CHAPTER ELEVEN

# The Clinician's Legal Responsibilities to Protect Others in the Safe Treatment and Management of Patients With IED

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*Intermittent Explosive Disorder*
https://doi.org/10.1016/B978-0-12-813858-8.00011-5

With some level of severity and frequency, patients with IED have by their very diagnostic criteria of IED demonstrated their potential for directing aggressive behavior externally (American Psychiatric Association, 2013a, 2013b). By definition this aggression is impulsive, not premeditated. Considerable literature has been developed and has improved our scientific understanding of primary impulsive aggression (Barratt, Stanford, Kent, & Felthous, 1997; Barratt & Slaughter, 1998; Felthous & Stanford, 2015) as well as IED (Coccaro, 2003; Coccaro, Kavoussi, Berman, & Lish, 1998; Felthous, Bryant, Wingerter, & Barratt, 1991), the essence of which is impulsive aggression. A diagnosis of IED itself raises the question as to whether the person could physically harm or assault another, based on the symptoms and characterization of the disorder alone. This no doubt presents a challenge to the clinician in ensuring the safety of the patient with IED and the safety of others who routinely interact with the patient.

The clinician's duty to protect others who may be subjected to an IED patient's physical outbursts varies by jurisdiction and by state. Most states recognize a relationship between clinician and patient that not only requires the clinician to exercise due care in the treatment of his or her patient, but extends a duty to protect nonpatients from the patient's potential violence. In order for the duty to protect to extend to nonpatients, the patient's potential for violence with resulting harm to another must be *foreseeable*. Whether such a duty exists and how foreseeability is to be determined depends upon jurisdictional law, that is, statutes and the applicable rules from common law.

Courts have addressed cases wherein the violence resulting in harm to another person could be considered as impulsive in two basic ways based on the foreseeability of violence that could be impulsive. From the review by Beck in 1998, courts typically held that impulsive violence was not foreseeable. In these cases, the violence seemed to have occurred "out of the blue," without a threat or warning in advance that would have allowed the clinician to take protective action. Another consideration, however, is that IED is characterized by recurrent, impulsive aggression; one of the best predictors of future violence is a history of past, recurrent violence. Of course, most externalized aggression does not result in actionable physical harm, but recurrent impulsive aggression, especially if assaultive, can arguably render future acts of violence much more foreseeable than verbal threats. Without identifying such acts as impulsive or symptomatic of IED, courts have recognized prior aggressive and violent conduct as a factor in determining foreseeability and thus, may bolster a plaintiff's claim of negligence and/or failure to protect (e.g., *Jablonski by Pahls v. United States*, 1983).

## The Duty to Hospitalize

Outpatients in treatment for IED typically do not require hospitalization and may not meet the requirements for emergency detention (ED) or civil commitment (CC). Nonetheless, in considering safe management and prevention of the most extreme forms of violence including homicide, we must consider the traditional and most effective method of preventing catastrophic violence available to clinicians, which is hospitalization. Failure to hospitalize or a wrongful discharge could be considered medical malpractice or it could be considered negligence without the need to establish deviation from standard medical care (Felthous, 1985). This type of protective duty and liability is based upon the fact that hospitalization allows the clinician to *control* the patient in order to prevent serious harm. The controlling nature of the relationship creates an exception to the general common law rule that one person (a clinician) is not responsible if a second person (a patient) harms a third person (the injured would be plaintiff).

Whether IED alone qualifies as a condition for which involuntary ED or CC applies is a matter for discussion (see Felthous, 1999, regarding protective dichotomous decisions such as whether to voluntarily or involuntarily hospitalize). Emergency hospitalization should be considered if extreme violence is determined to be imminent (and therefore foreseeable). Since IED is treatable, hospitalization not only serves the legitimate purpose of incapacitation and protection, but of adjusting pharmacotherapy and making other interventions more effectively. IED does not always occur as a single disorder; the patient may have co-occurring disorder(s) that further justify hospital admission. Thus hospitalization at least voluntarily, and sometimes involuntarily, can be an important and justified, even morally imperative, intervention in the safe treatment and management of a patient with IED.

This nonetheless begs the question of whether the law *requires* hospitalization. In many mental health codes the operational auxiliary verb is "may," not "shall," seemingly making hospitalization an optional intervention for the clinician, not a legal duty. Leading up to California's *Tarasoff* decision, to be discussed later, the California state legislature enacted law that provided immunity for a clinician's alleged failure to hospitalize or wrongfully discharge (Lanterman-Petris-Short Act, 1967). This was in support of the dehospitalization and community mental health public policies at the time. Other state courts found decisions not to hospitalize or to discharge followed by the patient harming another person, were also protected from liability by

sovereign immunity where the clinicians were employed by the state, and by the honest error in professional judgment rule (Felthous, 1987). The latter depended upon such decisions being discretionary. "Discretion implies the right to be wrong" (*Canon v. Thumudo*, 1988) or the possibility of miscalculation.

But jurisdiction can make all the difference. Although statutory immunity in California precluded claims of failure to hospitalize or of wrongful discharge, the *Tarasoff* decision has been used to support wrongful discharge claims in other states wherein the individual victims themselves could not have been foreseeable, such as where the plaintiffs were injured or killed in motor vehicular crashes caused by the discharged patient (Felthous, 1989a).

An important feature of hospitalization is that the petition and testimony for involuntary civil commitment, although requiring the disclosure of otherwise confidential medical or mental health information, does not create a legal dilemma for the clinician. This is because civil commitment is uniformly recognized as an exception to privileged communication between patients and their physicians. Another important aspect of involuntary hospitalization is that it requires the clinician to make a judgment about the patient's risk (e.g., "imminent" or "substantial" danger to self or others). The basis of the determination of risk (e.g., "serious threat") should also be stated, but just weighing protective and risk factors is insufficient to initiate involuntary hospitalization. Some clinical determination of risk is essential.

## The Duty to Warn or Protect

The watershed decision creating protective duties for clinicians beyond the traditional hospitalization option was the California Supreme Court's *Tarasoff* decision in 1976. Without recounting the facts and legal history of this case available elsewhere (e.g., Felthous, 1989b), we should attempt to unpack the Tarasoff principle itself, which is often misunderstood:

> *When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances (*Tarasoff v. Regents of the University of California*, 1976, p. 431).*

With *Tarasoff* the control through hospitalization is not the only method of protecting others; hospitalization is not even mentioned. As mentioned before, failure to hospitalize was protected by statutory immunity in California. So how did the Court find an exception to the general rule of nonresponsibility? With the help of a then recent law review article (Fleming & Maximov, 1974), the court interpreted the "Special Relation" exception of the Restatement (Second) of Torts, requiring "control" (American Law Institute, 1965), to mean that even in outpatient treatment, the therapist has enough control or influence over the patient so as to have a duty to protect other persons from the potential violent acts of the patient.

The Tarasoff Principle is a duty to protect, that is, to take any reasonable steps to protect. This is not simply a duty to warn, although protective disclosures are the only measures explicitly specified in this principle. The principle does not require that the patient must have expressed a threat to trigger the duty to take protective action: the psychotherapist could have identified a serious danger by any conceivable means, perhaps even a "gut feeling." Or the therapist could have come to this determination by following the standards of his profession, standards that the American Psychiatric Association asserted were nonexistent, in their amicus brief to the Court (American Psychiatric Association, 1974). In fact, this most unclear "foreseeability" determination could be left to the fact-finder without the testimony and cross-examination of a professional peer or expert witness, that would typically be required in malpractice lawsuits.

The jurisprudence of the mental health clinician's duty to warn or protect potential victims of a patient's serious danger has become diverse and inconsistent. Clinicians must familiarize themselves with the relevant jurisdictional laws. Texas, for example, has no clinical duty to warn, to control or protect (*Thapar v. Zezulka*, 1999) whereas the Washington Supreme Court has formulated a duty so broad that clinician's duties go beyond protective disclosures and measures to control the potentially violent patient (*Volk v. DeMeerleer*, 2016).

Unlike protection through hospitalizing the patient, protective disclosures do create a confidentiality versus protective disclosure dilemma. The disclosure could be to anyone who is thought to be at risk. Depending on the circumstances, protective disclosure can have adverse consequences for the patient, for example, job dismissal after an employer is warned or divorce after a spouse is warned. Relational or financial harm to the patient

can mean legal liability for the clinician; and even without harm to anyone, disciplinary action from one's professional ethical board. In advancing protective disclosures as methods of protection under the new Tarasoff duty to protect, the California Supreme Court declared, "The protective privilege ends where the public peril begins" (*Tarasoff v. Regents of the University of California*, 1976, p. 347). Although a mellifluous and memorable alliteration, Justice Tobriner's statement was misleading in that protective disclosures are not in violation of privileged communication but of patient-physician/therapist confidentiality.

Impulsive aggression often occurs together with and may be considered as symptomatic and even diagnostic of antisocial and borderline personality disorders. If the aggression can be explained by one of these personality disorders, then the clinician should not diagnose the patient with IED. However, studies demonstrating pharmacotherapeutic efficacy in treating IED or impulsive aggression were conducted on subjects with antisocial or borderline personality disorder (See Felthous & Stanford, 2015). A Federal Court in Kansas upheld a claim of failure to warn where the patient's only diagnosis was antisocial personality disorder (*Durflinger v. Artiles*, 1981). In *Doyle v. United States* (1982), a patient with an antisocial personality disorder shot and killed a college police officer. The Federal Court did not consider the act foreseeable because the patient had not threatened that particular police officer but the diagnosis was not a factor. In *Jablonski*, the Ninth Circuit upheld a claim of failure to warn where a patient diagnosed first with schizophrenic reaction, and then personality disorder with explosive features, killed the woman with whom he was living (*Jablonski by Pahls v. United States*, 1983).

Today's APA ethics code, in comparison with earlier editions, is more permissive of protective disclosures where the psychiatrist has concluded that such disclosure is necessary to prevent serious harm (American Psychiatric Association, 2013a, 2013b). Clinicians must nonetheless attend to jurisdictional law concerning both confidentiality and protective duties, as one can err in either direction, with resulting liability or other consequences.

## The Duty of "Due Care"

From the inception of the Tarasoff Principle in 1976 to today, there have been several attempts to summarize this ever changing law

(Felthous, 1989a, 1989b; Felthous & Kachigian, 2001; Felthous & Kachigian, 2017; Walcott, Cerundolo, & Beck, 2001). After a period of remarkable diversification of this jurisprudence in the 1980s, courts at the end of the century appeared to be backing away from, limiting or rejecting Tarasoff-like duties (Felthous & Kachigian, 2001).

In the more recent publication of The Restatement (Third) of Torts, the American Law Institute inserted a new section, § 41, with a subsection directly addressing the diverse rules that have developed since the California Supreme Court rendered its more expansive interpretation of the Special Relation exception with its duty to control. The Third Restatement describes a duty of "due care" which was not limited to protective disclosures or hospitalization, but included various aspects of treating, managing, and caring for the patient, which if deficient, could, in the court's view, result in the patient harming others (American Law Institute, 2012). Thus according to the Third Restatement, the due care that the clinician owes to his patient now extends to anyone who could be harmed by the patient. Thus far, courts have not rushed to embrace Section 41 as applied to clinicians.

However, the Washington Supreme Court stands as one court that recently adopted Section 41 (*Volk v. DeMeerleer*, 2016). Previously, the Washington Supreme Court's earlier Section 315 Petersen rule had applied the Tarasoff duty to protect to find a clinician at fault in a case wherein the patient was discharged and then crashed his car into that of another driver, even though the driver's identity was not known in advance (*Petersen v. State*, 1988). In one sense the *Volk* "due care" rule makes sense. Where violence is due to a mental disorder, adequate treatment and safe management, including hospitalization of a potentially dangerous patient, may be more efficacious than protective disclosures alone. In principle, this approach expands the protective options for the clinician, as suggested in the last sentence of the Tarasoff Principle itself ("or to take whatever other steps are reasonably necessary under the circumstances" (p. 431)). At the same time, however, the due care rule also provides the trier of fact greater flexibility in speculating with hindsight what might have been done differently. Unrestrained Monday morning quarterbacking can be especially pernicious when not informed by the relevant standard of practice, as medical negligence, unlike medical malpractice, does not necessarily require expert testimony with opportunity for cross-examination. That a claim of medical negligence can be upheld without courtroom medical testimony is illustrated by the *Volk* case.

## Current Directions in the Duty to Protect

As noted before, several courts began to retreat from Tarasoff in the last decade of the 20th century. Commentators agreed that courts were beginning to reject the Tarasoff Principle (Felthous & Kachigian, 2001; Walcott et al., 2001). But what then are the current directions since the turn of the century? We identified appellate "duty to protect" cases since the turn of the century. Following are highlighted cases both before and after the 2012 publication of the Third Restatement, with close attention to courts that have adopted or referenced Section 41, which expands third-party liability.

## Twenty-First Century Cases Prior to the Third Restatement

### Kentucky

The Commonwealth of Kentucky has a protective disclosure statute (KR § 202A.400 (1986)). Although state courts do not always acknowledge their state's Tarasoff statute (Kachigian & Felthous, 2004), the Sixth Circuit Court of Appeals has found that the facts of cases in Kentucky comported with Kentucky's statute which abrogates a common law duty (*Evans v. Morehead Clinic*, 1988; *Riley v. United Health Care of Hardin*, 1998). In *DeVasier v. James* (2009), the Supreme Court of Kentucky also recognized the duty and its limitations as established by the Kentucky statute. When Rene Cissell was evaluated in a hospital emergency room after having held a knife to his girlfriend's throat and inflicting a small cut, he told the intake nurse of this violent incident and she charted that he had "homicidal ideation," but no such threat was expressed to the attending psychiatrist who decided against hospitalization and released the patient. Cissell had told the clinical social worker that he did not want to harm his girlfriend but did not know if he could control himself. The following day, Cissell stabbed and killed his girlfriend.

Based upon the wording of the Tarasoff statute, the Supreme Court of Kentucky found in favor of the defendant psychiatrist because Cissell had not communicated a threat directly to Dr. James, as required by the statute, thus Dr. James had no duty to warn Cissell's girlfriend. Although the doctor knew of Cissell's recent violence toward his girlfriend, simply "being a threat"

is insufficient to require warning, the only protective measure specified by statute. (For a concise summary, see Martin & Thomas, 2010.)

## Arizona

*Graham v. Value Options, Inc.* (2010)[1] stands *per* se as an example of expansion of the liability application of foreseeability. According to the Arizona Court of Appeals, foreseeability was not necessary to establish a duty, but to establish causation, hence an issue for the jury, not the judge, and a determination of fact, not admissibility. In *Graham* patient Liu shot and killed two individuals he did not know. Previously, he was in treatment with the Regional Behavioral Health Authorities for Maricopa County, and followed primarily by Nurse Practitioner Sherry Young. He eventually showed "relapse indicators" but was assessed to not be a threat to himself or others. Because of his delusions, hallucinations, and difficulty functioning, Young recommended increasing evaluations from quarterly to monthly, home visits, and monthly psychiatric assessments to address dangerousness. Liu cancelled appointments and became difficult to contact. Eventually, Liu shot his victims. One of the victims' families filed suit, a claim against Value Options-AZ, alleging neglectful monitoring of Liu and failure in their duty to seek a court order for confinement and involuntary treatment. This claim asserted negligence, medical negligence, and independent negligence by the state. The jury trial awarded the Grahams $11 million as compensatory damages and $25 million in punitive damages.

The Arizona Court of Appeals upheld the compensatory but not the punitive award. This case appears to recognize potential liability for failing to hospitalize a psychotic patient who is not making violent threats and a duty to protect the general public including unidentified victims not limited by Arizona's earlier zone of danger rule (*Hamman v. County of Maricopa*, 1989). Arizona had enacted a Tarasoff statute in 1989 (Ariz. Rev. Stat. § 36-517.02 (2015)). In an earlier duty to protect case the Court of Appeals failed to reference the statute (*Tamsen v. Weber*, 1990). In a subsequent case the court found the state's Tarasoff statute to be unconstitutional (*Little v. All Phoenix South Community Mental Health Center*, 1995). Not surprisingly, the Court of Appeals made no mention of the state's Tarasoff statute in *Graham*.

[1] *Graham* was not published and created neither legal precedent nor persuasive application under Arizona Supreme Court rules (Ariz. R. Sup. Ct. 111(c)).

## Colorado

Similar to Kentucky but dissimilar from Arizona, Colorado's courts have analyzed duty to protect cases based upon its Tarasoff statute (Colo. Rev. Stat. 13-21-117 (2016)). The Court of Appeals used the statute in analyzing the case and found that it created a duty. In *Fredericks v. Jonsson* (2010) the Colorado Probation Department asked for a mental health evaluation to assess, among other items, Wellington's risk for reoffending, victimizing, and violent and aggressive behavior. Psychologist Dr. Jonsson conducted the evaluation. The court opinion does not mention whether she made a judgment about his risk, but according to her evaluation and Wellington's deposition testimony, "Wellington told Dr. Jonsson that he used to have frequent violent fantasies involving family members of the Fredericks family but that he no longer had violent thoughts directed at them" (p. 1098). Two weeks after Dr. Jonsson submitted her report, Wellington became intoxicated, stole a car, drove to the Fredericks' home, and apparently attempted to enter the home by breaking a window. The Fredericks filed a complaint against Dr. Jonsson "claiming that she negligently failed to warn them or the probation department of the dangers" (p. 1098) Wellington posed to them. The Tenth Circuit interpreted Colorado's Tarasoff Statute to mean, "… the mental health provider has a duty to warn only when the patient himself predicts his violent behavior (by communicating—that is, expressing—his threat to the mental-health provider)" (p. 1105). Because Wellington did not tell Dr. Jonsson that he was dangerous, the Tenth Circuit found that Dr. Jonsson was not liable under Colorado's Tarasoff statute and supported the summary judgment granted by the district court.

In general, the literature and jurisprudence are divided on whether it is the risk of violence or the expressed threat that can trigger a duty to issue a protective warning (Felthous, 2006). From the Tenth Circuit's interpretation of Colorado's Tarasoff statute, it is the expressed threat, specifically: "[a] serious threat of imminent physical violence against a specific person or persons" (Col. Rev. Stat. § 13-21-117 (2016)) (for further analysis of *Fredericks* see Maxey, Wortzel, & Martinez, 2011).

## Massachusetts

In *Shea v. Cartinas Hospital, Inc.* (2011), the Appeals Court of Massachusetts gave careful attention to the Commonwealth's Tarasoff statute (Mass. Gen. Law Ch. 123 § 36B(1)(b) (2018)). Potter was brought to the emergency

room where he manifested evidence of mental instability. He was paranoid, disorganized, confused, and depressed and had a history of violent behavior, but he was thought to be in good self-control. He denied hallucinations and thoughts of suicide and homicide. He was admitted voluntarily and assessed to be "impulsive and a noncompliance risk but not a danger to himself or others" (p. 530). He was admitted voluntarily but requested to be discharged the next day. He had made no homicidal statements during his brief stay. He was discharged against medical advice whereupon the following day he met with a mental health services provider and stated he would not harm his girlfriend or anyone else. In a follow-up assessment by another provider, Potter again denied having thoughts of homicide or suicide. Following this assessment, Potter returned to the home of his mother and stepfather and stabbed them to death.

The Appeals Court of Massachusetts compared the facts of this case with the Commonwealth's Tarasoff Statute. Potter's history of physical violence was known to the clinicians. However, they had no "reasonable basis to believe there [was] a clear and present danger" and there was no "reasonably identified victim" (p. 530) as required by statute. Therefore the Appeals Court affirmed the summary judgment of the trial court.

## Twenty-First Century Cases Since the Third Restatement Louisiana

The Third Restatement was published in 2012, but it was not cited in *Brice v. Braggs* (2017) wherein the Court supported the trial court's summary judgment in favor of the psychiatrist, because the conditions of Louisiana's Tarasoff statute for triggering the duty to warn or protect were not met. In *Brice*, the psychiatrist stated that he did not have knowledge that the patient, who attacked a nurse during a home visit, had a history of violence or being violent.

This is consistent with prior Court of Appeals decisions in Louisiana. In *Grady v. Riley* (2002) and *Clark v. Baird* (1998) the Court found that the case did not meet the statutory conditions and in *Barbarin v. Dudley* (2000), *Durapau v. Jenkins* (1995), and *Hines v. Bick* (1990) the cases also did not meet the statutory conditions, but the Fourth Circuit Court of Appeals indicated that Louisiana may still have a common law duty (Kachigian & Felthous, 2004).

## Montana

In Montana the clinician's duty to warn or protect is governed by its Tarasoff statute (Mont. Code. Ann. § 27-1-1102 (1987)). A district court issued summary judgment for the defendant, finding that the following three requirements of the statute were not present: (1) An actual threat of physical violence, (2) by specific means, (3) against a clearly identified or reasonably identifiable victim (*Gudmundsen v. State*, 2009), citing the *DeVasier* decision of Kentucky requiring a verbal threat over "being a threat" as critical to the statutory duty in that state. In a 2010 case, the Supreme Court of Montana found that the statutory duty was met, that is, "we considered a man's statement that he would kill his wife with his bare hands if she ever called the police to constitute an actual threat of physical violence by specific means against an identified victim" (*In re Mental Health of M.C.D.*, 2010).

Finally, in 2015, the Montana Supreme Court restated its position, in this case supporting a district court's summary judgment granted to the defendant, because there was no evidence of an actual, specific communicated threat (*Woods v. State*, 2015). Schiller had a history of becoming aggressive with his girlfriend when drinking and evaluators acknowledged that interruptions in his relationship with Catherine could result in "high-risk behavior" (p. 1255). Less than one month after his release from Montana State Hospital, Schiller purchased a handgun, his relationship with Catherine ended, and he saw her with a male acquaintance in a bar where Schiller was drinking. After Catherine and her companion left the bar, Schiller assaulted her companion and shot and killed Catherine. In supporting the district court's summary judgment, the Montana Supreme Court explained, "In this state there is no common law in any case where the law is declared by statute" (p. 1258), citing the Montana statute that so states (Section 1-1-108, MCA).

## Vermont

Vermont does not have a Tarasoff statute. The Supreme Court of Vermont is one of only two courts to have cited Section 41 in a Tarasoff-like case, which it considered an evolution of Section 315 of the Second Restatement. In a previous decision, the court adopted the Tarasoff Principle in a case wherein the court expanded the duty and liability to include property damage (arson) but limited the duty and liability to identifiable victims (*Peck v. Counselling Services of Addision County*, 1985). In *Peck*, the Court

relied on the Special Relation exception, Section 315 of the Second Restatement, as had the California Supreme Court in *Tarasoff*.

In *Kuligoski v. Brattleboro Retreat* (2016), E.R., a patient at Brattleboro Retreat, a mental health treatment facility, was diagnosed with schizophrenia and transferred to a state hospital. His violent behavior required restraints and he threatened to kill staff members. Despite having stopped his medication and threatening to kill himself, he was discharged. Although outpatient follow-up had been arranged and his mother was instructed to administer his medication, he did not attend his outpatient appointments and did not take medication. About three months later he assaulted a random victim, Michael Kuligoski.

Members of the Kuligoski family filed suit against Brattleboro Retreat and Northeast Kingdom Human Services (NKHS) claiming failure to warn of E.R.'s danger to others, failure to train his parents in how to manage him, failure to treat him, improper release, and negligent undertaking. The superior court found that the defendants owed no duty to the plaintiffs "because Michael Kuligoski was not an identifiable victim and the defendants were under no duty to control" (p. 436).

Despite discussing Section 41, the Vermont Supreme Court did not adopt it. However, in relying on Section 315 of the Second Restatement, the court did not find a duty to the general public. However, in finding that E.R.'s parents had the role as his caretakers, the Court found that the Retreat had a duty to warn E.R.'s parents of his propensity toward violence (*Kuligoski v. Brattleboro Retreat*, 2016).

## Washington

To our knowledge, Section 41 of the Third Restatement has been explicitly integrated into Tarasoff jurisprudence only in the State of Washington. In *Volk v. DeMeerleer* (2016), the Washington State Supreme Court extended the clinician's duty to protect third persons from a patient who was undergoing outpatient psychiatric treatment. The patient James DeMeerleer had not been hospitalized and had not expressed a threat to harm his victims. Years before, he expressed thoughts of suicide and homicide upon learning his wife was having an affair and was going to divorce him but he assured his psychiatrist he would not act on such thoughts. In the course of treatment, DeMeerleer showed evidence of aggressive behavior, emotional distress and mental instability, and poor medication compliance but neither psychotic nor threatening behavior. He subsequently began

dating a woman, Schiering. At some point, their relationship also ended. In his last visit with Dr. Ashby, DeMeerleer's condition had shown some improvement.

Around four months following DeMeerleer's last appointment with Dr. Ashby, he entered the house of Schiering, his ex-girlfriend, and shot and killed her and her son. He attempted to slash the throat of another son who managed to flee. Sometime after DeMeerleer's last visit with Dr. Ashby, he and Schiering mended their relationship but then ended it.

Schiering's mother, Beverly Volk, and Winkler (Schiering's older son) filed medical negligence and medical malpractice claims against Dr. Ashby and the Clinic. Defendants argued that the actual act of violence was not foreseeable, so the only protective recourse would have been civil commitment but that Washington's Tarasoff statute (Wash. Rev. Code § 71.05.120(2) (2016)) would have provided immunity because DeMeerleer never communicated to Dr. Ashby "an actual threat of physical violence against a reasonably identifiable victim or victims" (Wash. Rev. Code § 71.05.120 (2) (2016)).

The Washington Supreme Court heard the case on appeal and decided that medical malpractice claims pertain only to the duty of care the physician owes to her/his patient, not to nonpatient third persons. The Washington Supreme Court sustained the claim of medical negligence which in contrast to medical malpractice can extend the protective duty of due care to nonpatients. Unlike medical malpractice, medical negligence does not require expert courtroom testimony with the opportunity of cross-examination. The instant case referred to an affidavit completed by an expert witness, but there was no courtroom testimony regarding the medical standard, duty, or breach of duty.

## Summary of Appellate Decisions in the 21st Century

The most recent cases in Tarasoff jurisprudence continued to show the diversity of opinions observed in the 1980s but with third-party liability constrained in several states (Colorado, Kentucky, Louisiana, Massachusetts, and Montana) by the state's Tarasoff statute. In general, courts respected the legislature's intent of defining and limiting the duty, more than was evident from an earlier survey of court responses to Tarasoff statutes (Kachigian & Felthous, 2004). Other courts expanded Tarasoff liability without requiring a threat of violence or an identifiable victim (Arizona, Vermont, and Washington), the Washington Supreme Court by adopting Section 41 of

the Third Restatement; the Vermont Supreme Court without adopting Section 41.

## Measures That May Protect the Clinician and Other Persons

Any measure that protects other persons from the patient's violent acts may also protect the clinician from third-party liability simply by preventing the damage that is essential for tort claims. This is not to conclude that all legal requirements actually reduce the risk of violence. According to one study, states with Tarasoff statutes requiring protective disclosures are associated with higher rates of homicide (Edwards, 2013). Although the study does not prove that warning the victim and police increases the risk of physical harm, it suggests the need for further examination as to whether and how disclosures are protective (Felthous & Kachigian, 2017). The California legislature amended its Tarasoff statute and changed the duty from one of warning to one of protection because of concern that in certain circumstances warnings themselves can be potentially counterproductive (Weinstock, Bonnici, Seroussi, & Leong, 2014).

### Know the Law

The uncertain effectiveness of legally required protective measures notwithstanding, legal practice is ethical practice. The ethics code of the American Psychiatric Association essentially states that it is unethical to practice psychiatry in violation of legal requirements (American Psychiatric Association, 2013a, 2013b). Thus it behooves clinicians to become familiar with the third-party jurisprudence by which their practice is regulated. In doing so, the clinician must turn to both statutory law (e.g., Tarasoff statutes and legal regulations of confidentiality and disclosure of health care information) and common law (Felthous & Kachigian, 2017). In some states, clinicians will find that separate jurisdictional laws may be complementary and consistent. Or they can be contrary to one another (Kachigian & Felthous, 2004). Moreover, the legal requirements can change over time. All five district courts in Texas referenced a duty to warn and protect prompting Felthous and Scarano to anticipate that Texas courts would likely accept a qualified Justice Tobriner's dictum in *Tarasoff*, "Privileged communication (or for that matter confidentiality) ends where the public peril begins" (1999, p. 78). The state supreme court subsequently ruled that there is no duty to warn or protect through hospitalization in Texas and clinicians

who issue protective disclosures do so "at their own peril" (*Thapar v. Zezulka*, 1999).

## Risk Assessment

We hesitate to suggest a standard for assessing the risk that a patient will inflict substantial harm on another person. Appelbaum stated early in the evaluation of Tarasoff-like jurisprudence that psychiatrists ought to at least be able to ask the right questions (Appelbaum, 1985); however, even decades later there seems to be little consensus on what those questions might be and the APA has consistently denied through multiple amici briefs with other health professional organizations (APA, 1974; Washington State Medical Association et al., 2017) that psychiatrists possess the ability to accurately predict future violence against others.

Most remarkable is that some authorities, including the California Supreme Court in its Tarasoff Principle and the APA itself in its amicus brief response to *Tarasoff I* (*Tarasoff v. Regents of the University of California*, 1976), would assign clinicians a responsibility to issue protective disclosures or take other measures, if the clinician predicts the violent act, regardless of how the clinician came to that prediction (APA, 1974). For such a duty, there is no professional standard.

Most published cases in this type of third-party jurisprudence do not show that the clinician defendant did or did not conduct a risk assessment to determine whether the patient posed a threat of violence against others. Case factual histories do not typically state whether a risk assessment was performed and documented, an assessment that might have reduced the risk. Perhaps a risk assessment, even abbreviated, could have reduced the likelihood of the incident violent act and resultant professional liability. In *Littleton v. Good Samaritan Hospital* (1988), the Ohio State Supreme Court recognized the common law defense of clinical judgment. Clinicians should not be held liable for honest errors in clinical judgment, but there must be evidence that clinical judgment was in fact exercised. This would include an attempt to assess the risk of violence.

It would exceed the scope of our discussion here to address all acute and long-term risk factors for externally directed violence, still a highly inexact and uncertain science. We can suggest a reasoned, fact-based approach to risk assessment. Appelbaum recommended a three-step approach to managing a potentially violent patient: (1) Assess the patient's dangerousness, (2) select a course of action, and (3) implement this plan (Appelbaum, 1985).

Realizing that a protective plan may require dichotomous protective decisions such as whether to issue warnings or to initiate hospitalization, Felthous proposed an algorithm of critical questions to be addressed in guiding one's protective strategy: (1) Is the patient dangerous to others?; (2) If yes, is his or her dangerousness due to serious mental illness?; (3) If not due to serious mental illness, is the dangerousness imminent?; (4) Are potential victims of the patient's violence reasonably identifiable? (Felthous, 1999). Simon's comments about suicide risk assessment could be applied to risk assessment for homicide which is also "fundamentally a reasoned clinical judgment call" (Simon, 2011, p. 2) for which a determination of high, moderate, or low is preferred to simply documenting whether suicidal or homicidal ideation is present (p. 3). Risk and protective factors must be analyzed and synthesized such that the logic and basis for the determination of risk are transparent.

While a professional standard of care remains elusive, we would recommend that where a patient shows evidence of physically aggressive behavior or threats of violence against others, the clinician should attempt to assess the risk. If the concern arises over a threat against an identifiable potential victim, an attempt should be made to assess the seriousness of the threat, using, for example, the Borum criteria (Borum & Reddy, 2001). Even without a threat, if externalized aggression appears to be an issue, such as when a patient presents with IED, some attempt to assess the risk of serious violence against others should be made, with a conclusion and reasoned response to the conclusion. For example, "This patient presents some elevated risk of violence against others because of his Type 1 IED, but based upon his expressed desire not to physically harm others and his history of not having seriously harmed anyone in the past, he is deemed to be at low risk for such serious harm and safe for continued outpatient treatment and management. I expect that with treatment and monitoring, this risk will be rendered lower yet." Of course, if the patient later acts in a more aggressive and dangerous manner than previously anticipated, the risk will have to be reassessed. Only after clinicians have begun to perform and document risk assessments routinely and this is reflected in another generation of third-party lawsuits, can one comment on the effectiveness of these assessments in preventing violence among psychiatric outpatients. The protective value of risk assessments before discharging NGRI acquittees from hospital care is supported by research. Other measures, such as graduated step-down in security measures and conditional release, certainly contribute to the safe management and favorable outcome in terms of risk of violence of such cases.

## Neutralization of Firearms

When a patient in treatment kills another person, it is often by means of a firearm (Felthous, 1989a, 1989b). Swanson et al. (2015) found that impulsively aggressive individuals tend to possess firearms or have easy access to them. Federal law requires background checks for firearm purchases and prohibits sales to individuals who have been committed or adjudicated as mentally ill or defective and state laws can be more restrictive (Swanson & Felthous, 2015). Whether impulsively aggressive individuals or those diagnosed with IED actually have a higher rate of homicide when they have access to firearms is an empirical question that remains to be investigated. Meanwhile, it is prudent to inquire about firearm access when treating a patient with IED or a patient who has threatened personal violence and to gain the patient's cooperation in having firearms removed from his access at least while his impulsive aggression is poorly controlled (Felthous & Kachigian, 2017).

## Appropriate Treatment

Not explicitly included within the Tarasoff Principle, or most derivative rules extending a protective duty to nonpatients, is the possibility of reducing the risk of violence by providing effective treatment including pharmacotherapy. Treatment is more explicitly included in the due care rule of § 41 and in Washington Supreme Court's *Volk* decision. As applied to IED, efficacious pharmacotherapy of the patient may be protective and reduce the need for protective disclosures or hospitalization. Although evidence supports the efficacy and propriety of pharmacotherapy with an antiimpulsive aggression agent (AIAA) (Felthous, 2013; Felthous, Lake, Rundle, & Stanford, 2013; Felthous & Stanford, 2015; Coccaro & Kavoussi, 1997; Coccaro, Lee, & Kavoussi, 2009; Stanford et al., 2001), the use of an AIAA alone may not mitigate liability in a case involving impulsive aggression, in that no AIAA has been approved by the FDA for treatment of IED. Many physicians and psychiatrists may be unfamiliar and unpracticed in the pharmacotherapy of IED, creating doubt as to the actual "standard of practice." And ultimately, efficacious pharmacotherapy may involve art and skill as much as reliable science.

Personality disorder alone, and particularly antisocial personality or psychopathy, are not typically strong justifications for involuntary mental health services, even when coupled with dangerousness (Winick, LoPiccolo, Anand, & Hartswick, 2007). Nonetheless, when the duty is expanded from

one of controlling a potentially dangerous patient through hospitalization to the broader duty of warning and/or protecting other, nonpatients, diagnosis matters less (Felthous, O'Shaughnessy, Kuten, François-Pursell, & Medrano, 2007), except for the association between antisocial and psychopathic disorders and aggressive behaviors (e.g., *Durflinger v. Artiles*, 1981).

## Conclusions

The diagnosis of IED or of impulsive aggression is not made in the majority of published cases concerning the clinician's duty to warn or protect others of his or her patient's potential for violence. The Tarasoff type of professional liability varies from state to state, thus clinicians must become familiar with their relevant jurisdictional law. Whether a violent act was considered foreseeable and therefore supportive of actionable negligence depends on the specific circumstances, nature of the impulsive aggression, and jurisdictional law. If the impulsive act is seen as one as having occurred "out of the blue" and without any warning or indication of aggression, courts would be less likely to decide in favor of the plaintiff. But like suicide (e.g., Busch, Fawcett, & Jacobs, 2003), violent and homicidal acts can occur without threats or warnings. Some courts have found other evidence of foreseeability. It therefore behooves the prudent physician to conduct and document an assessment of risk, however imprecise such assessment may be, and to monitor and manage the risk by whatever means are clinically indicated, not limited to hospitalization and warning potential victims, such as by providing psychoeducation to the family and patient, pharmacotherapy, increasing outpatient visits, and/or implementing evidence-based therapies.

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