THE FUTURE OF "THE DUTY TO PROECT": SCIENTIFIC AND LEGAL PERSPECTIVES ON *TARASOFF'S* THIRTIETH ANNIVERSARY

SYMPOSIUM INTRODUCTION

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Tarasoff v. Regents of the University of California,[1] the seminal case establishing a therapist's civil liability for her patient's violence toward third parties, is as significant today as it was controversial in 1976.[2] *Tarasoff* has had a "unique impact" both on "law-and-mental-health scholarship" and on "day-to-day mental health practice."[3] Legal decisionmakers and commentators remain divided on the wisdom and proper application of *Tarasoff*. Courts and legislatures have embraced, expanded, restricted or rejected *Tarasoff's* basic premise that mental health professionals have a duty to predict which of their patients will commit acts of violence and to protect third parties from that violence.[4]

At its heart, this doctrine imposes civil liability on a therapist for failing to make reasonable assessments of the likelihood that a patient will inflict violence on a third party or to take sufficient steps to prevent that violence. While this core doctrine can be stated simply, its periphery cannot be defined neatly. The "*Tarasoff* doctrine" or "*Tarasoff* principles" refer to a varied collection of common law and statutory provisions that differ on, among other things, the nature and scope of the therapist's duty, the parties to whom the therapist owes the duty, the dangers that the therapist is expected to anticipate and respond to, the other professions (if any) that are subject to this duty, and the

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1. 551 P.2d 334 (1976).

2. For a concise summary of the content and tenor of the "torrent" of criticism unleashed by the *Tarasoff* decision, see Michael L. Perlin, "*You Got No Secrets to Conceal": Considering the Application of the* Tarasoff *Doctrine Abroad*, 75 U. CIN. L. REV. 611, 615–16 (2006).

3. Douglas Mossman, *Critique of Pure Risk Assessment, or Kant Meets* Tarasoff, 75 U. CIN. L. REV. 523, 526 (2006); *id.* at 524, 526 (citing Thomas G. Gutheil, *Moral Justification for* Tarasoff-*Type Warnings and Breach of Confidentiality: A Clinician's Perspective*, 19 BEHAV. SCI. & L. 345, 345 (2001) (asserting that "no court ruling has had a broader or more enduring impact on day-to-day mental health practice")); *id.* at 524 (after thirty years, "*Tarasoff* remains, to mental health professionals, the most influential ruling in mental disability law").

4. These distinctions are discussed in several of the Symposium articles. *See, e.g.*, Christopher Slobogin, Tarasoff *as a Duty to Treat: Insights from Criminal Law*, 75 U. CIN. L. REV. 645, 645–46 (2006); Mossman, *supra* note 3, at 529 n.26.

measures that may or will satisfy that duty. Moreover, the medical, scientific and policy judgments that undergird *Tarasoff* decisions need to be revisited regularly to reflect and respond to new developments and approaches in violence risk assessment, violence prevention, mental health services, and theories and developments in tort liability.

This Symposium brings together some of the nation's leading experts on law and mental health to discuss the most recent scientific advances and best practices in violence risk assessment and mental health care and to contribute fresh ideas about the principles supporting or opposing the imposition of this tort liability. They examine legal and ethical principles that justify or undermine *Tarasoff* liability, developments in violence risk assessments that make violence predictions more realistic and reliable, and changes in mental health practices that may make *Tarasoff* interventions less onerous for some patients. They expose how the easy certainty of language used in law or science masks the uncertainty of real-world challenges and decisions. Their work reflects respect and concern for all the individuals whose interests play out in *Tarasoff* situations: the patients whose privacy or liberty may be sacrificed in the service of public policy, the identified victims whose lives or well-being are at risk, the therapists faced with the dilemma of fulfilling competing and often incompatible duties, and the larger population, including people concerned about public safety or about the availability of confidential counseling services.

In short, the papers in this Symposium examine the application and implications of *Tarasoff*—past, present and future—and analyze its virtues, shortcomings, risks and promises. This Introduction begins with a brief recap of the 1976 decision that launched three decades of litigation, legislation and literature, then provides an overview of recurring themes, concerns and recommendations presented by the authors in this Symposium.

I. THE BIRTH OF *TARASOFF*

Professor Mossman recounts the story of *Tarasoff v. Regents* in engaging and helpful detail,[5] so a brief description will serve here. In the events leading to the *Tarasoff* decision, the therapist took seriously his patient's threat to kill a young woman, Tatiana Tarasoff, who had spurned the patient's advances. The therapist concluded that the patient, Prosenjit Poddar, a graduate student and an outpatient, was potentially dangerous and should be committed for observation. He promptly

5. *See* Mossman, *supra* note 2, at Part II.A.

alerted college law enforcement officers about Poddar's threat and sought their cooperation in having Poddar hospitalized. The campus police interviewed Poddar, but concluded that he seemed rational and could not legally be confined. Accordingly, they released him. The concerned therapist consulted his hospital's director of mental health, who instructed him to do nothing further.

Not surprisingly, Poddar did not return to this (or any other) therapist. Two months later, however, after Tarasoff had returned from her summer abroad, he went to her home, stabbed her to death with a knife, and promptly called the police to turn himself in.

In a negligence case brought by Tatiana's parents, a sharply divided California Supreme Court held that the parents had stated a claim for negligence against the therapist, the hospital where he worked and the other doctors whom he consulted about this matter. The court held that therapists can have a legal duty to protect third parties from harm by their patients, despite the absence of any "special relationship" between the therapist and the third party. That duty has two components. First, the therapist must assess the likelihood that the patient will act violently. Second, if the therapist identifies a sufficient risk of violence, she must take steps to prevent that violence; those steps might include warning the intended victim, confining the patient, or modifying or intensifying the outpatient treatment to address the violent urges or actions.

Both the majority and the dissent recognized (as they had to) that the therapist fulfilled the first of these two duties: he assessed his patient's potential for violence and reasonably (and, alas, accurately) determined that the patient was likely to follow through on his threats. The majority was not so approving of the therapist's attempt to forestall that violence. Notifying law enforcement was not necessarily enough. Rather, the court held that Tatiana's parents could state a negligence claim based on the therapist's failure to warn Tatiana or them about the threat.[6]

The majority opinion seems to confirm Professor Douglas Mossman's view that judges, like others, resolve "complex moral and legal issues . . . [by] com[ing] to a conclusion, then fill[ing] in a rationale."[7] Indeed, the court acknowledged that its recognition of a therapist's duty toward third parties was a "conclusory expression" of its view that

6. As Dr. Mossman astutely observes, it was impracticable to try to warn the young woman, as she was in Brazil for the summer. Her absence also meant that the threatened harm was not "imminent," as she was safely out of reach. For a critique of this "imminence" standard, see Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and the Law*, 75 U. CIN. L. REV. 631 (2006). Moreover, even had the therapist succeeded in having Poddar civilly committed, that confinement could not last indefinitely, and, absent more, almost certainly would not have continued throughout the intervening two months.

7. Mossman, *supra* note 2 at 535 n.52.

public policy considerations supported the imposition of liability. It emphasized the interests of the victims and others in avoiding physical harm, using dramatic language that made the dangers sound vivid and certain: "In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal."[8] At the same time, the opinion minimized the other interests at stake.[9]

The *Tarasoff* dissent accused the majority of sidestepping or dismissing important legal, scientific and ethical obstacles to reach its result. In the dissenters' view, requiring a therapist to violate the confidences of his patient was impermissible under the law and unwise as public policy. The dissent's principal objections foreshadowed the debates that continue today. Its first objection was legal: In recognizing the therapist's liability to the Tarasoffs, the majority created an exception to the long-standing tort principle that, absent special circumstances or a special relationship, an individual owes a third party neither a general duty of care nor a specific duty to protect against violence. Nor did the dissent see a sound policy reason for this departure. Creating such a duty to warn or protect offered "virtually no benefit to society, [but] . . . w[ould] frustrate psychiatric treatment, invade fundamental patient rights and increase violence."[10]

While the majority focused on prospective victims of violence, the dissent highlighted the interests of patients and therapists. From the patients' perspective, requiring a therapist to disclose patient confidences created yet another obstacle to seeking treatment about intensively private and often painful matters.[11] Once in therapy, patients would hesitate to talk freely and openly about unwelcome violent impulses or ideations.[12] More broadly, when the therapist could not promise confidentiality, it would be harder to build a therapeutic relationship of trust.[13] This, in turn, would undermine therapists' ability to dissuade their patients from violence and to equip them with other,

8. Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 348 (1976); *id.* ("The protective privilege ends where the public peril begins.").

9. *E.g.*, *id.* at 346 ("The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved."); *id.* at 362 (dismissing concerns that the threat of liability will make therapists too readily commit patients); *id.* at 346 (weighing the "uncertain and conjectural character of the alleged damage done the patient" by the issuance of a warning against "the peril to the victim's life").

10. *Id.* at 358.

11. *Id.* at 358–60.

12. *Id.* at 359.

13. *Id.* at 359–60.

more productive responses to their distress.[14]

The therapists, for their part, faced a "Draconian dilemma."[15] If a therapist did not issue a warning, she could be liable for harm inflicted by her patient. If she did warn, she might be held to account for violating her ethical obligation to preserve patient confidences. Compounding the dilemma, no clear legal or professional standards and little judicial guidance existed on how to reconcile these competing duties.[16]

Finally, the dissent objected to imposing a duty on therapists to do what simply was not possible: to accurately predict future violence. The state of the art of violence risk assessment at that time did not allow a therapist to reliably or accurately predict which patients would become violent.[17] The dissent was not comforted by the majority's assurance that the therapist was not required to make accurate predictions, but only to exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of (that professional specialty) under similar circumstances."[18] There was not, the dissent insisted, a recognized standard of care in these circumstances, nor even an expectation that psychiatrists generally would agree about who was dangerous.[19] To the contrary, there was agreement in the profession that "the therapist cannot accurately predict dangerousness,"[20] effectively making this a "standardless" standard of care.

Thus, in 1976, the promise and the pitfalls of *Tarasoff* loomed large. Have thirty years of experience, experimentation and research resolved these controversies? In a word, no, as the divergent opinions expressed in this Symposium attest. While commentators today concede that

14. Indeed, in *Tarasoff* itself, when the therapist notified officials about Poddar, that ended the therapy relationship, and along with it, any chance that the therapist could help Poddar resolve the shame or anger that animated his violent impulses.

15. *Id.* at 358.

16. *Id.* at 361.

17. *Id*. at 360 (citing recognition by "the legal and psychiatric communities" that predicting violence in a patient is "fraught with complexity and uncertainty"); *id.* at 361 n.6 (criticizing the majority for "inform[ing] the therapists that they must accurately predict dangerousness--a task recognized as extremely difficult--or face crushing civil liability"); *see id.* at 354 (Mosk, J., concurring in result and dissenting in part) (citing "an impressive body of literature" and the amicus brief of the American Psychiatric Association as demonstrating that "psychiatric predictions of violence are inherently unreliable").

18. *Id.* at 361 n.6.

19. *Id.*

20. *Id.* (deeming the standard of care "inappropriate for lack of a relevant criterion by which to judge the therapist's decision"). The dissent suggested that violence prediction was a "problem[] that balk[s] at standardization." *Id.* This may be an area in which the science of risk assessment, after thirty years, is poised to overcome this objection, as explained in John Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 497 (2006).

Tarasoff was not the "unmitigated disaster" they once feared,[21] many continue to question its wisdom, workability, fairness and effectiveness.

II. *TARASOFF* AT THIRTY

Contributors to this Symposium shed new light on the *Tarasoff* controversies through provocative proposals, expert analysis, and an array of competing perspectives and opinions. Four broad themes or questions recur in these diverse writings. First, can we, in fact, predict violence? Are there accurate methods or instruments available, and are they usable and used in clinical settings? Second, even if therapists make (or can learn to make) accurate predictions about future violence, how do we want them to respond to such a prediction? What course of action best accommodates the needs and interests of the patient, the intended victim, the therapist and the broader community? Third, if we require mental health professionals to fulfill the public safety function of protecting third parties, is there a principled reason for assigning that duty to them, but not to other health care professionals or other groups of people? What, if anything, distinguishes therapists from medical doctors, lawyers, or ordinary citizens who have no duty to avert danger to third persons? Finally, what does the future hold for *Tarasoff*? What legal, medical, social or scientific developments might inform the continued development—or bring about the ultimate demise—of this doctrine? At the risk of doing an injustice to the thorough inquiries and nuanced positions of the Symposium contributors, I will briefly highlight and synthesize some of their insights on these issues.

A. The Predictability of Violence

In 1976, when *Tarasoff* was decided, violence risk assessments were notoriously unreliable, inviting well-founded objections to the unfairness of imposing civil liability on a practitioner who fails to predict what is largely unpredictable.[22] But as Professor John Monahan comments in this Symposium, "what a difference three decades make."[23] Today, the field of violence risk assessment, a "vast and vibrant area of

21. ALAN A. STONE, LAW, PSYCHIATRY, AND MORALITY: ESSAYS AND ANALYSIS 161, 181 (1984); *cf.* Alan Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

22. For examples of commentary and analyses following the *Tarasoff* decision, see Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 734–35 (1974); Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 600 (1978).

23. Monahan, *supra* note 20, at 497.

interdisciplinary scholarship," offers new tools that rely on empirically validated criteria to assess an individual's risk of violence.[24] The most promising advance has been the development and validation of new instruments for "structured risk assessments." Research demonstrates that these assessments, which focus on objective criteria, provide more accurate indications of future violence than do assessments based purely on subjective professional judgment, the principal method used today.

Monahan himself, recognized as one of the nation's premier violence researchers, advocates making dangerousness determinations based on a combination of objective criteria and professional judgment. In his model, the Classification of Violence Risk (COVR), as in others, the first step in the evaluation is a structured risk assessment, considering a predetermined set of variables that have been empirically proved to correlate to future violence. The patient is assigned a score for each applicable factor. The evaluator then combines these scores to produce an overall estimate of risk of violence.[25] While other structured assessment models would stop here, COVR contemplates that this report will not displace, but inform, clinical review, using the evaluator's observations and professional judgment. To make a final estimate of risk, the evaluator may consider the risk assessment along with clinical observations, information from the patient's family or friends, and available hospital or criminal records.

This and other breakthrough techniques in violence risk assessment, if widely implemented, could alleviate many, but certainly not all, objections to obligating mental health professionals to make violence predictions under *Tarasoff*. The problem, as seen by Professors Robert Simon and Douglas Mossman, is not only in the science, but in the fit between the science and the law. Professor Simon focuses on the shortcomings in predictions of "imminent" danger, when there is no clear concept of "imminence" and no effective way to predict immediate or short-term danger.[26] Existing research addresses the *prevalence* of violence during longer specified periods (say, 150 days), but "we know

24. *Id.*

25. *Id.* at 507–09.

26. Simon, *supra* note 6, at 631. "Imminence" is included in many civil commitment and duty to warn or protect statutes. *Id.* (citing Christopher Slobogin, *Involuntary Community Treatment of People Who Are Violent and Mentally Ill: A Legal Analysis*, 45 HOSP. COMMUNITY PSYCHIATRY 711, 712 (1994)). Thus, while "imminence" is not "a psychiatric or medical term," current legal standards and practices make "imminence" relevant to mental health professionals who are asked to express "dangerousness" opinions for courts and to base their own decisions on the "imminent" threat of danger from a patient. The profession's uneasy relationship with the concept is seen in the 1995 deletion—and the 1998 "mysterious[] reappear[ance]"—of references to "imminence" in the APA's ethical guidelines on revealing confidential information from a patient who presents a significant risk of danger. *Id.* at 638.

little about the *imminence* of violent behavior," such as the extent to which violence occurs in the first days following discharge from an institution.[27] Alternative terms, such as "in the foreseeable future" or "impending" or "in the near future," suffer the same flaws.[28]

Professor Mossman points out that more sophisticated measures of the likelihood that a patient will be violent do nothing to determine the likelihood of violence that is serious enough to warrant certain responses, such as a *Tarasoff* warning or civil commitment. In other words, answering the science question does not answer the policy question: what is the threshold of risk that we as a society are willing to accept in order to avoid institutionalizing non-dangerous people?[29] Dangerousness determinations, Mossman reminds us, are not the binary questions some courts envision, where the patient is either dangerous or not, the risk is either acceptable or not, and the chosen means of violence intervention is either effective or not. Instead, predictions of violence reflect different probabilities of risk of different types and degrees of harm. Therapists have little direction from courts or legislatures as to the level of risk that justifies—indeed requires—a particular protective measure, such as a warning.[30] The courts that enforce and in some cases create the *Tarasoff* duty have never suggested the proper risk threshold. In fact, in a recent study that asked judges what minimum level of risk of violence would justify a civil commitment, the respondents' answers varied wildly from *one to fifty-six percent*.[31] Although statutes and case law may specify that the therapist must protect third parties only against a "significant" or

27. *Id.* (citing JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE 31 (2001)).

28. *Id.*

29. Mossman, *supra* note 3, at 577.

30. *Id.* at 602.

31. *Id.* at 577 (citing John Monahan & Eric Silver, *Judicial Decision Thresholds for Violence Risk Management*, 2 INT'L J. FORENSIC MENTAL HEALTH 1, 4 (2003)). For the proposition that a one percent risk warrants action is controversial, even in the context of avoiding a cataclysmic terrorist attack, see RON SUSKIND, THE ONE PERCENT DOCTRINE (2006) (chronicling the struggles within the federal government in response to Vice President Cheney's mandate that possible terrorist threats with even a one percent likelihood must be treated as certainties).

Nor is there a consensus in society or even among mental health professionals, according to Professor Mossman's empirical research. *See* Mossman, *supra* note 3, at 571 (citing Douglas Mossman & Kathleen J. Hart, *How Bad Is Civil Commitment? A Study of Attitudes Toward Violence and Involuntary Hospitalization*, 21 BULL. AM. ACAD. PSYCHIATRY L. 181, 182–90 (1993), and unpublished research). Mossman and his colleague asked their subjects which they considered worse, being attacked by a man wielding a knife or spending varying amounts of time as a psychiatric inpatient. One in ten mental health professionals would rather be attacked by an assailant with a knife than to spend even a week as an inpatient; an equal number said they would be willing to spend two years or more in a hospital to avoid the knife attack. *Id.*

"substantial" risk, therapists generally are left to determine on the spot and on their own how much risk is "significant" for these purposes, subject to possible judicial review—or second-guessing. Accordingly, more accurate predictions of dangerousness are necessary, but not sufficient, to clarify the therapist's duties under *Tarasoff*.

B. The Therapist's Role

Assume for the moment that newer, more accurate risk assessment tools and clearer standards from the courts make meaningful violence predictions feasible. This does not necessarily make it appropriate or even useful to expect therapists to predict their patients' violent conduct and intervene to prevent it, as expressed in several Symposium papers. Professor Simon puts it succinctly: "The psychiatrists' stock-in-trade is the treatment and management of acutely mentally ill patients. Treatment and risk reduction, not prediction, is their appropriate focus."[32] In other words, the clinician's role "is to identify, assess and aggressively treat the individual patient who is at risk for violence," not to attempt to quantify that risk or place it on a scale.[33]

Moreover, under *Tarasoff*, identifying or quantifying a violence risk does not discharge the therapist's duties. He then has to decide how to respond to it: Notify authorities, warn any likely victims, attempt to dissuade or confine the patient? And what are the consequences of those choices for the therapist and his patient? If the therapist does too little, he faces *Tarasoff* liability; if he does too much, he violates his ethical duty of confidentiality. Worse, his intervention on behalf of a third party may compromise or even destroy his therapeutic relationship with the patient, leaving the patient to manage or direct his violent impulses on his own.

Professor Mossman calls attention to the ethical dimensions of the therapist's "choice," as framed and constrained by *Tarasoff*. Too often, he observes, when courts or legislatures are weighing these "mental patient vs. public good" trade-offs, they make public safety "paramount," discounting or dismissing the patient's best interests, including his significant interests in safeguarding his privacy and avoiding commitment to a mental hospital.[34] The underlying and

32. Simon, *supra* note 6, at 639.

33. *Id.* To illustrate the irrelevance of prediction, Simon uses an example offered earlier by Mossman: If a patient is at risk for serious violence, a mental health professional will "exercise high levels of concern in making follow-up plans and other treatment arrangements," whether the risk would be pegged at ten or fifty percent." *Id.* at 640 (citing Douglas Mossman, *Commentary: Assessing the Risk of Violence—Are "Accurate" Predictions Useful?*, 28 J. AM. ACAD. PSYCHIATRY L. 272–81 (2000)).

34. Mossman, *supra* note 3, at 578.

usually unspoken justification is that "[w]hat is good for the individual must be sacrificed for the (greater) good of society."[35] This, asserts Mossman, "should cause ethical discomfort."[36] Indeed, he argues that this one-sided calculus violates Immanuel Kant's "categorical imperative," which prohibits using any person only as a means, and not also as an end in him or herself.[37]

Thus, Mossman's first objection to *Tarasoff* liability—that it privileges third parties and shortchanges patients—is moral. The second is practical: therapists are asked to determine the degree of risk and the proportionate response to it without knowing what level of risk society (or a future jury) will consider socially acceptable. Mossman would revise *Tarasoff* to respond to both criticisms: A therapist would have a duty to intervene to protect a third party only in response to a patient's explicit, credible threat of violence. This takes the "guesswork" out of violence predictions, allowing the therapist to respond to what the patient has said and done, not anticipate what he might do. Fulfilling this duty to protect a third party may require breaching the patient's confidentiality with a *Tarasoff* warning or curtailing the patient's freedom through involuntary commitment. Mossman concludes that these actions are consonant with a therapist's Kantian duty to the patient because "preventing the patient from harming a victim. . . . is . . . beneficial to the patient him or herself," because "the patient is spared the emotional, legal, and social consequences of having harmed another, perhaps while mentally impaired."[38]

Professor Christopher Slobogin recommends a similar trigger for *Tarasoff* liability,[39] but a more limited *Tarasoff* duty. He identifies the therapist's ability and authority to treat the patient as the justification for imposing *Tarasoff* liability. It is mental health professionals' *ability* to treat that singles them out for the corresponding *responsibility* to treat a

35. *Id.*

36. *Id.*

37. *Id.* at 581 ("Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end." (quoting IMMANUEL KANT, GROUNDWORK OF THE METAPHYSIC OF MORALS 96 (H.J. Paton trans., Harper & Row 1964))); *id.* at 586 (explaining that "countenancing needless confinement as a statistical consequence of clinicians' imperfect predictions . . . explicitly treats nonviolent patients' loss of freedom as a means toward the end of protecting other members of society").

38. *Id.* at 599. Protective action also is justified under a Kantian analysis because it is universalizable; the "categorical imperative" requires that your actions be based on a principle that you would "will that it should be universal law." *Id.* "[B]y averting violence, the action brings the world closer to an ideal in which no one improperly impinges (through violence or other means) on the freedom of others." *Id.*

39. Slobogin, *supra* note 4, at 647 (suggesting that therapist has *Tarasoff* duty only when he knows that his patient has threatened serious bodily harm to an identifiable victim).

potentially violent patient. Slobogin therefore would define the *Tarasoff* duty as a *duty to treat*, not a duty to predict, to protect or to warn.[40] Those other duties, he explains, are not the exclusive province of mental health professionals. They do not derive from any professional training, expertise or authority, and there is no sound argument that therapists are uniquely qualified (or even more qualified than others) to recognize a threat and report it to a third party. Accordingly, there is no justification for "saddling them" with liability for failing to take those actions—unless we are willing to create a general duty for non-clinicians to prevent harm to third parties.[41] This, of course, would be a radical departure from the tort principle that, absent special circumstances or a special relationship, such as parent-child or principal-agent, a person cannot be held liable for harm that another person inflicted on a third party.

C. Limiting Principles

Professor Slobogin's arguments distinguishing mental health professionals from other professionals (doctors, lawyers, teachers and the like) and laypeople are directly relevant to a third recurring theme in post-*Tarasoff* litigation and literature, including this Symposium: If we hold therapists liable for violent acts by their patients under some version of *Tarasoff*, is there a principled basis for limiting that liability to mental health professionals? Or do fairness and sound public policy call for assigning similar protective duties to other professionals, such as professors or lawyers, or even to ordinary citizens who have knowledge of likely or threatened wrongdoing? Symposium contributors who agree on the need for consistency would achieve it by drawing the line at different points.

While Slobogin would limit *Tarasoff* exposure to mental health professionals, two other Symposium contributors go in the other direction, arguing for more expansive *Tarasoff* liability. Professors Sarah Buel and Margaret Drew advocate *Tarasoff*-like duties for lawyers. They argue that, at least in domestic abuse cases, lawyers have a duty to recognize signs of impending violence in their clients and to warn foreseeable victims.[42] Buel and Drew focus on the lawyer representing an alleged batterer in a domestic violence case (perhaps a divorce proceeding or a tort claim for assault and battery). They

40. *Id.* at 647, 657.

41. *Id.*

42. Sarah Buel & Margaret Drew, *Do Ask and Do Tell: Rethinking the Lawyer's Duty to Warn in Domestic Violence Cases*, 75 U. CIN. L. REV. 447, 449 (2006).

contend that, because of the nature of domestic abuse, where the alleged batterer "ha[s] indicated a likelihood of harming others," his lawyer has an affirmative duty to investigate and inform herself about "the client's intention and ability to carry out such threats."[43] Further, they contend, the lawyer must try to dissuade the client from carrying out planned violent crimes and, if need be, warn identifiable persons whom the client has threatened.[44] In support of their proposal, the authors point not only to the therapist's duty under *Tarasoff*, but also to statutory and case law requiring warning or disclosure in other contexts, such as a hospital's duty to alert either a health care worker or a patient about contact with a person who has HIV, or a teacher or social worker's duty to report credible allegations of child abuse. They also cite a number of state statutes requiring or permitting an attorney to disclose information that her client intends to commit a criminal act.[45] Although Buel and Drew make the case that the attorney's duty exists under current law, this bold and expansive interpretation of that law challenges lawyers' notions of confidentiality and duty.

D. Ever-Expanding Perspectives

With so many unresolved questions, far-reaching proposals, and an ever-changing science of risk assessment, what is the future of *Tarasoff*? What legal, medical, social or scientific developments might inform the continued development—or the eventual demise—of this doctrine? And where can we look for guidance? The Symposium contributors demonstrate the dynamic, original and expansive nature of thinking and research on this topic.

Professor Michael Perlin, whose expertise encompasses mental disability law and international human rights law, looks at *Tarasoff* through the prism of international public and private law. One notable development that he examines is the recent European interest in tort law generally and the duty to warn specifically. Looking to tort law, some international and comparative law scholars "have been urging the creation of a legally integrated body of tort law among European nations," which would give plaintiffs "full access to domestic courts" in the individual countries.[46] Perlin himself sees an emerging convergence of tort law and human rights law, domestic and international law, and public and private liability.

43. *Id.*
44. *Id.*
45. *Id.* at 457–58 (nn. 26–37)
46. Perlin, *supra* note 2, at 619.

More specifically, this merging of human rights acts and conventions with tort law has formed the basis for high-profile litigation seeking damages for a public defendant's breach of a duty to warn or protect a private individual from foreseeable injuries. The duty to protect has been linked, for example, to Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which provides that "everyone's right to life shall be protected by law."[47]

The leading duty-to-protect case to date, *Osman v. United Kingdom*,[48] is an early sign of how the law on duties to third parties may develop. In *Osman*, a widow alleged that the police had violated their duty to protect her husband from their son's obsessed and unstable teacher, despite communications from the family, school officials and a school psychologist. When courts in the United Kingdom refused to hear her case, ruling that she had failed to state a claim, she appealed to the European Court of Human Rights. That Court rejected her Article 2 claim based on the facts before it. It concluded that the plaintiff had not met her burden of establishing both that "the authorities knew or ought to have known . . . of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party," and that "they failed to take measures within the scope of their powers" that reasonably "might have been expected to avoid that risk."[49]

The Court did, however, rule that the courts below had violated the woman's human rights when they refused to hear her claim. She had a right under negligence law, the Court held, to "seek an adjudication on the admissibility and merits of an arguable claim that [she and her family] were in a relationship of proximity to the police, [and] that the harm caused was foreseeable."[50] Asserting this right brought her within the protection of Article 6(1) of the European Convention on Human Rights, which provides that,[51] "[i]n the determination of his civil rights and obligations, . . . everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law." [52]

47. *Id.* (quoting Convention for the Protection of Human Rights and Fundamental Freedoms, art. 2, Nov. 4, 1950, Europ. T.S. No. 5, *available at* http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/EnglishAnglais.pdf). This guarantee has the effect of domestic law in the United Kingdom through the Human Rights Act. *See* Human Rights Act, 1998, c. 42 §§ 2(1), 3, 6(1).

48. 29 Eur. Ct. H.R. 245, 305 (1998).

49. *Id*.

50. *Id.* at 313.

51. *Id.*

52. *Id.*

What do *Osman* and other early developments portend for *Tarasoff* liability in the United States and abroad? For Perlin, the Court's reliance on the European Convention on Human Rights suggests that being deprived of a forum for a *Tarasoff* claim may be treated as a violation of international human rights. This, he predicts, could "have profound implications for future developments in this area."[53] In addition, Perlin agrees with the commentators who have hailed this decision as a "serious reappraisal of public negligence claims"[54] and a signal that courts are "now more favourably disposed" to such claims.[55] *Osman* should not, however, be dismissed as limited to public entity liability; European courts "appear[] to have no problem whatsoever in intertwining" what we see as "private law" issues arising in tort law with "what we see as public law issues (which we often treat as 'civil rights cases')."[56] Moreover, he counsels, courts outside the United States have shown little concern that requiring therapists to disclose the verbal threats and threatening conduct of their patients might do irreparable harm to the patient-psychotherapist relationship. Thus, he concludes, liability for a failure to warn or to protect does have vitality outside the United States. This, in turn, could shape the development of law in the United States, as courts and commentators here show growing appreciation of international law as a source of domestic law.[57]

Like Perlin, other Symposium contributors looked beyond doctrinal tort law for insights into the ongoing development of *Tarasoff*. Professor Christopher Slobogin looks to criminal law, exploring the implications and justifications for imposing *criminal* as well as *civil* liability for a failure to act to protect a third party from threatened harm. He makes the provocative proposal that the therapist who fails to act on a patient's threat of harm to a third party could, in limited circumstances, be prosecuted for the violent crime committed by the patient.[58]

53. Perlin *supra* note 2, at 627.

54. Andrew Lidbetter & James George, *Negligent Public Authorities and Convention Rights – The Legacy of* Osman, 2001 EUROPEAN HUM. R. L. REV. 599, 605.

55. *Id.* at 599.

56. Perlin, *supra* note 2, at 627 n.115 (citing 42 U.S.C. § 1983 (2006)).

57. *Id.* at 627 (predicting that, if European courts "maintain a keen interest in this area," this could affect "the extent to which US courts are willing to consider the European cases in future *Tarasoff*-type litigation here"); *id.* at 611 (citing Steven G. Calabresi & Stephanie Dotson Zimdahl, *The Supreme Court and Foreign Sources of Law: Two Hundred Years of Practice and the Juvenile Death Penalty Decision*, 47 WM. & MARY L. REV. 743 (2005)).

58. Slobogin, *supra* note 4, at 647–53. Such a harsh penalty would be imposed only in limited circumstances. The therapist would need to *know,* not merely suspect or predict, that the patient intended harm to another, and arguably would need to know that the patient had taken some action toward that goal. The threatened harm must be death or serious bodily harm, and the victim must be identified or identifiable. *Id.* at 647.

Significantly, the therapist's duty would not be an "omnibus duty to prevent harm to third parties," but a specific duty to treat dangerousness.[59] Thus, it would not be a crime to fail to warn the victim or notify the police, because these acts are not related to treatment and do not rest on any special expertise or authority. Rather, they are actions anybody could take.[60]

Professor Monahan's evolving assessment of the appropriateness and the risks of a therapist's duty to predict dangerousness relies largely on two nonlegal developments: advances in the science of violence risk assessment and the changing nature of mental health treatment.[61] The first, as we saw, lowers the risk of an erroneous determination by increasing both the ease and the accuracy of predictions. Second, advances in mental health treatment lower the harmful costs and repercussions of overestimating the danger a patient presents. The emergence of options for outpatient commitment, Monahan observes, gives the therapist an alternative to involuntary hospitalization, an alternative that is less restrictive, less stigmatizing and possibly less traumatic for the patient. Thus, in a "close" case, the therapist who is troubled both by the uncertain prospect of violence toward a third party and by the certain consequences of inpatient commitment to his patient has a course of action that responds to both concerns. Monahan holds out the hope that continued advances on both sides of the equation—predicting violence and treating violence—will benefit therapists, patients, potential victims of violence, and society as a whole.

Professors Buel and Drew invoke both legal and nonlegal sources to advocate for a lawyer's duty to protect a targeted domestic violence victim from harm by the lawyer's client. That duty to a third party is warranted, they contend, because domestic violence satisfies *Tarasoff*'s "special circumstances" exception to the tort law principle that individuals have no duty to protect or rescue third parties.[62] Experts, advocates and victims alert us to these circumstances: batterers are overwhelmingly repeat offenders; there are known situations in which the risk of abuse is heightened; and the victim is typically isolated, vulnerable and fearful of the consequences of reporting the abuse to the police.[63] For these and other reasons,[64] Buel and Drew conclude that

59. *Id.* at 647.

60. *Id*. And the therapist would have various defenses to liability, including her belief that the risk was not great or that her attempts to thwart her patient's stated intentions could exacerbate the risk.

61. Monahan, *supra* note 20, at 497.

62. Buel & Drew, *supra* note 42, at 452.

63. *Id.* at 473–74.

64. Additional considerations include the increased risk to the victim if she prepares to leave the abuser or otherwise asserts herself; the reluctance of domestic abuse victims to disclose their trauma,

victims of domestic violence warrant the protection of mandatory reporting requirements, akin to state statutes requiring educators, social workers, health care workers or other professionals to report signs of child abuse.[65] Indeed, as with *Tarasoff* liability for mental health professionals, there is a patchwork of state statutes and ethics rules either permitting or requiring lawyers to act on their client's threats of criminal harm.[66]

Professor Simon's criticism of *Tarasoff* liability is rooted firmly in the proper understanding of the role of the mental health professional. The psychotherapist's paramount duty is to *treat* patients.[67] If the patient reasonably appears to present a risk of violence, this duty to treat includes the duty to develop and implement a treatment plan designed to reduce that risk. Drawing on research about the nature of an urge to harm oneself or others, Simon offers evidence that the urge often is not enduring and can be responsive to treatment. For that reason alone, he concludes, it is inappropriate to ask a psychotherapist to predict future violence based on a clinical assessment of the patient's state at the time of the observation and evaluation.[68] Moreover, a patient's behavior and risk factors may be so idiosyncratic that any attempt to come up with a "one size fits all" violence risk assessment is misguided.[69]

Professor Mossman's thoroughgoing analysis of *Tarasoff* integrates insights from diverse sources, including legal doctrine, his extensive experience as a teacher and psychotherapist, principles of metaphysics and the science of risk assessment. But perhaps most notably, he incorporates philosophy and faith. He finds Kant's "categorical imperative" harmonious with his own deep-felt ethical commitment to his patients: to respect their humanity, promote their autonomy, and bolster their healthy sides.[70] His ethical reflections, in turn, are informed by Judaism; indeed, his current views on *Tarasoff* liability were shaped, in part, by his rabbi's sermon.[71] He thus offers a model for marrying empiricism with belief.

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and the sometimes dismissive response of their audience (including law enforcement officers) when they do; the particular vulnerability of intimate partners; and the fact that the alleged batterer may confide in nobody except his lawyer. *Id.* at 482–84.

65. *Id.* at 489–91.

66. *Id.* at 457–58.

67. Simon, *supra* note 6, at 640.

68. *Id.* at 643.

69. *Id.* at 638–42.

70. Mossman, *supra* note 3, at 599.

71. See Douglas Mossman, *How a Rabbi's Sermon Resolved My* Tarasoff *Conflict*, 32 J. AM. ACAD. PSYCHIATRY L. 359 (2004).

III. CONCLUSION

Together, the papers in this Symposium demonstrate that the value and validity of the *Tarasoff* doctrine today, as well as the legal, medical and policy developments that will shape its scope and direction tomorrow, are still unsettled. Moreover, as varied as these authors' approaches are, they do not exhaust the legal and interdisciplinary frameworks that hold promise for rethinking *Tarasoff* or the broader questions it raises. How do we balance public good and private rights? What are the beliefs, the fallacies and the truths underlying our unexamined fears or our ready assumptions about "the mentally ill"? How does the *Tarasoff* doctrine either reflect or reinforce society's evolving collective fears and its corresponding tolerance or demand for social control of any person who can be deemed "deviant"? As neuroscience develops or discovers new avenues for exploring the human brain, or "reading our minds," will the law demand even more intrusive or restrictive measures to detect "unacceptable" thoughts, impulses or inclinations? This Symposium provides both a model and a foundation for future work in this important area.