (rev. 1980), reprinted in CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION at ix (1982); AMERICAN PSYCHIATRIC ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 9, reprinted in 131 AM. J. PSYCHIATRY 1057, 1063 (1973); THE HIPPOCRATIC OATH, reprinted in STEDMAN'S MEDICAL DICTIONARY 647 (23d ed. 1976). The legal right and obligation to withhold disclosure of patient confidences in a judicial setting, manifest in testimonial privilege statutes which vary from state to state, does not necessarily apply to every type of therapist. But the professional ethical obligation of physicians to maintain confidentiality is shared by nurses, psychologists, social workers, and other counselors. See, e.g., AMERICAN NURSES' ASSOCIATION, CODE FOR NURSES WITH INTERPRETIVE STATEMENTS § 2 (rev. ed. 1976), reprinted in 4 ENCYCLOPEDIA OF BIOETHICS at 1789 (W.T. Reich ed. 1978); AMERICAN PSYCHOLOGICAL ASSOCIATION, ETHICAL PRINCIPLES OF PSYCHOLOGISTS, Principle 5 (rev. ed. 1981), reprinted in 36 AM. PSYCHOLOGIST 633, 635 (1981); NATIONAL ASSOCIATION OF SOCIAL WORKERS, REVISED CODE OF ETHICS § 2(H), reprinted in 24 N.A.S.W. NEWS 13 (1979). In addition, state regulations often broadly define the professions in which confidentiality is required. See, e.g., STATE OF NEW YORK, OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS, tit. 8, part 29, § 29.1(b)(8)(1977) (defining "unprofessional conduct in the practice of any profession licensed or certified" to include the "revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law").

⁹⁵ *Simonson v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920) (statute that defines betrayal of confidential patient information as unprofessional conduct provides basis for liability for breach, but duty of confidentiality subject to qualification that physician may reveal information reasonably necessary to prevent outbreak of contagious disease); *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (1962) (physician has duty not to disclose patient information except to third party with legitimate interest in patient's health; for example, prospective insurer of patient's life); *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960) (patient held to have waived right to confidentiality when psychiatrist revealed patient's alcoholism to employer as underlying cause of repeated absences; patient had requested "medical certificates" excusing absences); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (psychiatrist may be permitted to reveal patient information for protection of third party, but must show due diligence in ascertaining truth, relevance, and necessity of revealing information); *Smith v. Driscoll*, 94 Wash. 441, 162 P. 572 (1917) (physician held immune from liability for disclosure of patient confidences when disclosures made during judicial proceedings).

tion, and malpractice.⁹⁶ Offenders may also, at least in principle, be

⁹⁶ See, e.g., *Hammonds v. Aetna Casualty & Sur. Co.*, 237 F. Supp. 96, *motion for reconsideration denied*, 243 F. Supp. 793 (N.D. Ohio 1965) (court applied Ohio law and held that cause of action against insurance company may be based on allegation that company wrongfully induced plaintiff's doctor to disclose confidential patient information); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (in absence of statutory doctor-patient privilege, public policy imposes on physicians a qualified duty of confidentiality the breach of which gives rise to a cause of action for damages); *MacDonald v. Clinger*, 446 N.Y.S. 801, 805 (4th Dep't 1982) (psychiatrist disclosed information to patient's wife; held, patient could sue in tort, for breach of fiduciary duty of confidentiality, and thus recover greater damages than if sued on implied contract; but affirmative defense of justification recognized "whenever there is a danger to the patient, the spouse or another person"); *Doe v. Roe*, 42 A.D.2d 559, 345 N.Y.S.2d 560 (1st Dep't 1973) (action will lie against psychiatrist for publication of book detailing patient's lengthy psychoanalysis, even if patient's identity somewhat disguised), *aff'd*, 33 N.Y.2d 902, 307 N.E.2d 823, 352 N.Y.S.2d 626 (1973), *cert. granted*, 417 U.S. 907 (1974), *cert. dismissed as improvidently granted*, 420 U.S. 307 (1975), *permanent injunction and damages awarded*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (1977); *Schaffer v. Spicer*, 215 N.W.2d 134 (S.D. 1974) (practitioner of healing arts may be liable in damages to patients for unauthorized disclosure). See generally Annot., 20 A.L.R.3d 1109 (1968 & Supp. 1981). But see *Panko v. Consolidated Mut. Ins. Co.*, 423 F.2d 41 (3d Cir. 1970) (pretrial disclosures to adversary actionable only if wrongful and resulted in loss of plaintiff-patient's lawsuit); *Collins v. Howard*, 156 F. Supp. 322 (S.D. Ga. 1957) (court applied Georgia law and held that absent statutory privilege, no cause of action for disclosure exists); *Hammer v. Polsky*, 36 Misc. 2d 482, 233 N.Y.S.2d 110, 112 (Sup. Ct. N.Y. Cty. 1962) (psychiatrist-defendant testified as to plaintiff's mental health on basis of observations made while treating plaintiff's wife; plaintiff's failure to assert existence of doctor-patient relationship held to defeat an action for malpractice, assuming without deciding that by statute such testimony was a breach of professional obligation of confidentiality); *Quarles v. Sutherland*, 215 Tenn. 651, 389 S.W.2d 249 (1965) (no cause of action may lie against company physician for disclosure of patient's records to company attorney because codes of ethics are not enforceable at law and no statutory privilege exists).

The argument has also been made that the patient's interest in confidentiality within a therapeutic relationship is not the creature of changeable statute, but is grounded in a constitutionally protected right of privacy. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (right to privacy in doctor-patient relationship precludes requiring parental or spousal consent to patient's abortion); *Roe v. Wade*, 410 U.S. 113 (1973) (constitutional right of privacy in the doctor-patient relationship recognized); *Doe v. Bolton*, 410 U.S. 179 (1973) (statute requiring approval of abortion by hospital staff abortion committee and by two licensed physicians other than the patient's physician; held, an unconstitutional infringement of right to private doctor-patient relationship); *Jones v. Superior Court*, 119 Cal. App. 3d 534, 174 Cal. Rptr. 148 (1981) (constitutional right to privacy in doctor-patient relationship not absolute but broader than statutory privilege establishing doctor-patient confidentiality); *In re "B,"* 394 A.2d 419 (Pa. 1978) (patient's interest in preventing disclosure by psychotherapist is constitutionally based, therefore therapist's conviction for refusal to comply with court order to reveal patient's records reversed). Cf. *Caesar v. Montanos*, 542 F.2d 1064 (9th Cir. 1976) (right to privacy in psychotherapist-patient relationship is not absolute; narrowly drawn patient-litigant exception to privilege rule is justified by compelling state interest in ascertainment of truth in court proceedings), *cert.*

disciplined by professional organizations.

The psychiatrist faced with deciding whether to reveal a patient's threat to a potential target is in an unenviable position. Frequently, such threats are directed toward family members or significant others,⁹⁷ and transmitting such a message could destroy or seriously disrupt a vital relationship. Merely revealing the fact of the patient's status *qua* psychiatric patient may in and of itself irreparably injure reputation, career, and other opportunities and interests. Should later judicial review determine that the therapist's apprehension was unreasonable or unjustified (according to the fairly nebulous "standard of the profession," of course) the therapist will suffer the civil and professional consequences. If the threat is *not* disclosed and *does* materialize, liability under a *Tarasoff* theory may attach. Had the California court consciously been trying to design a double bind, it could hardly have been more successful.

3. *The Exercise of Professional Judgment*

What seems most disturbing to the psychiatrists who oppose the *Tarasoff* doctrine, however, is not just their potential liability for wrong choices, but the infringement on their professional discretion to make such choices. In contrast, consider the statutes in a majority of the states which foster the preservation of confidentiality by creating a physician-patient privilege, limiting even judicial power to compel disclosure of treatment-related communications in the absence of the patient's consent.⁹⁸ Although the privilege is

denied, 430 U.S. 954 (1977); *In re Lifschutz*, 2 Cal. 3d 415, 467 P.2d 557, 8 Cal. Rptr. 829 (1970) (patient-litigant exception did not violate constitutional right to confidentiality in psychotherapy).

⁹⁷ See A.P.A. TASK FORCE ON CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL, *supra* note 80, at 7-9.

⁹⁸ See, e.g., N.Y. CIV. PRAC. LAW § 4504(a) (McKinney 1963 & Supp. 1979) ("Unless the patient waives the privilege, a person authorized to practice medicine . . . shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity."). The California privileges with respect to psychiatrist-patient and psychologist-patient relationships are somewhat more inclusive, and their exceptions more narrowly drawn than the rule with respect to the physician-patient relationship. See CAL. EVID. CODE §§ 1010-1028 (West 1966 & Supp. 1977). In California, privilege statutes explicitly apply not only to licensed psychol-

always circumscribed by provisions that allow its breach under certain conditions,⁹⁹ these only *permit* disclosure, without requiring it, and leave to the professional's informed and conscientious judgment when they should be invoked. Mandatory reporting of confidential information traditionally has been confined to situations of immediate and objectively perceptible peril—typically child abuse, venereal or other highly contagious diseases, gunshot wounds, and conditions such as epilepsy, which may affect a patient's ability to drive safely.

The *Tarasoff* court seemed to view disclosure of Poddar's threats in the same light. 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. A classic formulation of this point is found in the oft-cited case of *Taylor v. United States*:¹⁰⁰

Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him. . . . "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express: he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. . . . It would be too much to expect them to do if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to

ogists and clinical social workers, but also to school psychologists and to family and marital counselors. *Id.* at § 1010.

⁹⁹ See, e.g., CAL. EVID. CODE § 1024 (West 1966 & Supp. 1977) ("There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."). For additional cases illustrating circumstances in which the duty of confidentiality may be qualified, see note 95 *supra*.

¹⁰⁰ 222 F.2d 398 (D.C. Cir. 1955).

the whole world from a witness stand."¹⁰¹

The legislative history of a proposed psychotherapist-patient privilege statute in New York reflects a similar concern:

This blanket privilege is premised on the need to protect confidentiality if patients are to make the communications required in psychotherapy. By contrast, successful treatment of physical conditions seldom depends on the assurance of confidentiality, so a privilege is extended in such cases only to disclosures which would tend to embarrass, humiliate, or disgrace the patient.¹⁰²

B. *Compromised Confidentiality*

1. *Destruction of Trust*

Given the emphasis on complete candor as an essential element of effective psychotherapy, some writers have proposed that the assurances of confidentiality offered by a therapist at the commencement of treatment should be coupled with quasi-*Miranda* warnings as to their limits, so that the patient's consent to treatment will be fully informed.¹⁰³ Psychiatrists argue that as patients are so ad-

¹⁰¹ *Id.* at 401 (quoting M. GUTTMACHER & H. WEIHOFEN, *PSYCHIATRY AND THE LAW* 272 (1952)). Taylor had been found incompetent to stand trial and confined to the notorious St. Elizabeth's Hospital in Washington. When finally returned to stand trial, he raised an insanity plea. The prosecution called a hospital staff psychiatrist who testified that Taylor had told him he was malingering. Based on this breach of a statutory privilege and numerous other errors, the conviction was reversed.

¹⁰² PROPOSED CODE OF EVIDENCE FOR THE STATE OF NEW YORK § 504 comment, at 78-79 (West 1982). See also PROPOSED FED. R. EVID. 504, 56 F.R.D. 240, 242 advisory committee note (1972) ("Among physicians, the psychiatrists had a special need to maintain confidentiality Therapeutic effectiveness necessitates going beyond a patient's awareness and in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.") (quoting GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 45 at 92 (1960)). This rule was not enacted, and to date there is no independent federal physician-patient or psychotherapist-patient privilege. For a thorough discussion of the physician-patient privilege in federal practice, see LARKIN, *FEDERAL TESTIMONIAL PRIVILEGES* §§ 3.01-3.04 (1982).

¹⁰³ See Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025, 1056-60 (1974); Sadoff, *Informed Consent, Confidentiality and Privilege in Psychiatry: Practical Applications*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 101, 105 (1974). One commentator has expressed surprise at the prevalence of the uncritical assumption that the therapist must inform the patient that a breach of confidentiality might be

vised, and as the general public becomes aware of these limits, those perhaps most in need of counselling and restraint will be deterred from seeking treatment *ab initio*. People who do enter treatment may be reluctant to place complete confidence in their therapists,¹⁰⁴ and such reluctance could aggravate the repression that is at the heart of their troubles.¹⁰⁵ Successful psychotherapy is said to depend on the patient's ability to communicate without reservation, which in turn requires a totally trusting relationship.

One of the major objectives of a therapeutic program is helping the patient learn how to discharge violent impulses and to develop socially acceptable behavior instead of acting out. To do this, the patient first must be able to allow the violent impulses into his or

necessary. See Dix, *Tarasoff and the Duty to Warn Potential Victims*, in *LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY* 118 (C.K. Hofling ed. 1981).

¹⁰⁴ One study of uncertain validity was cited by Justice Clark, author of the *Tarasoff* dissent, to the effect that most people would be less open with a psychiatrist in the absence of a guarantee of confidentiality. See Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 *YALE L.J.* 1226, 1255 (1962). See also Note, *Imposing a Duty to Warn On Psychiatrists: A Judicial Threat to the Psychiatric Profession*, 48 *U. COLO. L. REV.* 283, 293, 308-09 (1977) (extension of *Tarasoff* doctrine will inhibit potential patients); California Senate Committee on Judicial Commentary on *CAL. EVID. CODE* § 1014 (Law Revision Commission has received "several reliable reports that persons in need of treatment sometimes refuse such treatment from psychiatrists because the confidentiality of their communications cannot be assured") quoted in *Grosslight v. Superior Court*, 72 *Cal. App. 3d* 502, 508, 140 *Cal. Rptr.* 278, 281 (1977). For further discussion of *Grosslight*, see note 113 *infra*.

One interesting recent study surveyed a random population sample, including both regular patients and nonpatients of internists, in an effort to determine the role played by knowledge and attitudes about confidentiality in utilization of health-care services. The questionnaire responses indicated that a sizable minority of those who rarely visit a doctor claim to have been deterred from doing so in part by fear that confidential information would be divulged. About half of those who were regular patients reported significant concern about possible breaches of confidentiality, and roughly 10% of both groups stated that they had evidence of prior breaches of confidentiality by internists. As the researchers themselves caution, this data is based on stated attitudes, not observed behavior, and major discrepancies between the two are likely. See Lindenthal & Thomas, *Consumers, Clinicians and Confidentiality*, 16 *Soc. Sci. Med.* 333 (1982). Compelling empirical data supporting the utilitarian justification for confidentiality and privacy in professional relationships have yet to be assembled.

¹⁰⁵ "Every person, however well-motivated, has to overcome resistances to therapeutic exploration. These resistances seek support from every possible source and the possibility of disclosure would easily be employed in the service of resistance." Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 *CONN. B.J.* 175, 179 (1962).

her own consciousness and then be able to reveal them to the therapist.¹⁰⁶ The "duty to warn" could render this objective much more difficult to achieve. We must not underestimate the potential effect on the psychiatric patient of disclosing a threat: the patient's willingness to make the threat in the therapist's presence may presage or follow a critical breakthrough of suppressed anger. The therapist's warning to a third party, if discovered by the patient, may even trigger the feared violence as the patient "lives up to" the therapist's expectations.¹⁰⁷ Or the intended victim, hyperagitated by the warning, might preemptively strike or protectively overreact to the patient, precipitating needless tragedy.¹⁰⁸ At the very least the therapist's disclosure will seriously undermine the entire therapeutic relationship, perhaps precluding the establishment of any other relationship of trust:

Confidentiality of communications . . . sets the stage for an exchange of thought, word and action at the emotional level. Without trust there can be no proper transference. In fact, the essence of much psychotherapy is the learning of trust in the external world by the formation of a trusting relationship with the therapist. This becomes the model for trust in the external world and ultimately in the self.¹⁰⁹

2. *Concern about Group Therapy*

After the *Tarasoff* decision, psychiatrists seem to have become acutely sensitive to questions of confidentiality, speculating about even such an esoteric issue as the applicability of the *Tarasoff* rule in the context of group therapy.¹¹⁰ Ordinarily, if anyone other than

¹⁰⁶ See Stone, *supra* note 56, at 369.

¹⁰⁷ See Brief of *Amicus Curiae* at 40, *Schneider v. Vine St. Clinic*, No. 15344, Ill. App. (4th Dist. 1979). See also *Schneider v. Vine St. Clinic*, 77 Ill. App. 3d 946, 397 N.E.2d 194 (1979) (appeal of dismissal of complaint dismissed for failure to file timely notice of appeal; no reference to merits of case by appellate court).

¹⁰⁸ See Griffith & Griffith, *Duty to Third Parties, Dangerousness and the Right to Refuse Treatment: Problematic Concepts for Psychiatrist and Lawyer*, 14 CAL. W.L. REV. 241, 254 (1978).

¹⁰⁹ D. DAWIDOFF, *THE MALPRACTICE OF PSYCHIATRISTS* 44 (1973). See also R. SLOVENKO & G. USDIN, *supra* note 6, at 41 (1966).

¹¹⁰ See S. HALLECK, *supra* note 8, at 190. While it is unclear how well *Tarasoff* is known, or what is thought about it in the psychiatric community—see discussion in text accompanying notes 118-29 *infra*—there are some indications that it has had significant

therapist and patient is privy to a communication, its secrecy is no longer protected by law; the evidentiary privilege is destroyed. Furthermore, because the therapist-patient or physician-patient privilege is a creature of statute in derogation of the common law, it usually is strictly construed.¹¹¹ But most courts and some statutes include within the ambit of privilege those third parties who are necessary to accomplish the purpose of the treatment: nurses and interpreters, for example.¹¹² So it is not clear how the law will define the bounds of confidentiality if the claim is made that the others present—i.e., therapy group members—are intrinsic to the treatment process, in some sense members of the treatment team. No case directly deciding the issue has yet been reported. Still, some courts that have been asked to extend the privilege to members of a patient's immediate family have done so,¹¹³ and the rule of reason suggests that the privilege ought to be upheld. Confidentiality is just as essential to the therapeutic function in the group setting as it is in the traditional dyad.¹¹⁴

impact. See Nugent, *Murder Mystery by Psychiatrist Deals With Controversial Confidentiality Issue*, CLINICAL PSYCHIATRY NEWS, Mar. 1982, at 3-22 ("Because of the *Tarasoff* case . . . the issue of confidentiality is both timely and controversial . . . the *Tarasoff* case has changed the way psychiatry is practiced.")

¹¹¹ See, e.g., 8 WIGMORE, EVIDENCE § 2291 (McNaughton rev. 1961) (citing *Foster v. Hall*, 29 Mass. (12 Pick.) 89, 97 (1831) ("the rule of privilege, having a tendency to prevent the full disclosure of the truth, ought to be construed strictly"). But see *Roberts v. Superior Court*, 9 Cal. 3d 330, 337, 508 P.2d 309, 313, 107 Cal. Rptr. 309, 313 (1973) (psychotherapist-patient privilege to be liberally construed in favor of patient because of constitutional overtones), and cases cited in note 96 *supra*.

¹¹² See, e.g., UNIF. R. EVID. Rule 27 (1953); CAL. EVID. CODE § 1012 (West 1966 & Supp. 1977).

¹¹³ See *Grosslight v. Superior Court*, 72 Cal. App. 3d 502, 140 Cal. Rptr. 278 (1977) (tort action against minor and against her parents for failure to control her; vacating order permitting *in camera* examination of psychiatric records, including communications of parents with hospital; held, privilege includes all relevant communications of intimate family members); *Yaron v. Yaron*, 83 Misc. 2d 276, 372 N.Y.S.2d 518 (Sup. Ct. 1975) (excluding from custody proceeding as privileged testimony and records of psychiatrist, social worker, and counselor jointly consulted by husband and wife); *Ellis v. Ellis*, 63 Tenn. App. 361, 472 S.W.2d 741 (1971) (privilege attaches to communications of patient's intimate family member to psychiatrist). But see *In re Humphrey*, 79 Misc. 2d 192, 359 N.Y.S.2d 733 (Fam. Ct. 1974) (admissions to social worker during joint consultation not privileged); *Herrington, Privilege Denied in Joint Therapy*, PSYCHIATRIC NEWS, May 4, 1979, at 1, col. 1. (in divorce proceedings, Virginia judge held unprivileged the disclosures of spouses in joint therapy with psychiatrist) (case name, court, and citation not given).

¹¹⁴ For group therapy patients,

Could the therapeutic character of the group, the very quality that may compel recognition of its confidentiality, also impose on its members a *Tarasoff* obligation to disclose threats of violence? The short answer is that it should not. Group members neither assert nor are accorded the power to predict one another's future behavior. Nor can they utilize such predictions to instigate another member's institutional confinement. That remains the province of licensed professionals.

3. *Changes in Therapeutic Approach*

Tarasoff may have aggravated the tendency of some psychiatrists to resort more quickly to commitment of patients, not just because they fear liability for failure to bring about preventive detention, but because they see commitment as a less destructive alternative, preferable to violating the covenant of confidentiality.¹¹⁵

To these psychiatrists, revealing a patient's threat to its target, someone who may be a central figure in the patient's affective life, seems far more treacherous than an emergency hospitalization. Some patients might agree. One psychiatric clinic claims to have experimented successfully with the approach of explaining the therapist's dilemma and enlisting the patient's aid.¹¹⁶ The patient is asked either to enter a secure facility voluntarily—once an inpa-

treatment is inexorably linked to completely frank self-disclosure in an environment that accepts their confidences without qualification and holds them inviolate to outsiders. It would seem that a mutual trust is inherent in the sort of multilateral soul-baring that occurs in group sessions. . . . If this trust cannot be established, many patients will discontinue therapy and others will be unable to make worthwhile contributions to the group.

Cross, *Privileged Communications Between Participants in Group Psychotherapy*, reprinted in *MEDICINE, LAW AND PUBLIC POLICY* 371, 376 (N. Kittrie, H. Hirsh, & G. Wegner eds. 1975). See also Slovenko, *Group Psychotherapy: Privileged Communication and Confidentiality*, 5 J. PSYCHIATRY & L. 405 (1977); Note, *Group Therapy and Privileged Communications*, 43 IND. L. J. 93 (1967). A psychologist reports one case in which a member of a therapy group disclosed statements of another member and the former brought suit for breach of confidentiality against the group psychologist. The case was dropped in exchange for the psychologist's forgiving his bill. See R.J. COHEN, *MALPRACTICE: A GUIDE FOR MENTAL HEALTH PROFESSIONALS* 147 (1979). (Case #5.71—case name, court, and citation withheld).

¹¹⁵ See, e.g., Stone, *supra* note 56, at 374-75.

¹¹⁶ See Roth & Meisel, *Dangerousness, Confidentiality and the Duty to Warn*, 13 AM. J. PSYCHIATRY 508, 509 (1977).

tient, his or her status can more easily be converted from voluntary to involuntary if necessary—or to give the therapist permission to contact the victim. The voluntariness of the “consent” in these circumstances is open to question, but at least the therapist is acknowledging and appealing to that part of the patient’s personality which is responsible and still capable of choice. And the honest admission of the therapist’s conflict and need is a refreshing note, one that might even enhance rather than detract from the harmony of the therapeutic relationship.

David Wexler, the mental health law specialist, has pointed out that *Tarasoff* could have a profoundly salutary effect if it leads therapists to heed the insights of victimology.¹¹⁷ A now well established subdiscipline of interactionist psychology, victimology holds that conflict analysis must include the factor of the victim—not necessarily as an *agent provocateur*, but as a contributor to the tension that ignites into violence. *Tarasoff* will perhaps induce therapists to expand their frame of reference and to try to involve in treatment the most likely objects of their primary patient’s homicidal impulses. Such involvement improves the chances of accomplishing substantial change in the patient’s life. *Tarasoff*-conscious therapy, Wexler suggests, may turn out to be more efficacious therapy.

It is fair to ask, however, how relevant the “patient-consent” and “victim-involvement” responses to the *Tarasoff* ruling are to the onerous task of treating patients who have been accused or convicted of criminal violence—a large subpopulation, one would guess, of the universe of potentially “dangerous” patients. Critics of the decision contend that therapists will become more hesitant than they already are to undertake the treatment of such patients. Particularly with respect to them, the profession’s newly conceded bias toward the overprediction of violence can only have been reinforced by *Tarasoff*.

¹¹⁷ See Wexler, *The Tarasoff Case and the Controversy over Its Therapeutic Implications*, in MENTAL HEALTH LAW: MAJOR ISSUES 157, 174-76 (1981).

C. *The Effects of Tarasoff on Role Conflict*

Psychiatrists believe that their professional territory has been invaded by a legal system ill-equipped to oversee the delicate calculation of risk and benefit, both individual and social, involved in deciding whether to violate a patient's trust. The California Supreme Court concluded that despite "professional inaccuracy in predicting violence" and "the risk of unnecessary warnings," "the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy" was outweighed by "the public interest in safety from violent assault." "The protective privilege ends where the public peril begins."¹¹⁸ But will the deleterious impact of *Tarasoff* on the practice of psychotherapy promote more violence and greater suffering than it will prevent? The court dismissed the claim that its ruling would result in a net increase in "public peril" as "dubious" and "speculative."¹¹⁹ At the time of the *Tarasoff* decision, neither the psychotherapist *amici* nor the court cited any convincing empirical evidence concerning the degree of harm that a duty to breach confidentiality might entail for private, and, indirectly, public, health and safety.

1. *An Empirical Study*

In the six years since, only one study of the actual effect of *Tarasoff* on the attitudes and practices of the California psychotherapists who have been living with it has been published.¹²⁰ (Another survey of over a thousand therapists is reportedly in progress.¹²¹) Although the results cannot be accepted as definitive, since they are based on the return of mailed questionnaires from only a third of a random sample of state licensed psychologists and members of the California Psychiatric Association,¹²² they do indicate that some change of uncertain magnitude has occurred. Of

¹¹⁸ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 442, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (1976).

¹¹⁹ *Id.* at 440 n.12, 551 P.2d at 346 n.12, 131 Cal. Rptr. at 25 n.12.

¹²⁰ See Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165 (1978).

¹²¹ See Appelbaum, *Tarasoff: An Update on the Duty to Warn*, 32 HOSP. & COMMUNITY PSYCHIATRY 14 (1981).

¹²² See Note, *supra* note 120, at 173-74.

this self-selected and therefore dubiously representative subset of therapists, all but an insignificant number had heard of the *Tarasoff* case, and almost nine in ten reported having discussed the case with other members of their profession.¹²³ One quarter of them claimed to have noticed increased reluctance to talk about violence among those patients who had been advised of this potential exception to the rule of confidentiality.¹²⁴ An equal proportion reported "losing" a patient who feared the possibility of such a breach.¹²⁵ While a small percentage stated that they now feel tempted to avoid probing into areas related to the subject of violence altogether, many others are spending more clinical time and attention than before on exploring propensities for violence in their patients.¹²⁶

Deficient as its methodology is, the survey nevertheless suggests that California therapists have revised the criteria by which they evaluate the seriousness of voiced threats, and that they tend to give such threats more credence. A substantial number of respondents claim to feel greater anxiety when material related to violence surfaces in the course of treatment, and a similar number feel increased concern about becoming objects of lawsuits because of their uncertainty about the parameters of the duty to warn.¹²⁷ Almost a fifth of those who responded to the questionnaire believe that the *Tarasoff* ruling applies to threats of suicide.¹²⁸ They are apparently unaware that the one California appellate court confronted with that issue to date declined to so extend the rule.¹²⁹

¹²³ *Id.* at 177 nn.68-69.

¹²⁴ *Id.* at 177.

¹²⁵ *Id.* at 177 n.67.

¹²⁶ *Id.* at 181, 182 n.87.

¹²⁷ *Id.* at 181.

¹²⁸ *Id.* at 178.

¹²⁹ See *Bellah v. Greenson*, 73 Cal. App. 3d 892, 141 Cal. Rptr. 92 (1977), modified on rehearing, 81 Cal. App. 3d 614, 620-21, 146 Cal. Rptr. 535, 539-40 (1978). Their confusion may in part be attributable to the publicity generated when a suit was filed on behalf of the family of comedian Freddie Prinze, who committed suicide after his psychiatrist returned to him a gun and tranquilizers. See Kirsch & Kasindorf, *Is Suicide Ever the Doctor's Fault?* NEW WEST, Nov. 21, 1977, at 15. Another determination limiting the scope of *Tarasoff* duty was made by the Supreme Court of Iowa in *Coles v. Taylor*, 301 N.W.2d 766 (Iowa 1981). Presented with the claim of a patient against her psychiatrist for negligently failing to prevent her from murdering her husband, the court wasted little time in rejecting the claim.

2. *Advising a Therapist*

Of particular interest are the data suggesting an increase in the practice of consulting an attorney when faced with a *Tarasoff* problem. A lawyer may feel no little anxiety about advising a therapist-client on the appropriate course of action in such a case.¹³⁰ Should the lawyer assume that the California precedent will be found persuasive by the courts of his or her own state? If so, what particular variation on the theme might they adopt? How certain is the therapist-client that the patient will act to effectuate the threat, and how is the lawyer supposed to judge the validity of that opinion? What if there has been no express threat, but the therapist nevertheless has an uneasy sense that the patient's anger is ready to erupt into violence?

The *Tarasoff* double bind would become a paralyzing reality for the lawyer. If disclosure or preventive detention is recommended, the client's patient conceivably could join the lawyer as codefendant with the therapist in a suit for breach of confidentiality and fiduciary duty, or perhaps even for false imprisonment. At least one suit against a therapist has already been brought by a disgruntled patient whose confidentiality had been violated.¹³¹ If the lawyer counsels instead that the therapist maintain confidentiality

"We have not adopted the rationale in *Tarasoff*. If we were to do so it would not control the question here." *Id.* at 768. The court held that the *Tarasoff* duty runs only to intended third-party victims, not to the patient.

¹³⁰ That this imagined reaction is not utterly idiosyncratic was corroborated by a talk with one California lawyer who has been consulted twice in three years by a therapist with a *Tarasoff* problem. Interview with Deborah Sanders, Esq. (Nov. 3, 1981). In both instances, the lawyer found it difficult to judge the substantiality of the risk, since the patients apparently expressed ambivalence and qualified their destructive urges even as they revealed them. In each case, the therapist had already tried to have the patient admitted voluntarily to an institution without success, due to a local shortage of beds. The commitment attempts compounded the problem, since they could subsequently have been seized upon as proof that the therapist considered the patient to be extremely dangerous, although the attorney was well aware that simple decompensation and loss of ego control are also indications for hospitalization. Both episodes eventually were resolved without injury to anyone, but the lawyer found them disquieting.

¹³¹ See Appelbaum, *supra* note 121, at 15; Simmons, *Issues Raised by Tarasoff Case Confusing to Psychiatrists, Courts*, CLINICAL PSYCHIATRY NEWS, Oct. 1981, at 1. See also *Shaw v. Glickman*, 45 Md. App. 718, 415 A.2d 625 (1980) discussed in text accompanying notes 165-70 *infra*; Note, *Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061 (1976); cases cited in note 96 *supra*.

and the threat subsequently materializes, the patient's victim or his or her survivors could file suit. While as a general rule third-party nonclients cannot sue a lawyer for malpractice, in certain circumstances such actions have been successfully prosecuted.¹³²

There is definitely a trend in some jurisdictions to hold attorneys responsible to third parties who suffer from their negligence, taking into account the extent to which the transactions involved were intended to protect or benefit those harmed and the foreseeability of that harm.¹³³ California is one of the more liberal states in this regard; New York has been more resistant to the trend, so far.¹³⁴ Attorneys in several states have been held liable to people

¹³² The leading Supreme Court case on the subject, *National Savings Bank v. Ward*, 100 U.S. 195 (1879), requires a direct fiduciary relationship between the injured party and the lawyer sought to be held liable for negligence, except in cases of fraud and collusion, a breach of duty to the general public, or "imminently dangerous" situations. A *Tarasoff* situation might well be considered "imminently dangerous."

¹³³ See Probert & Hendricks, *Lawyer Malpractice: Duty Relationships Beyond Contract*, 55 NOTRE DAME LAW. 708 (1980); Note, *Attorneys' Negligence and Third Parties*, 57 N.Y.U.L. REV. 126 (1982) (attorneys should be held to standard of due care with regard to third parties foreseeably injured by their negligence); Note, *Attorneys' Liability to Third Parties for Malpractice: The Growing Acceptance of Liability in the Absence of Privity*, 21 WASHBURN L.J. 48 (1981) (trend toward rejection of privity requirement, allowing third parties to recover on both tort and contract theories). For a state-by-state summary of authorities, see R. MALLEN & V. LEVIT, *LEGAL MALPRACTICE* §§ 57-59 (1977).

¹³⁴ See *Lucas v. Hamm*, 56 Cal. 2d 583, 364 P.2d 685, 15 Cal. Rptr. 821 (1961) (attorney could be held liable to would-be beneficiary of testator in absence of privity; *but*, not negligence to fail to draft will in accord with Rule Against Perpetuities), *cert. denied*, 368 U.S. 987 (1962); *Biakanja v. Irving*, 49 Cal. 2d 647, 320 P.2d 16 (1958) (public policy balancing test of foreseeability should replace privity as limit of duty); *Donald v. Garry*, 19 Cal. App. 3d 769, 97 Cal. Rptr. 191 (1971) (third-party creditor could sue lawyer for negligence in pursuit of collection agency claim). *Cf.* *Victor v. Goldman*, 74 Misc. 2d 685, 344 N.Y.S.2d 672 (Sup. Ct. 1973), *aff'd*, 43 A.D.2d 1021, 351 N.Y.S.2d 956 (App. Div. 1974) (absent privity of contract, no liability to putative beneficiary for failure to prepare new will); *Maneri v. Aurodeo*, 38 Misc. 2d 190, 238 N.Y.S.2d 302 (Sup. Ct. 1963) (attorney not liable to third party unless fraud, collusion, or malicious or tortious act other than simple negligence). See also *Drago v. Buonagurio*, 46 N.Y.2d 778, 386 N.E.2d 821, 413 N.Y.S.2d 910 (1978), *reinstating*, 89 Misc. 2d 171, 391 N.Y.S.2d 61 (Sup. Ct. 1977) (physician countersuit against attorney for bringing "frivolous" malpractice action; held, attorney not liable to third parties for negligent performance of obligation to client even if negligence results in damage to third parties). *But see* *Baer v. Broder*, 106 Misc. 2d 929, 935-36, 436 N.Y.S.2d 693, 696-97 (Sup. Ct. 1981) (court permitted executrix who had brought wrongful death action to sue, in her individual capacity, attorney for negligence, and noted that it was "time to embrace the California rule . . . the citadel of privity is not invulnerable to the assault made upon it in this case"), *aff'd on other grounds*, 447 N.Y.S.2d 538 (App. Div. 1982); *Singer v. Whitman &*

who sustained financial losses from faultily drafted wills, even though it was the testator-client, not the potential beneficiary, who had relied on and paid for the attorney's professional judgment.¹³⁵ Dictum in a leading California case implies that if an attorney improperly advises a client concerning the discharge of an obligation to one with whom the client has an ongoing fiduciary relationship, that attorney may be sued by either party.¹³⁶ A *Tarasoff* case could logically be encompassed in that category. The therapist-client obviously has a fiduciary relationship with the patient and, following *Tarasoff*, may be considered to owe a special duty to the potential victim of a patient. Advice to the therapist surely could be construed as intended to protect and benefit both the patient and the putative victim, as well as the therapist.

In theory a lawyer can no more be penalized for an honest mistake of judgment within the bounds of the "standard of the profession" than can a therapist for a similarly wrong but reasonable choice. In reality the prospect of an accusation of professional misconduct or incompetence evokes nearly as much fear as an actual

Ransom, 83 A.D.2d 862, 442 N.Y.S.2d 26 (App. Div. 1981) (holding that a New York law firm owed a duty of care to a nonclient shareholder in a corporation which had retained the firm); Estate of Douglas, 104 Misc. 2d 430, 428 N.Y.S.2d 558 (Surr. Ct. 1980) (although New York cases continue to require privity, contrary trend may be emerging; applying balancing test, attorney not liable to trustee and beneficiary with whom not in privity).

¹³⁵ See, e.g., *Licata v. Spector*, 26 Conn. Supp. 378, 225 A.2d 28 (Conn. C.P. '1966); *McAbee v. Edwards*, 340 So. 2d 1167 (Fla. Dist. Ct. App. 1976); *Shideler v. Dwyer*, 386 N.E. 2d 1211 (Ind. App. 1979); *Succession of Killingsworth*, 292 So. 2d 536 (La. 1974); *Guy v. Liederbach*, 280 Pa. Super. 134, 421 A.2d 333 (1980).

¹³⁶ *Goodman v. Kennedy*, 18 Cal. 3d 335, 556 P.2d 737, 134 Cal. Rptr. 375 (1976) (holding purchasers of securities from corporate officers who had been incorrectly advised by their attorney that the stocks could be sold without affecting their tax exemption could not sue attorney, since plaintiffs were not intended to benefit from attorney's advice to client and advice was not given to enable corporate officers to discharge obligation to plaintiffs). See also *Roberts v. Ball, Hunt, Hart, Brown & Baerwitz*, 57 Cal. App. 3d 104, 111, 128 Cal. Rptr. 901, 906 (1976) (issuance of opinion letter to client, knowing it would be shown to creditors to induce loan, held negligent because "a legal opinion intended to secure a benefit for the client, either monetary or otherwise, must be issued with due care, or the attorneys who do not act carefully will have breached a duty owed to those they attempted or expected to influence on behalf of the client") (emphasis added). Cf. *Prescott v. Coppage*, 266 Md. 562, 296 A.2d 150 (1972) (attorney liable to preferred creditor for loss suffered from incorrect distribution of assets by attorney's client, receiver of debtor); *United Leasing Corp. v. Miller*, 45 N.C. App. 400, 263 S.E.2d 313 (1980) (holding lessor could sue lawyer for failure to discover lien on property used by clients as collateral for lease).

imposition of liability. The time and energy consumed by involvement in litigation; the pressure often exerted by a malpractice insurer to settle quickly, regardless of fault, in order to avoid an expensive trial defense; the publicity attendant on the institution of the suit, whatever the outcome—all combine to eliminate the solace of any ultimate vindication.¹³⁷ Considering the risk of misjudgment and the complexity of the law in this area, lawyers might be wise to take refuge in asserting sheer lack of ability to give proper advice—acknowledging the limits of their expertise, as it were—and to simply refuse to discuss a *Tarasoff* problem with any therapist who tries to consult them.¹³⁸ More timid souls can only salute the intrepid attorneys who have contracted with the American Psychiatric Association to offer a prepaid legal consultation program to its members, who now can call a toll-free phone number for unlimited advice on “all aspects of . . . practice” including “confidentiality.”¹³⁹ No doubt everyone is well-insured.

V. THE EVOLUTION OF THE *Tarasoff* Doctrine

A. *Two Subsequent Cases*

1. *No Explicit Threat Admitted*

The professional insecurity generated by the *Tarasoff* decision clearly will not be restricted to California psychotherapists and their lawyers. The first of what may be called *Tarasoff's* progeny arrived on June 12, 1979, in the form of *McIntosh v. Milano*,¹⁴⁰ a New Jersey lower court decision still on appeal. Though the facts of *McIntosh* bear startling similarity to those of *Tarasoff*, there are

¹³⁷ While in a certain karmic sense lawyers have less standing than other professionals to complain of the distress entailed in defending a malpractice action, our suffering may be all the more acute because of our familiarity with the process. The ability to foresee from the outset just how protracted, inconvenient, and unpleasant an experience will be is at best a mixed blessing.

¹³⁸ The only other option would seem to be giving conditional advice, coupled with an agreement that the therapist will indemnify the lawyer should the advice prove faulty. This approach might well be considered an unethical attempt to limit liability for malpractice, which is prohibited with regard to clients. See ABA CODE, *supra* note 24, DR 6-102 (“A lawyer shall not attempt to exonerate himself from or limit his liability to his client for his personal malpractice.”).

¹³⁹ *APA Prepaid Legal Consultation Program*, PSYCHIATRIC NEWS, Dec. 18, 1981, at 15.

¹⁴⁰ 168 N.J. Super. 466, 403 A.2d 500 (1979).

significant differences. The patient, Lee Morgenstein, was a seventeen-year-old boy who had been in therapy for two years for problems associated with drug abuse and adolescent adjustment reaction. Just prior to beginning therapy, Morgenstein apparently had been sexually involved with a young woman, Kimberly McIntosh, who lived next door. The affair, such as it was, had ended, but the boy continued to suffer from feelings of possessiveness, jealousy, and hatred for the men who had replaced him in Kimberly's affections. Morgenstein confided to his psychiatrist, Dr. Milano, certain "fantasies of magical power and violence,"¹⁴¹ but never made a direct threat against his eventual victim. However, he had engaged in some fairly aggressive behavior, including firing a BB gun at her car, and had once shown the doctor a knife that he had bought "to scare people away."¹⁴²

On the critical day, Morgenstein tried to obtain seconal¹⁴³ with a stolen prescription blank. When a suspicious pharmacist contacted the psychiatrist, Dr. Milano instructed him to let the boy go home, where the doctor tried, but failed, to reach him. By mischance, Kimberly, who had moved away from her parents' house, returned to visit them that very evening. Morgenstein convinced her to go for a walk to a nearby park. There he shot her.

The McIntoshes sued Dr. Milano on a *Tarasoff* theory, claiming that he had been negligent in not warning them of the danger Morgenstein posed to their daughter. The trial court found the facts of their complaint sufficient to defeat the psychiatrist's motion for summary judgment, holding that a therapist (not necessarily a psychiatrist) may be required to take steps to protect a potential victim from a "dangerous" patient. Comparing this duty to that of a physician who discovers that a patient is contagious, the court suggested that its ruling was based as much on the general responsibility of the medical profession to community welfare as

¹⁴¹ *Id.* at 476, 403 A.2d at 505.

¹⁴² *Id.* at 473, 403 A.2d at 503.

¹⁴³ Seconal is a brand of barbiturate which depresses the central nervous system and is used as a sedative, sometimes for chronic insomnia. It is habit-forming and interacts dangerously with other central nervous system depressants like alcohol. The manufacturers caution against prescribing it in quantity for patients who have a history of emotional disturbance, suicidal ideation, or substance abuse. PHYSICIANS' DESK REFERENCE 1092-93 (35th ed. 1981).

on any "special relationship" of therapist and patient.¹⁴⁴

In some ways, this result seems more palatable than that of *Tarasoff*. Dr. Milano had been treating the boy for two years and knew of at least one overt act of aggression that Morgenstein had directed against his victim. But in terms of foreseeability—the keynote of the *Tarasoff* decision—how could anyone have anticipated Kimberly's coincidental return home? Is there any reason that Dr. Milano should have concluded from the boy's behavior that day that he was likely to erupt into violence, particularly in the absence of an explicit threat? Dr. Milano, unlike Poddar's therapist, had made no effort to have his patient committed. Does that bespeak negligence, or does it indicate rather that the psychiatrist did not believe the boy to be dangerous?

2. *Discovering the Basis for a Tarasoff Suit*

Dr. Milano's crucial mistake may have been less in his therapeutic judgment and more in his subsequent attempts to help his patient.¹⁴⁵ At Morgenstein's criminal trial, Dr. Milano testified in the boy's defense.¹⁴⁶ During that testimony, he admitted that when a patient did seem dangerous, it was his practice to "look into it" and sometimes to contact a third party close to the patient.¹⁴⁷ In the civil suit, plaintiff used this testimony to good effect, and the court characterized it as an implicit concession of a *Tarasoff* duty.¹⁴⁸ In fact, as the court noted, the civil suit was "based in large part" on Milano's testimony in Morgenstein's trial.¹⁴⁹

Were it not for that testimony, one may wonder whether the

¹⁴⁴ *McIntosh v. Milano*, 168 N.J. Super. 466, 489-90, 403 A.2d 500, 511-12 (1979).

¹⁴⁵ Undoubtedly, another critical error was the state of some of the doctor's reports, which contained detectable deletions and additions tending to minimize the patient's desire for revenge and intention to retaliate against his ex-girlfriend. *Id.* at 475 n.6, 403 A.2d at 504 n.6.

¹⁴⁶ *Id.* at 471, 403 A.2d at 502. Morgenstein was convicted of first-degree murder, and was sentenced to life imprisonment, but the conviction was reversed on appeal due to improper and prejudicial statements by the prosecutor during the trial. At the time of the *McIntosh* decision, the Morgenstein case still had not been finally resolved. *Id.* at 470 n.1, 403 A.2d at 502 n.1.

¹⁴⁷ *Id.* at 489, 403 A.2d at 511.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 476, 403 A.2d at 505.

McIntoshes would ever have had a clue that their daughter's killer had expressed fantasies of violence to his doctor. It strains credulity to believe that a therapist would volunteer such information to a potential plaintiff who had been injured by a patient. In those states in which it is privileged, this information would be essentially undiscoverable, unless the patient waived the privilege with respect to communications during treatment—presumably a rare occurrence when such communications include an explicit and subsequently consummated threat. In most states which recognize a therapist-patient privilege, it can be waived either explicitly, by the patient's consent or calling the therapist as a witness, or implicitly, by the patient's placing his or her state of mind in issue (for example, by raising an insanity defense at a criminal trial). Once waived for any reason, the privilege no longer obtains.¹⁵⁰ Unless it has been waived, however, the therapist is not merely entitled but legally bound to assert the privilege if a potential plaintiff tries to depose or interview the therapist.¹⁵¹

One intermediate appellate court in California has ruled on a request to produce psychiatric records in the absence of patient con-

¹⁵⁰ See, e.g., *People v. Garaux*, 34 Cal. App. 3d 611, 110 Cal. Rptr. 119 (1973) (psychotherapist-patient privilege waived in second case by patient's having called therapist to testify in first case); *UNIF. R. EVID.* 27(7) (1953); 8 J.H. WIGMORE, *EVIDENCE* §§ 2389-2390 (McNaughton rev. 1961).

¹⁵¹ Even when the privilege has been implicitly waived, a doctor is not supposed to disclose patient confidences without the patient's express authority. See *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793, 805 (N.D. Ohio 1965) (mere waiver of privilege does not release a doctor from duty of loyalty to patient; should not permit unsupervised conversation with adversary); *Wenninger v. Muesing*, 307 Minn. 405, 240 N.W.2d 333 (1976) (public policy precludes private interview of opponent's physician); *Anker v. Brodnitz*, 98 Misc. 2d 148, 413 N.Y.S.2d 582 (recognizing causes of action against both a doctor who discloses patient confidences and an insurer who, in the course of investigating a lawsuit, induces the doctor to do so), *aff'd*, 73 A.D.2d 589, 422 N.Y.S.2d 887 (Sup. Ct. 1979); *Alexander v. Knight*, 197 Pa. Super. 79, 177 A.2d 142, 146 (1962) ("members of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients. They owe their patients more than just medical care for which payment is exacted; there is a duty of total care; that includes and comprehends a duty to aid the patient in litigation, to render reports when necessary and to attend court when needed. That further includes a duty to refuse affirmative assistance to the patient's antagonist in litigation. The doctor, of course, owes a duty to conscience to speak the truth; he need, however, speak only at the proper time"). See also Committee on Professional Ethics of Bar Ass'n of Nassau County, New York, Op. No. 82-2, reprinted in *N.Y.L.J.*, Feb. 5, 1982, at 26 (attorney may not privately interview adverse party's physician without party's express consent).

sent or waiver. In *Mavroudis v. Superior Court*,¹⁵² the petitioners sought the records in order to ascertain whether there were grounds to sue the therapist under a *Tarasoff* theory. The court struggled to find some way to bring the requested material within the definition of California Evidence Code § 1024,¹⁵³ although, as the court admitted, a literal reading seems to limit that provision to permitting disclosure when necessary to *prevent* prospective harm, not in a court proceeding long after the threatened danger has been realized. The court devised a somewhat contorted procedure to govern both the instant request and future ones. First, a judge would review the psychiatric records *in camera* to determine if the plaintiffs had been "readily identifiable as victims."¹⁵⁴ Only if that threshold of relevance were reached would the same judge then decide whether the patient had "posed a serious danger of violence . . . and [whether] disclosure of confidential communications [had been] necessary to prevent that threatened danger."¹⁵⁵ Although this decision is to be made in accordance with "the standard of the profession," *Mavroudis* suggests that in some cases a judge could resolve the issue without the benefit of expert assistance. When a court perceives the need for such assistance, however, it should appoint an independent expert instead of relying on one retained by a party to the action.¹⁵⁶

The *in camera* procedure does not differ greatly from the standard method of resolving privilege claims. But because of the unique characteristics of a *Tarasoff* claim, the procedure could present a distinctive problem in such cases. Finding the patient's communications to the psychiatrist unprivileged is virtually equivalent to ruling that the plaintiff has made out a *prima facie* case of tort liability. Under the statute's terms, the court would have to conclude that the psychiatrist had reasonable cause to believe that the patient's conditions presented a danger requiring disclosure to thwart. Such a predetermination on the merits can

¹⁵² 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980).

¹⁵³ CAL. EVID. CODE § 1024 (West 1966 & Supp. 1977), *quoted* at note 99 *supra*.

¹⁵⁴ *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 605, 162 Cal. Rptr. 724, 733 (1980).

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 605, 162 Cal. Rptr. at 732-33.

have prejudicial ramifications for a defendant.¹⁵⁷ More significant, however, is the irreparable harm done when a judge reviews a patient's records only to discover no basis for abrogation of the privilege. Requests to invade the privacy of the therapeutic relationship with judicial scrutiny must not be granted routinely on a showing of no more than an assault committed by someone who is or has been in psychotherapy. Whether the facts of *Mavroudis* are sufficient to justify such an invasion is arguable. The petitioners in *Mavroudis* may have evoked greater sympathy than would the average assault victim fishing for grounds to file a lawsuit, since they were the patient's parents, whom he had attacked and seriously wounded with a hammer.

B. *An Unanticipated Consequence of the Tarasoff Rule*

Legal doctrine and court decisions, like medical interventions, sometimes have undesirable consequences that were neither intended nor anticipated by those responsible.¹⁵⁸ For instance, a troubling side effect of the liability that *Tarasoff* imposes on psychiatrists may be to render them even more reluctant than they previously were to cooperate in criminal proceedings against a patient accused of assault or murder, for fear of furnishing ammunition for a civil suit. In this connection it is noteworthy that the defendant-therapists in *Tarasoff* testified on Poddar's behalf at his criminal trial, substantiating his defense of diminished capacity.¹⁵⁹ Although it is not possible from the case reports to ascertain the temporal relationship between that testimony and the initiation of the civil suit, one may fairly speculate that the therapists' testimony did not have a pacifying effect on the Tarasoffs.

¹⁵⁷ See generally Note, *Discovery of Psychotherapist-Patient Communications after Tarasoff*, 15 SAN DIEGO L. REV. 265 (1978).

¹⁵⁸ Any examination of the sociological phenomena of "unanticipated consequences" must start with Merton, *The Unanticipated Consequences of Purposive Social Action*, 1 AM. SOC. REV. 894 (1936). See generally S. SIEBER, *FATAL REMEDIES: THE IRONIES OF SOCIAL INTERVENTION* (1981); *UNANTICIPATED CONSEQUENCES OF SOCIAL ACTION: VARIATIONS ON A SOCIOLOGICAL THEME* (R.K. Merton ed. in press).

¹⁵⁹ See *People v. Poddar*, 10 Cal. 3d 750, 759 n.13, 518 P.2d 342, 348 n.13, 111 Cal. Rptr. 910, 916 n.13 (1974) (both psychiatrists and the psychologist who had participated in Poddar's therapy testified).

Since there is no legal obligation to provide information or answer questions, other than under oath in response to a judicially enforceable summons,¹⁶⁰ therapists concerned about possible *Tarasoff* liability might be well-advised simply to refuse to discuss with a patient's lawyer anything that transpired in the course of therapy—even if the erstwhile patient begged them to do so—no matter what essential element of the defense they might be in a position to supply. A recalcitrant therapist could of course be summoned to testify before a grand jury, at a pretrial hearing, or at trial. Even in those jurisdictions which recognize it, the psychotherapist or physician-patient privilege may not be applicable in criminal proceedings.¹⁶¹ Grand jury testimony, however, ordinarily remains unavailable to the defense unless and until the witness testifies at trial.¹⁶² The defense lawyer might have a legitimate basis for calling the therapist to the stand, for example, at a pretrial hearing on the voluntariness of a statement allegedly made by the defendant. Or at trial, the patient could choose to waive the privilege and thus require the doctor to testify. But competent defense counsel likely would not take such steps without some notion of what the doctor would say. No lawyer wants to put on the stand a

¹⁶⁰ See A. AMSTERDAM, B. SEGAL, & M. MILLER, TRIAL MANUAL FOR THE DEFENSE OF CRIMINAL CASES § 116, at 1-101 (1978); K. HEGLAND, TRIAL AND PRACTICE SKILLS IN A NUTSHELL 228 (1978) ("witnesses are not legally obligated to talk to you"). Cf. New York County District Attorney Witness Aid Service Unit, *Your Rights as a Witness in a Criminal Proceeding*, ¶ 3 ("If you choose to speak to anyone other than the ADA concerning a pending matter, you may answer any questions asked of you or you may decline to answer any questions") (sic) (improperly suggesting that the witness has no choice about speaking to the ADA). See, e.g., *United States v. White*, 454 F.2d 435 (7th Cir. 1971), cert. denied, 406 U.S. 962 (1972) (witnesses free to decide whether to grant or refuse lawyer a pretestimonial interview) (citing *Gregory v. United States*, 369 F.2d 185, 188 (D.C. Cir. 1966), cert. denied, 396 U.S. 865 (1969), and *United States v. Bowens*, 318 F.2d 828, 829 (7th Cir. 1963)). Accord *United States v. Miranda*, 443 F.2d 1351 (9th Cir. 1971), cert. denied, 404 U.S. 966 (1971). See also *People v. Dawson*, 50 N.Y.2d 311, 406 N.E.2d 771, 428 N.Y.S.2d 914 (1980) (absent specific legislative directive, or a command or request for assistance by law enforcement officials, citizen has no obligation to volunteer exculpatory information to law enforcement authorities) and cases cited therein.

¹⁶¹ See, e.g., C. MCCORMICK, HANDBOOK OF THE LAW OF EVIDENCE §§ 103-104 (E. Cleary 2d ed. 1972).

¹⁶² See, e.g., 18 U.S.C. § 3500 (1969); FED. R. CRIM. P. 6(e), 16(a)(3) (1966). Material evidence favorable to the defense should be disclosed prior to trial pursuant to *United States v. Agurs*, 427 U.S. 97 (1976) and *Brady v. Maryland*, 373 U.S. 83 (1963), but prosecutors' and defense attorneys' interpretations of "favorable" have been known to differ.

witness whose testimony is an unknown quantity. Particularly in the delicate area of expert opinion, unpredictable responses from a noncooperative, though not demonstrably hostile, witness could be devastating. The elementary maxim, "never ask a question without knowing what the witness will answer" cannot always be honored, but it is not departed from lightly. Ideally, a trial lawyer engages in extensive preparation of witnesses, in accord with a definite strategy and an overall theory of the case.¹⁶³

True, a psychiatrist's records generally would be obtainable by subpoena and if explicit enough might embolden the attorney to seek the live testimony, notwithstanding the fact that many psychiatrists (and other physicians) have become highly circumspect in what they include in discoverable treatment records. The point is that a therapist concerned about potential *Tarasoff* liability is not going to be a very helpful partner in the development of an effective defense. It is not hard to imagine a case in which the result could be a miscarriage of justice. This possible consequence of *Tarasoff* seems at least as serious as the one so frequently alluded to in the literature: the deterrence of therapists from undertaking the treatment of potentially violent patients. The *McIntosh* court disposed of that issue in short order, asking, "If the psychiatrist claims inability to predict dangerousness or detect a dangerous

¹⁶³ See, e.g., A. AMSTERDAM, B. SEGAL, & M. MILLER, *supra* note 160, §§ 106-119 at 1-95 to 1-104 (1978); T. MAUET, *FUNDAMENTALS OF TRIAL TECHNIQUES* § 1.5 at 11 (1980); ALI-ABA COMMITTEE ON CONTINUING PROFESSIONAL EDUCATION, *CIVIL TRIAL MANUAL* 385-91 (R. McCullough & J. Underwood 2d ed. 1981); OFFICE OF PROJECTS DEVELOPMENT, *APPELLATE DIVISION OF THE SUPREME COURT OF THE STATE OF NEW YORK, FIRST DEP'T, CRIMINAL TRIAL ADVOCACY* 431-33 (4th ed. 1980). See also *Spencer v. Burglass*, 337 So. 2d 596 (La. App. 1976) (failure to interview witnesses prior to trial can be construed as negligence and ineptitude in trial preparation and might constitute malpractice if it causes client's loss); *People v. Droz*, 39 N.Y.2d 457, 348 N.E.2d 880, 384 N.Y.S.2d 404 (1976) (failure to investigate and contact witnesses, along with other questionable conduct, held to constitute ineffective assistance of counsel) (unanimous bench); New York State Bar Ass'n Comm. on Professional Ethics, Op. 245 (1972) (lawyers permitted to interview adverse witnesses, since failure to investigate facts could be considered a dereliction of duty); ABA STANDING COMMITTEE ON ASSOCIATION STANDARDS FOR CRIMINAL JUSTICE, *STANDARDS FOR CRIMINAL JUSTICE—THE DEFENSE FUNCTION*, Standard 4-4.1 (2d ed. 1980) (duty of defense counsel to investigate carefully all available defenses of fact and of law; defense attorney should interview not only own witnesses but also accessible prosecution witnesses and should try to secure information from prosecutor and police). See generally G. BELLOW & B. MOULTON, *THE LAWYERING PROCESS* 339-407, 676-92 (1978).

person, how will he make the determination to weed out 'potentially violent patients'?"¹⁶⁴

C. In Other Jurisdictions

The courts of several other jurisdictions have been asked to impose *Tarasoff* liability on psychotherapists. In Maryland, a dentist named Shaw sued a husband-wife psychiatric team who had simultaneously been treating Shaw, his mistress, and her husband (a situation that may have been in the best interactionist-therapy tradition but seems ethically problematic). One night the estranged husband caught his wife and Shaw *in flagrante delicto* and fired five bullets into him. Shaw survived and had the audacity to file suit not only against the by-then divorced husband, who eventually paid him \$20,000, but also against the psychiatric team, claiming that he should have been warned of the husband's "unstable and violent condition" which presented a "foreseeable and immediate danger."¹⁶⁵ During discovery it developed that on the day of the assault the wife had heard from her son, and had relayed to Shaw, the information that her husband was "acting in a bizarre way" and carrying a pistol.¹⁶⁶ The trial court granted the defense motion for summary judgment, concluding that under the circumstances, the proximate cause of Shaw's injuries was his own assumption of risk in going to bed nude with the wife of a distraught and armed man.¹⁶⁷

On appeal, the reviewing court affirmed the result but did not endorse the lower court's reasoning. It distinguished Shaw's position from that of the *Tarasoffs* because he had failed to allege in his complaint that his assailant had ever communicated to the defendant-therapists an intention to kill or injure Shaw. (Considering that the husband must have been aware that the other two members of this *folie à trois* were also patients, his reticence is not surprising). Absent that allegation, the court found no cause of ac-

¹⁶⁴ *McIntosh v. Milano*, 168 N.J. Super. 466, 493, 403 A.2d 500, 514 (1979).

¹⁶⁵ *Shaw v. Glickman*, 45 Md. App. 718, 721, 415 A.2d 625, 628 (1980).

¹⁶⁶ *Id.* at 721, 415 A.2d at 627.

¹⁶⁷ *Id.* at 722, 415 A.2d at 628.

tion.¹⁶⁸ The court then went on, quite gratuitously, to quote the Hippocratic Oath¹⁶⁹ and to declare that had the psychiatric team revealed to Shaw the husband's vengeful propensities, they would have violated the state's privilege statute. This construction is hardly self-evident, since the statute as written appears applicable only to judicial proceedings, not to private communication.¹⁷⁰ The court did not comment on alternative courses of action to disclosure. Whether it intended to signal a covert rejection of the *Tarasoff* principle is difficult to determine. Those Maryland psychotherapists who are aware of the court's opinion must find it frustratingly opaque.

Altogether clear in its holding, although less so in its reasoning, is the opinion of the federal district court in *Lipari v. Sears, Roebuck & Co.*¹⁷¹ In that case the court was called upon to deduce whether Nebraska courts would require psychotherapists to "initiate whatever precautions are reasonably necessary to protect potential victims" of their patients.¹⁷² The plaintiffs had claimed that Veterans Administration therapists were negligent in their treatment of a psychiatric outpatient who took a shotgun on a shooting spree in a crowded Omaha nightclub, killing plaintiffs' decedent. Applying Nebraska law in accord with the Federal Tort Claims Act,¹⁷³ the court characterized *Tarasoff* and *McIntosh* as providing a "just and reasoned analysis" of the issues and expressly adopted their holdings.¹⁷⁴ The court was careful to emphasize that the *Tarasoff* standard could be met by taking "those precautions which would be taken by a reasonable therapist under similar

¹⁶⁸ *Id.* at 725, 415 A.2d at 630.

¹⁶⁹ "All that may come to my knowledge in the exercise of my profession . . . which ought not to be spread abroad, I will keep secret and never reveal." *Id.* at 725, 415 A.2d at 630.

¹⁷⁰ *Id.* at 727 n.9, 415 A.2d at 630 n.9, (citing MD. CTS. & JUD. PROC. CODE ANN. § 9-109(b) (1974) ("Unless otherwise provided, in all judicial, administrative or legislative proceedings, a patient or his authorized representative has a privilege to refuse to disclose, and to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental or emotional disorder.") (emphasis added).

¹⁷¹ *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 193 (D. Neb. 1980).

¹⁷² *Id.*

¹⁷³ 28 U.S.C. § 1346(b) (1976 West & Supp. 1980).

¹⁷⁴ *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 189 (D. Neb. 1980).

circumstances.”¹⁷⁵

On the facts of this case, it is not clear whom the therapists were expected to warn, or what precautions they could have taken other than committing their patient. The relevance of *Tarasoff* and *McIntosh* is not apparent; plaintiffs’ decedent was hardly a “readily identifiable” potential victim.¹⁷⁶ Perhaps the court as a matter of public policy wished to avoid finding the hospital negligent for failing to commit an outpatient,¹⁷⁷ but its decision seems just as likely to create an incentive for Nebraska therapists to resort to commitment.

In *Leedy v. Hartnett*,¹⁷⁸ a Pennsylvania federal district court had to decide what position the courts of that state would take in a case of first impression. The defendants in this case were also Veterans Administration psychiatrists. Hartnett, a disabled veteran and alcoholic with a history of violence, had signed himself out of the hospital where he was a voluntary patient and had gone to live with the plaintiffs, who generously had offered him a home. About six months later, Hartnett attacked his hosts and gave them an unprovoked beating. The victims sued the hospital for having failed to apprise them, not of a threat, but of Hartnett’s assaultive tendencies. Taking an inventive approach to the issue of foreseeability, the plaintiffs contended that the hospital ought to have realized that they comprised a “readily identifiable” target of Hartnett’s violence, based on the statistical probability that the more one was in contact with him, the more likely one was to become his victim.¹⁷⁹ The court assumed that Pennsylvania courts would entertain a *Tarasoff* theory of liability, but that to keep it within “workable limits” it could not be extended to cover the facts of a case such as this.¹⁸⁰ Only when a particular victim can be identified in advance is there good reason to impose a duty to warn, held the

¹⁷⁵ *Id.* at 193.

¹⁷⁶ See *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980); *Thompson v. County of Alameda*, 88 Cal. App. 3d 936, 152 Cal. Rptr. 226 (1979).

¹⁷⁷ See, e.g., *Centeno v. New York*, 48 A.D.2d 812, 369 N.Y.S.2d 710 (1st Dep’t 1975), *aff’d*, 40 N.Y.2d 932 (1976), *quoted* at note 61 *supra*.

¹⁷⁸ 510 F. Supp. 1125 (M.D. Pa. 1981).

¹⁷⁹ *Id.* at 1130.

¹⁸⁰ *Id.*

court.¹⁸¹

Finally,¹⁸² in an unreported Illinois decision, an intermediate Illinois court refused to follow *Tarasoff* and upheld the dismissal of plaintiff's complaint against a clinic, a psychiatrist, and a social worker for failing to warn their patient's family of his express intention to "kill rich people."¹⁸³ The court may have been swayed by the fact that the statutory strictures on professional breaches of confidentiality which were in effect at the time plaintiff's decedent was murdered contained no exceptions for notifying anyone, not even the patient's family, of suspected danger. (A subsequent enactment has given providers of mental health-care the discretionary power to disclose a "clear, imminent risk of serious physical or mental injury."¹⁸⁴) Too, the court may have found the plaintiff's

¹⁸¹ *Id.*

¹⁸² For a more recent incident occurring in New York that received a great deal of publicity, see N.Y. Times, Feb. 12, 1980, at C3, col. 1; N.Y. Times, Dec. 19, 1979, at B1, col. 6; N.Y. Times, Dec. 9, 1979, at 50, col. 1. The articles include frequent reference to possible *Tarasoff* liability, but the situation is not comparable to the *Tarasoff* case. Adam Berwid, a "model" patient at Pilgrim State Psychiatric Hospital, had been judicially committed following threats to kill his ex-wife. He was given a day's furlough on December 6, 1979—the second anniversary of his divorce—and promptly went to his ex-wife's home and stabbed her to death. The next day Berwid called the police and surrendered. Subsequently, the two psychiatrists associated with the decision to grant furlough were subjected to disciplinary proceedings by the State Department of Mental Health and threatened by the Nassau County District Attorney with criminal prosecution, although reportedly the Nassau County grand jury refused to indict them. See N.Y. Times, June 20, 1980, at B2, col. 1.

Predictably, the incident led to demands for legislative enactment to require notification of courts and law enforcement officers whenever "potentially dangerous" patients are furloughed, and in 1980 New York's Criminal Procedure Law was amended to prohibit the discharge, conditional release, or even transfer to a less secure facility or status, of anyone found incompetent to stand trial on a criminal charge, without four days' prior notice, not only to local police and prosecutors, but to "any person who may reasonably be expected to be the victim" of the committed person. N.Y. CRIM. PROC. LAW § 730.60(6)(a)(5) (McKinney Supp. 1981-1982). See also N.Y. CRIM. PROC. LAW § 730.60 supplementary practice commentaries (McKinney Supp. 1981-1982).

The Berwid case is not a true *Tarasoff* situation. Any civil liability predicated on these facts would not require affirmation or adoption of a *Tarasoff* duty by New York courts. Rather, it would derive from the longstanding and accepted principle that one with a custodial relationship to a previously-diagnosed dangerous person can be held responsible for acts of violence committed after that person's negligent release. See note 61 *supra* and accompanying text. There was obviously no issue of disclosure of a confidentially communicated threat, since Mrs. Berwid was well aware of her ex-husband's desire to kill her.

¹⁸³ See Brief of Amicus Curiae, *Schneider v. Vine St. Clinic*, *supra* note 107, at 2.

¹⁸⁴ *Id.* at 49-50.

theory of proximate causation a bit farfetched. The plaintiff's theory presumed that the patient's family and the patient's personal physician, had they been warned by defendants about the patient's statement, would have tried to hospitalize the patient; that their efforts would have been successful; and that the hospitalization would have prevented the murder.

VI. A *Tarasoff* DUTY FOR OTHER PROFESSIONS

A. A Lawyer's Duty to Disclose

1. The Proposed Model Rule

It may be some consolation to psychiatrists embroiled in the "no-win" conflict between their traditional role of confidant and their new role of informant to learn that the legal profession, *sua sponte*, is on the verge of placing its members in a similar double bind. Lawyers, like psychiatrists, have always had the discretion to reveal a confidential communication in order to avert future harm to another.¹⁸⁵ The relevant provision of the Model Code of Professional Responsibility permits a lawyer to reveal "the intention of his client to commit a crime and the information necessary to prevent the crime."¹⁸⁶ This has been interpreted, however, to allow

¹⁸⁵ Unlike many therapists' codes, the MODEL CODE OF PROFESSIONAL RESPONSIBILITY is also explicit in giving lawyers discretion to reveal a confidence in order to avert harm to *themselves*: in defense to an accusation of misconduct or malpractice or in order to collect a fee. ABA Code, *supra* note 24, DR 4-101(c)(4). See Levine, *Self-Interest or Self Defense: Lawyer Disregard of the Attorney-Client Privilege for Profit and Protection*, 5 HOFSTRA L. REV. 783 (1977). This provision has been interpreted to allow lawyers to breach confidentiality even when the charge of misconduct comes from a third party, not from the client. See *Meyerhofer v. Empire Fire & Marine Ins. Co.*, 497 F.2d 1190 (2d Cir. 1974), *cert. denied*, 419 U.S. 998 (1975). Under the PROPOSED MODEL RULES, *supra* note 24, this exception is described as narrowed to "situations where the client's conduct was involved," which does not seem all that much more narrow. Rule 1.6, Notes: Code Comparison. Arguably, the *Tarasoff* doctrine can be viewed as based on *anticipating* an accusation of misconduct or malpractice; if lawyers are permitted to disclose client confidences in order to defend themselves, why not in order to forestall such accusations? The circular nature of this reasoning should be apparent. You could be held responsible for failing to tell, therefore you are entitled to tell to protect yourself, therefore you ought to tell; if you ought to tell and do not, you can be held responsible.

¹⁸⁶ ABA CODE, *supra* note 24, DR 4-101(c)(3). In addition, DR 7-102(b) *appears* to require lawyers to reveal confidential information in order to rectify client fraud, but its 1974 amendment and its construction in ABA Comm. on Ethics and Professional Responsi-

violation of a confidence only if "the facts in the attorney's possession indicate beyond a reasonable doubt that a crime will be committed."¹⁸⁷ That standard probably would not be met by the client's merely stating an unlawful intention. Most attorneys would require a more substantive indication of danger to overcome their reluctance to violate the rule of confidentiality.

The exceptions to that rule have been fiercely debated within the profession during the major reconstruction of the Code now in progress. The first Discussion Draft of the Model Rules of Professional Conduct provided that: A lawyer *shall* disclose information about a client to the extent it appears necessary to prevent the client from committing an act that would result in death or serious bodily harm to another person, and to the extent required by law or the Rules of Professional Conduct.¹⁸⁸

Were that rule or some other quasi-*Tarasoff* standard of conduct for lawyers to be adopted by the courts, a host of problems parallel to those experienced by psychiatrists would emerge. Clearly there is no "standard of the profession" which even the most experienced attorney can realistically use as a basis to discriminate between the empty threat and the truly ominous one. Clients in various kinds of legal trouble frequently make irrational and regrettable statements that could be interpreted as threats. Whatever their other sins, lawyers have never promulgated the notion that they have the ability to detect a predilection for violence in clients. I, for one, cannot imagine assessing with any degree of accuracy how genuine a threat is represented when a client mutters "I oughta take care of that guy" in reference to an opposing party or witness. I have heard such comments on occasion, and beyond advising the client that such conduct would be the height of self-destructive folly as well as a vicious and criminal act, I have done nothing. (To my knowledge no violence ever ensued). Many of

bility, Formal Op. 341 (1975) have all but eliminated that effect in those states which have adopted it. See generally Kramer, *Client's Frauds and Their Lawyers' Obligations: A Study in Professional Irresponsibility*, 67 GEO. L.J. 991 (1979).

¹⁸⁷ ABA Comm. on Professional Ethics, Formal Op. 314 (1965).

¹⁸⁸ Discussion Draft, PROPOSED MODEL RULES, *supra* note 24, Rule 1.7(b) (emphasis added).

these clients stood accused, and in the past had been convicted, of violence and lawlessness. If anything is a reliable indicator of a real potential for violence, according to our psychiatric colleagues, it is previous violent behavior. It is troubling to think that my failure to act may have endangered an innocent person. Yet I can see no reliable way to ascertain the difference between the routine and the deadly remark.

At this point, while recognition of a *Tarasoff* duty for lawyers remains an abstract possibility, I can comfortably assert that I would not sacrifice my clients' interests by reporting statements that might increase their chances of conviction, for threatening an accuser could serve as convincing evidence against an accused. However, fear of civil liability and professional sanction might well lead some attorneys, particularly those who rarely handle criminal matters and are unfamiliar with the pattern of casually uttered threats, to overcome their sense of obligation to their clients and to disclose those threats, since under present law they have the discretion, although no duty, to do so. They might recall that before *Tarasoff*, psychiatrists also had little reason to suspect that their professional discretion would be converted into actionable duty.

What about a case similar to *McIntosh* or *Shaw* in which no explicit threat was made? The language of the originally proposed Rule of Professional Conduct was not limited to statements by clients, but was framed in terms of "information about" them. Would it be sufficient justification for disclosure to know that a client is violently angry at or possessive of an estranged spouse, and secretly wishes the latter would "die a thousand painful deaths," as a client in a matrimonial action once told me? Warning the client's spouse of such suspicion, if it came to the attention of the court, could cost the client a considerable sum of alimony, not to mention its effect on a child-custody arrangement. If the lawyer had misjudged the situation, the client might have an excellent claim for breach of fiduciary duty or even malpractice.¹⁸⁹

¹⁸⁹ See *Citizens State Bank v. Shapiro*, 575 S.W.2d 375, 386 (Tex. Civ. App. 1978) (dictum that violation of the ABA CODE, *supra* note 24—attorney revealing to wife confidential communication of client husband—could constitute basis for malpractice claim). But see the disclaimer in the Preliminary Statement of the ABA CODE, *supra* note 24: "The Code [does

The widespread consternation in the bar over the Discussion Draft apparently persuaded the Kutak Commission to beat an orderly retreat. The Final Draft of the Proposed Model Rules defines the exceptions to the lawyer's obligation of confidentiality as purely permissive—not mandatory.¹⁹⁰ Candidates for discretionary disclosure include those criminal or fraudulent acts which “the lawyer believes . . . likely to result in death or substantial bodily harm, or substantial injury to another's financial interest or property of another.”¹⁹¹ Unfortunately, in its comment on the lawyer's responsibility with respect to this broad category, the Commission chose to justify its *volte-face* with reference to that perennial shibboleth, *scienter*. The Commission explains that lawyers would find it difficult to “know” whether a client's heinous purpose will be carried out because the client “may always have a change of mind.”¹⁹² That formulation seems practically to beg for the psychiatrists' retort: How, then, are we supposed to “know” when our patients are dangerous? Our patients are just as likely as your clients to repent their threats. Instead of this excursion into epistemology and the vagaries of human nature, the Kutak Commission could have based its position on one simple proposition: lawyers lack the expertise to predict client behavior and, unlike psychiatrists, lawyers have never acted as if they had such expertise.

The Commission also stated that it did not want fear of professional discipline to enter into lawyers' resolution of this “inherently difficult moral dilemma.”¹⁹³ What is puzzling about this observation, aside from the not uninteresting question of when ethical principles might better be invoked, is that the Commission's Comment also appears to contemplate circumstances in which a lawyer's failure to prevent a client's injury to a nonclient

not] undertake to define standards for civil liability of lawyers for professional conduct.” Cf. PROPOSED MODEL RULES, *supra* note 24, at 3 (“violation of the Rules should not necessarily result in civil liability. . . . The Rules . . . may have relevance in determining civil liability, but they should not be uncritically incorporated into that context.”).

¹⁹⁰ See PROPOSED MODEL RULES, *supra* note 24, Rule 1.6, at 37-38. A proposal at the August 1982 ABA House of Delegates convention to reinstate the mandatory disclosure requirement was resoundingly defeated. See Taylor, *supra* note 24.

¹⁹¹ See PROPOSED MODEL RULES, *supra* note 24, Rule 1.6, at 37-38.

¹⁹² *Id.*

¹⁹³ *Id.* at 39.

could be the predicate for tort liability.¹⁹⁴ It seems improbable that the lawyer who might be induced to disclose client confidences prematurely or unnecessarily by a threat of disciplinary sanction would hesitate *longer* if the only risk involved were exposure to civil suit. If the Commission's concern is to preserve unhampered professional discretion, it might better have questioned the legitimacy of imposing quasi-*Tarasoff* liability on a lawyer instead of appearing to lend the theory credence.

2. *The Dangerous Defendant*

In the only reported decision on a claim against an attorney comparable to that of the Tarasoffs, a Washington court granted summary judgment to the defendant.¹⁹⁵ Curiously, the case involved a psychiatric prediction of "dangerousness." The attorney was charged with having failed to disclose at a bail hearing that he had been told that his client was mentally ill and dangerous. The sources of this information were a lawyer and a psychiatrist in the employ of the client's mother, who was trying to bring about her son's civil commitment. The client, in jail on a marijuana charge, had told the attorney that he wanted to get out; the attorney proceeded to apply for his release on personal recognizance, an application that was granted. It is not clear why the mother or her agents did not attend the hearing and, through the prosecutor, contest the application, since the attorney had made his intentions plain. The client's mother was informed of his release. Eight days later, the boy assaulted her and then attempted suicide. He survived, at the cost of an amputation of both legs. His mother brought suit both on his and on her own behalf, alleging malpractice based on a violation of ethical responsibility as well as on the common law duty to warn foreseeable victims.

¹⁹⁴ "When the threatened injury is grave, such as homicide or serious bodily injury, the lawyer may have an obligation under tort or criminal law to take reasonable preventive measures." *Id.* Concern about precisely this issue was expressed by the Special Comm. of the New York State Bar Ass'n in its report recommending that the PROPOSED MODEL RULES not be adopted. See REPORT OF THE SPECIAL COMMITTEE TO REVIEW ABA DRAFT MODEL RULES OF PROFESSIONAL CONDUCT at 15-17 (1981).

¹⁹⁵ See *Hawkins v. King County Dep't of Rehabilitation Servs.*, 24 Wash. App. 338, 602 P.2d 361 (1979).

In its analysis, the court assumed without deciding that the psychiatric opinion provided to the attorney was not only unprivileged but also neither a confidence nor a secret within the meaning of Disciplinary Rule 4-101(a).¹⁹⁶ Technically, the attorney could have presented that opinion to the court without breaching an obligation of confidentiality; but to an old-school, adversarially trained lawyer, the very idea seems preposterous. As the court noted: "We believe that the duty of counsel to be loyal to his client and to represent zealously his client's interest overrides the nebulous and unsupported theory that our rules and ethical code mandate disclosure of information which counsel considers detrimental to his client's *stated* interest."¹⁹⁷

After taking this straightforward stance, the court's subsequent painstaking effort to distinguish *Tarasoff* is somewhat mystifying. First, the court said, perhaps not entirely accurately, that in *Tarasoff*, the victim had been "wholly unaware of her danger,"¹⁹⁸ while here the victim knew all about her son's condition. Second, the Berkeley therapists' information came from their patient; here the attorney's information was third-hand.¹⁹⁹ If anything, that would seem to undercut the lawyer's obligation to keep silent, in terms of confidentiality; in terms of *reliability*, however, the court may have had a point. Finally, the court bootstrapped its finding of no ethical duty by emphasizing that an *ethical* duty to disclose could apply only to that which an attorney was "required by law"

¹⁹⁶ *Id.* at 364.

¹⁹⁷ *Id.* at 365-66 (emphasis added). Whether or not a lawyer is at all concerned for the welfare of anyone other than the client, the lawyer who perceives some reason not to accept a client's statement at face value *for the client's sake* experiences considerable conflict. Unlike psychiatrists, lawyers do not usually feel capable of probing the ultimate meaning behind such a statement. To some extent, lawyers take refuge in this incapacity; it is almost, in Veblen's phrase, a "trained incapacity," see T. VEULEN, *THE INSTINCT OF WORKMANSHIP* 347 (1914), a lack of skill which paradoxically simplifies and streamlines getting the job done. Increasingly, however, lawyers are paying attention to this dimension of their work. See, e.g., Lehman, *The Pursuit of a Client's Interest*, 77 MICH. L. REV. 1078 (1979); Shaffer, *The Practice of Law as Moral Discourse*, 55 NOTRE DAME LAW. 231 (1979); Spiegel, *Lawyer-ing and Client Decision Making: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41 (1979).

¹⁹⁸ *Hawkins v. King County Dep't of Rehabilitation Servs.*, 24 Wash. App. 338, 343-44, 602 P.2d 361, 365 (1979).

¹⁹⁹ *Id.*

to disclose.²⁰⁰ Since the court did not recognize a legal duty, *a la Tarasoff*, to disclose the psychiatrist's opinion, the theory of liability based on ethical duty could not be sustained on these facts. But in dictum, the court did suggest that a common law duty to volunteer information to a court considering pretrial release of a client might exist if the attorney were convinced beyond a reasonable doubt that "the client has formed a firm intention to inflict serious personal injuries on an unknowing third person."²⁰¹

The disquieting implication of this suggestion is that a successful defense attorney might in some circumstances be held responsible for a client's future crimes. The judge who grants the bail application is immune;²⁰² the prosecutor who fails to argue for or achieve the defendant's continued incarceration is also privileged by office.²⁰³ Neither of them owes the defendant loyalty or confidentiality; both have an obvious duty to the public. But the sole function of the defense lawyer is to try to persuade the court to free the client. What sense does it make to impose liability on the defense lawyer and not on the other participants?²⁰⁴

²⁰⁰ *Id.* at 343, 602 P.2d at 365.

²⁰¹ *Id.*

²⁰² On the extent of judicial immunity, see, e.g., *Stump v. Sparkman*, 435 U.S. 349 (1978) (minor sterilized without her consent, based on judicial approval of parents' petition in *ex parte* proceeding with no semblance of due process; held, judges not civilly liable for judicial acts, even when acts were in excess of authority, done maliciously, or erroneously) See also *Pierson v. Ray*, 386 U.S. 547, 553-54 (1967) ("few doctrines . . . more solidly established at common law than the immunity of judges from liability . . . for acts committed within their judicial jurisdiction").

²⁰³ See, e.g., *Seibel v. Honolulu*, 61 Hawaii 253, 602 P.2d 532 (1979), in which the Hawaii Supreme Court took pains to distinguish *Tarasoff* in affirming a lower court's dismissal of a suit against a prosecutor for failing to report a serious breach by a convicted violent sex offender of the terms on which he had been conditionally released. See generally *Imbler v. Pachtman*, 424 U.S. 409 (1976) (review of historical development of common law rule of prosecutorial immunity and public policy considerations dictate holding state prosecutor acting within scope of duties absolutely immune from § 1983 suit, even when prosecutor knowingly used perjured testimony or deliberately withheld exculpatory information).

²⁰⁴ The defense lawyer is hardly devoid of moral guilt when a client commits another crime. We cannot brag about our acquittals and exult in the heady sensation of "walking someone out"—and we do—without also partaking of some responsibility for what follows, anymore than a prosecutor can wholly disavow the injustice when an innocent person suffers a false accusation. This immense and complex subject simply cannot be tackled in this paper; all that I can try to point out is the incoherence of attempts to extend *legal* liability to lawyers in this situation. Perhaps in an extraordinary case—if a lawyer actively misrepre-

3. *The Suicidal Client*

Since the *Hawkins* case involved transmission of someone else's opinion that a client was "dangerous," the court avoided addressing the question of when, if ever, lawyers should be expected to rely on their own predictions of "dangerousness," an opinion which nothing in their professional training or experience enables them to call more than conjecture, an opinion which probably would not even be admissible in, for example, an involuntary commitment hearing.²⁰⁵ One New York court, in dictum, has suggested that in extreme circumstances lawyers may be expected to act on such judgments.²⁰⁶ The facts of that case were somewhat more emotionally charged for the lawyer than those in *Hawkins*. At 2 a.m., Albert Fentress called his long-time friend Wallace Schwartz, a lawyer in civil practice, to announce that he had just killed someone

sent to the court that the client had never mentioned harming a particular individual, when the client had been threatening that person for the duration of the lawyer-client interview—liability might be appropriate. Even then, however, we must keep in mind the intervening causal factors—principally the judge who actually orders release. There is likewise a profound difference between the court-appointed psychiatrist who recommends release and the court-appointed attorney who argues for it. One presents an opinion and claims to have made an objective judgment; the other takes a forthrightly subjective position and presents whatever reasons can be found to support it. Again, the lawyer *speaks for* clients, not dispassionately *about* them. And unlike the psychiatric witness whose testimony in a commitment proceeding is almost always dispositive, *see* authorities cited in note 47 *supra*, the lawyer's impact on the judge's decision is limited because the judge is usually well aware of the purpose underlying all that the lawyer says. Yet psychiatrists who render such opinions have been accorded the absolute immunity of judges and prosecutors from liability for an erroneous expert opinion that results in the release of a "dangerous" individual who subsequently harms another. *See* Seibel v. Kemble, 631 P.2d 173 (Hawaii 1981) (holding court-appointed psychiatrist absolutely immune) and authorities cited therein. *See also* Seibel v. Honolulu, 61 Hawaii 253, 602 P.2d 532 (1979) (case, mentioned in note 203 *supra*, has same plaintiff and facts as in Seibel v. Kemble, 631 P.2d 173 (Hawaii 1981)).

²⁰⁵ *But see* Esquivel v. Texas, 595 S.W.2d 516 (Tex. Crim. App. 1980). Among the seventeen grounds urged in this appeal of a capital murder conviction and death sentence was the admission during the penalty phase of the trial of the opinion of a former district attorney who had prosecuted the defendant for rape some twenty-five years previously. The witness, based on his knowledge of the defendant's prior criminal record, predicted that he would commit future offenses and pose a continuing threat to society. The appellate court finding no error, stated that objections to the witness' lack of qualifications for making a prediction of future violence went to the weight, not the admissibility, of the evidence, and suggested that an experienced prosecutor might be just as competent to render such an opinion as a psychiatrist after an average forensic interview. *Id.* at 527-28.

²⁰⁶ *People v. Fentress*, 103 Misc. 2d 179, 425 N.Y.S.2d 485 (Dutchess Cty. Ct. 1980).

and was about to take his own life. Schwartz coped tolerably well, all things considered, and attempted to obtain for Fentress some immediate aid and comfort. (Schwartz lived some fifty miles away). Through a complex chain of phone calls, the police were alerted and Fentress was taken into custody, along with his victim's body and his gun. Saved from suicide, he would stand trial for intentional homicide.

The germane issue before the court was whether the attorney's breach of confidentiality had immunized his client from prosecution, since all the evidence presented to the grand jury that indicted him flowed from that initial breach. The court managed to avoid this unpalatable result by emphasizing the intervening independent variables, principally a colorable waiver on Fentress' part.²⁰⁷ The court could not, however, take the client's communications out of the privilege entirely. The "future crime" exception did not apply; suicide is not a crime in New York.²⁰⁸ Nonetheless, the court's dissection of the attorney's trilemma culminated in these observations:

The ethical oath of secrecy must be measured by common sense. . . . To exalt the oath of silence, in the face of imminent death, would, under these circumstances, be not only morally reprehensible, but ethically unsound. As Professor Monroe Freedman reminds us, "At one extreme, it seems clear that the lawyer should reveal information necessary to save a life." [citations omitted] . . . Thus, even if [Fentress] flatly forbade Schwartz from calling the police, the ethical duty of silence would be of dubious operability. . . . Had [Schwartz] acted any differently, he would have blindly and unpardonably converted a valued ethical duty into a caricature, a mockery of

²⁰⁷ *Id.* at 194-96, 425 N.Y.S.2d at 494-96. Despite the fact that Schwartz had "never for a moment envisioned himself as being Fentress' attorney," *id.* at 187, 425 N.Y.S.2d at 491, the court concluded that he had been consulted in his professional capacity, and therefore an attorney-client relationship had been formed. *Id.* "That Wallace Schwartz was in effect called upon to serve as psychologist, therapist, counselor, and friend, does not derogate from his role as lawyer [cit. omit.]" *Id.* at 190, 425 N.Y.S.2d at 492.

²⁰⁸ *Id.* at 197-98, 425 N.Y.S.2d at 497; see also New York State Bar Ass'n Comm. on Professional Ethics, Op. 486 (1978) (lawyer may take appropriate action to prevent client suicide, including disclosure of client intentions even though suicide does not fall into the category of "future crimes").

justice and life itself.²⁰⁹

Would the court have declaimed in similar fashion had the lawyer kept his counsel, Fentress gone ahead and shot himself, and the lawyer been sued for failing to prevent his death? Possibly yes. The court found the underlying justification for the duty of confidentiality in the protection of client interests, and then asked: "What interest can there be superior to the client's life itself?"²¹⁰ The question sounds uncannily like that of a physician whose patient's refusal of lifesaving treatment has just been upheld as competent by an anti-paternalistic court. In contrast, consider the reasoning of the *Bellah* court which, following *Tarasoff*, would not countenance a psychiatrist's violation of confidentiality unless it were necessary to prevent harm to others. That court held that a threat to hurt oneself could not authorize, let alone require, disclosure.²¹¹ Perhaps the courts are in the process of developing a bilaterally symmetrical division of professional responsibility: lawyers will be held liable for failing to prevent client suicides, but not their homicides, while psychiatrists can be sued for patient homicides, but not their suicides.

4. *Statistical Risks*

There is another category of conflict between third-party interests and patient or client rights which certain lawyers are likely to experience but most psychiatrists are not. In the world of corporate and commercial practice, attorneys may often find that their clients' business decisions present an increased risk to the health and safety of some statistically predictable, though not individually identifiable, set of consumers, employees, or members of the public. The paradigm of this conflict is (mercifully) a hypothetical concocted by Judge Ferren of the D.C. Circuit. Known to legal-ethics buffs as the "Trireme Case," it centers on the Trireme Aluminum Company, which has recently become profitable through its

²⁰⁹ *People v. Fentress*, 103 Misc. 2d 179, 197-98, 425 N.Y.S.2d 485, 497 (Dutchess Cty. Ct. 1980). Invoking Monroe Freedman in support of disclosure of client confidences is certainly citing the strongest authority imaginable.

²¹⁰ *Id.*

²¹¹ *Bellah v. Greenson*, 73 Cal. App. 3d 911, 141 Cal. Rptr. 92 (1977).

sales of an aircraft alloy. The alloy, despite having passed all the required safety tests, has a tendency to crack at high altitudes. Assured of this by the company's chief engineer, speaking for the entire engineering staff, Trireme's counsel informs the company president and board of directors. They disagree with the chief engineer, insist that there is no problem worth recalling the product, and veto any notion of going public with the news. A month later, a plane made with the alloy crashes, killing all aboard. It is not certain that the alloy is to blame. The government investigation begins and counsel is called upon to represent Trireme's interests. The company wants to continue to conceal evidence of defects in the alloy. Should the lawyer reveal the evidence?

Judge Ferren concluded, after an exhaustive analysis of the current Code of Professional Responsibility and the relevant ABA opinions, that it was by no means clear that the attorney had the right, let alone the duty, to disclose.²¹² According to the original, broadly worded Proposed Model Rules, disclosure would seem to be in order; but the final version, which constrains lawyers to reveal only criminal or fraudulent acts *likely* to result in injury, might well not support disclosure.²¹³ Can a lawyer predict death or injury with greater reliability in this context than when an individual client threatens a wife or a witness? If we follow the reasoning of the *Tarasoff* line of cases, the fact that the victims in this instance are not "readily identifiable"—that the client's actions pose, if anything, a generalized danger to the public—would preclude an attempt to hold the lawyer responsible if injury did occur.²¹⁴ The car manufacturer who chooses to economize on safety equipment, the government official who launches a counter-insurgency operation or revokes a safety regulation, the megafarmer who fattens stock on diethylstilbestrol—each is probably some lawyer's client and they all probably discuss their intentions with their lawyers in

²¹² See Ferren, *supra* note 24, at 1262, 1264.

²¹³ See PROPOSED MODEL RULES, *supra* note 24, Rule 1.6(b)(2), Note, Exceptions to Confidentiality at 47 (when failure to disclose prospective crime or fraud may result in substantial harm, disclosure discretionary; mandatory disclosure "limited to circumstances in which the lawyer's conduct is inextricably bound to the client's misconduct, for example, assisting fraud . . . upon a tribunal").

²¹⁴ See note 74 *supra*.

advance. A *Tarasoff* rule for lawyers that did *not* limit the universe of potential plaintiffs to identifiable individuals could lead to legal malpractice premiums that would eclipse the neurosurgeons'.

B. *No "Draconian Dilemma" for Law Enforcement*

Ironically, the imposition of a *Tarasoff* rule has been considered only with respect to the helping professions whose obligations of confidentiality it threatens most. The effort to extend *Tarasoff* to members of the one profession whose mandate is public protection—law enforcement—has been unsuccessful. The argument that it is no less reasonable to create an incentive for police officers to prevent anticipated and avoidable violence than it is to create a similar incentive for psychotherapists has not prevailed. Unless evidence is proffered that the person injured had justifiably relied on a specific promise to provide special protection, the police are not held liable.²¹⁵

Recently a wrongful death action was brought against an Arizona police officer.²¹⁶ The man whom he was questioning had explicitly told the officer that he had firearms and, in the officer's opinion, recorded at the time, "gave . . . the impression that he might resort to violence."²¹⁷ The officer did nothing but fill out a form and leave. Fifteen minutes later, that man shot and killed another, whose family subsequently sued. The action was dismissed because: "A police officer in a field situation should not have to resolve the dilemma of whether to make a preventative detention which might turn out to be a false arrest, or not to do so and risk a tort suit for later consequences."²¹⁸

The Arizona court followed *Tarasoff*'s lead in declaring that the decisive factor was the lack of a "special relationship" between the police and either the killer or the decedent—such as a relationship

²¹⁵ See *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 449-50, 551 P.2d 334, 352-53, 131 Cal. Rptr. 14, 32-33 (1976). See also *Henderson v. Petersburg*, 247 So. 2d 23 (Fla. Dist. Ct. App. 1971); *Campbell v. State*, 259 Ind. 55, 284 N.E.2d 733 (1972) (dictum); *Weiner v. Metropolitan Transp. Auth.*, 55 N.Y.2d 175, 448 N.Y.S.2d 141 (1982).

²¹⁶ See *McGeorge v. Phoenix*, 117 Ariz. 272, 572 P.2d 100 (Ariz. Ct. App. 1977).

²¹⁷ *Id.* at 274 n.1, 572 P.2d at 102 n.1.

²¹⁸ *Id.* at 277, 572 P.2d at 105.

created by a promise of protection to the decedent, or by prior custodial responsibility for the killer.²¹⁹ Adherence to this traditional rule has somewhat paradoxical effects. It may be true, for example, that a therapist generally has access to more information about a patient than a police officer has about a temporary detainee. Yet the courts seem to say that even a police officer who *has been informed* by a therapist that someone is dangerous—as in *Tarasoff*—or who *actually formed* that opinion from personal observation—as in the Arizona case—risks no liability for a failure to act on that information. On the other hand, a therapist who did not perceive a patient to be dangerous—as, perhaps, in *McIntosh*—is exposed to the possibility of suit.

This outcome makes little sense unless the *Tarasoff* duty rests exclusively on a claimed and recognized ability to predict violent behavior—an ability the police do not officially assert, although in some quarters their hunches may be regarded as at least as reliable as psychiatric expertise. The term “special relationship,” as used by the Arizona court and in *Tarasoff*, must be understood to refer to, in addition to the two classic categories of tort law already mentioned, a relationship in which one party’s power over the other is derived from that party’s supposed talent for predicting “dangerousness.” In the evolution of the limits of the *Tarasoff* principle, attorneys, who are quite innocent of such pretension and devoid of such power, should properly be classified with other officers of the law, not with psychiatrists.

VII. CONCLUSION

There is reason to suspect that the *Tarasoff* doctrine, as it takes shape through the common law, will exacerbate psychiatric role conflict and compromise loyalty to patients while achieving little in the way of compensatory objectives. If its application were confined, as Judge Mosk suggested, to situations in which a psychotherapist actually *had* predicted a patient’s violence and then failed to act—avoiding, in the judge’s choice phrase, “the wonderland of clairvoyance”²²⁰—it would produce a somewhat more incremental

²¹⁹ *Id.* at 277, 572 P.2d at 105-06.

²²⁰ *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 452, 551 P.2d 334, 354, 131

adjustment of the delicate balance of conflicting professional obligations.

Psychiatrists should remember that all that is expected of them, in this as in other areas of tort liability, is that they conduct their practice with due care and in conformity with the standards of their profession. Some psychiatrists may even find *Tarasoff* a spur to more innovative and honest forms of therapy. But the negative potential—the temptation *Tarasoff* may pose for psychiatrists to resolve doubtful situations in favor of self-protection—suggests how problematic it is to impose professional standards of practice from outside the profession. As professionals in many fields are finding to their dismay, failure to resolve their role conflicts and to grapple with the limits of their expertise eventually invites regulation by outsiders who are less sensitive to the profession's special problems and less knowledgeable about them. *Tarasoff* exemplifies this phenomenon.

This paper opened with the suggestion that further development of the *Tarasoff* rule is not necessarily inexorable, and that if psychiatrists were to divest themselves of some of their "powers," particularly of their claimed ability to predict future "dangerousness," the rule might be subject to judicial revision or legislative repeal. If psychiatrists *en masse* refused to render opinions of "dangerousness" during their testimony in commitment proceedings and at death-penalty trials, it is hard to see how the *Tarasoff* rationale could survive.²²¹ However, this problem cannot be solved wholly

Cal. Rptr. 14, 34 (1976) (Mosk, J., concurring in part and dissenting in part).

²²¹ The potential efficacy and the pitfalls of such an approach are both manifest in the decision in *Teasley v. United States*, 662 F.2d 787 (D.C. Cir. 1980), granting summary judgment in favor of employees of St. Elizabeth's Hospital. The plaintiff was robbed, raped, and sodomized by a former patient three weeks after his release from the hospital. She claimed that the hospital had negligently failed to produce evidence at a civil commitment proceeding which would have established the patient's dangerousness and resulted in his being kept in the hospital. The record revealed that the clinical psychologist and ward administrator who testified at the hearing refused to say whether the patient was dangerous or not, indicating (in appropriate interactionist fashion) that that would depend upon whether he took his medication, his home situation, etc. The court found that since there was no basis for a "prediction to a mathematical certainty" and since the only duty of the expert witness is to disclose the facts that tend to support or negate the expert opinion, the defendant Hospital and its agents could not be held liable. *Id.* at 791-92. Plaintiff *Teasley*, of course, may have

through the unilateral action of psychiatrists. Lawyers and judges must do their part by learning to challenge psychiatrists who continue to make such claims and by encouraging psychiatrists who resist the pressure to do so. In trying to clarify the basis for the imposition of *Tarasoff* liability on psychiatrists, I hope to have somewhat advanced that collaborative process.

wished that one of the old-fashioned, danger-predicting doctors of yore had testified at that hearing. Following a not guilty by reason of insanity verdict, the former patient was successfully committed to St. Elizabeth's.