Within the past 17 years, a psychiatrist's responsibilities to people other than the patient have become far more complicated than anyone could have imagined. Who could have anticipated the California Supreme Court's Tarasoff decisions in 1974 (Tarasoff v Regents of the University of California, 529 P2d 553, 118 Cal Rptr 129) and 1976 (Tarasoff v Regents of the University of California, 17 Cal3d 425) and the diverse court decisions that followed?

The psychiatrist's duty to warn or protect is not a simple doctrine. A quotation from Justice Tobriner's majority opinion on Tarasoff II no longer captures the concept. There is no single guiding legal rule. It would be more accurate to speak of various rules and diverse perspectives. In formulating this update, the issue will be addressed from three views: judicial, legislative, and clinical.

A JUDICIAL VIEW

Perhaps the most frequently quoted statement regarding a judicially mandated duty to warn or protect is the essential holding of the Supreme Court of California in its 1976 Tarasoff decision (Tarasoff v Regents of the University of California, 17 Cal3d 425). Justice Tobriner wrote in the majority opinion:

When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient represents 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 such duty, depending on the nature of the case, may call for the therapist 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.

This is often referred to as the "Tarasoff Principle" and is a good rule for psychiatrists to know. But it would be a mistake for all psychiatrists to believe that this is the duty to warn or protect that applies to them. In the 1980s, a number of courts fashioned diverse duties to warn or protect.1 Even before the California legislature enacted a statute to clarify the issue, the court-mandated duty in that state had undergone some curious twists and turns (Thompson v County of Alameda, 167 Cal Rptr 70 [1980], Hedin v Superior Court of Orange Cty, 194 Cal Rptr 805 [Cal 1983]).

Court decisions today are in disarray.1 There is no single uniform duty to warn or protect. Some courts apply the duty when the specificity rule is satisfied, ie, the patient makes a serious threat against an identifiable victim.
(Brady v. Hopper, 751 F.2d 329 [10th Cir 1984]). Others find a duty even without a threat or predesignated victim, if the violence is otherwise foreseeable (Lipari v. Sears, Roebuck & Co, 497 F. Supp. 185 [D Neb 1980]). Discretionary immunity protects state psychiatrists in Michigan (Canion v. Thumma, 422 N.W.2d 688 [Mich 1988]), but not in other states. Not only the nature of the duty (when it arises and how it should be fulfilled), but the legal foundations for such a duty vary from one court to another. Not all courts rest the duty on the special relationship exception to the common-law rule of nonresistance, as the California Supreme Court did in Tarasoff. The Wisconsin Supreme Court based the duty on the caselaw within that state (Schuster v. Allentown, Wis 87-0115, 1988). The Oregon State Supreme Court assembled a duty to protect on a platform that combined caselaw and statutory law (Carr v. Rijken, 717 P.2d 140 [Ore 1986]).

Concerning court-mandated duties to warn or protect, the prudent psychiatrist will become familiar with the case law in the state where he or she practices. Knowledge of the original Tarasoff decision in California is no longer enough. For example, psychiatrists in Ohio must now know the three-point professional judgment rule enunciated by the Supreme Court of Ohio (Littleton v. Good Samaritan Hosp, 529 NE2d 449 [Ohio 1988]). Psychiatrists in Nebraska (Lipari v. Sears, Roebuck & Co, 497 F. Supp. 185 [D Neb 1980]) and Wisconsin (Schust v. Allentown, Wis 87-0115, 1988) should know that the courts may consider violence foreseeable even without an expressed threat or a named victim. This type of liability is probably greater for inpatients who are released prematurely from the hospital than for outpatients.

A STATUTORY VIEW

There is a commonly held and accurate presumption that when faced with a case with facts sufficiently supportive of the "foreseeability" of severe violence to a third person, courts will establish or uphold a duty to warn or protect.6 Already, scores of court decisions have followed this pattern. Beyond this, however, one cannot prophesy how a given court will define the nature of the duty, the conditions under which it arises, and how it is to be fulfilled. Only after the appropriate court has addressed the issue will clinicians have any notion of the extent and limitation of the duty that will apply to them. Even after an appellate court has acknowledged a duty to warn or protect, the nature of the obligation is subject to change when another case comes along.

California, the home state of Tarasoff and other cases that originated and melded the duty to warn or protect, was the first to attempt statutory clarity for its psychotherapists (California Civil Code, §43.92.13). According to the 1985 enactment, the therapist "may" make a protective disclosure when the patient expresses a "serious threat of violence against a reasonably identifiable victim." The therapist fulfills the duty to protect, if one exists, by making reasonable efforts to convey the threat to the victim and a law enforcement agency (California Civil Code, §43.92.13). Having done this, the therapist has fulfilled the duty to warn or protect and incurs no liability for failing to take preventive action or for violating the patient's confidentiality. Note that the California law neither establishes nor upholds the duty to protect. In this respect California is one of only a few states with so-called Tarasoff legislation that does not affirm a therapist's duty to protect.

When state legislatures began to struggle with the conceptual complexities of formulating the best law to address this issue, the American Psychiatric Association provided assistance by developing a resource document.3 The APA's Council on Psychiatry and Law developed the document, which was approved by the Board of Trustees in June 1987. This was to serve as a guide to district branches "in those states in which case law has expanded the potential 'duty to protect' liability of psychiatrists." The logic of this restricted application is elusive, as it seems more provident to close the proverbial stable gate before the equids ascend rather than afterward.

Similar to the California statutory law, this document does not acknowledge or support a duty to warn or protect, but states conditions under which protective disclosures may be made and what protective action should be considered. An affirmative duty to warn or protect is not present in the APA ethical code, the APA Model Law on Confidentiality, the APA resource document, the ethical code of the American Psychological Association, the ethical code of the National Association of Social Workers, or the first statute to address this issue. It is curious, then, that most Tarasoff statutes affirmed such a duty.

According to the resource document, confidentiality may be breached if:

the patient has communicated to the physician an explicit threat to kill or seriously injure a clearly identified or reasonably identifiable victim or victims, or to destroy property under circumstances likely to lead to serious personal injury or death, and the patient has the apparent intent and ability to carry out the threat . . .

The resource document recom- (continued on page 59b)
mends against a single option such as warning the identifiable victim. Rather, the psychiatrist should take reasonable precautions and select from several courses of action. The physician or therapist may either:

a) [communicate] the threat to any identifiable victim or victims; or b) [notify] a law enforcement agency in the vicinity where the patient or any potential victim resides; or c) [arrange] for the patient to be hospitalized voluntarily; or d) [take] legally appropriate steps to initiate proceedings for involuntary hospitalization.3

State protective disclosure statutes are not boilerplate replicas.4 Despite the considerable variation, some elements are common to most statutes. Similar to the APA resource document, most require an actual threat and an identifiable victim, but not threatened property damage. Statutes are about evenly divided on whether to inform the potential victim or the police, or whether both types of communication must be made to satisfy the duty. Statutes of all but one state specify notification of either victims or police, or both.

Most statutes provide protection from liability associated with breach of confidentiality when the specified conditions are satisfied. Certainly one reason for this type of legislation is to curb expanding liability for clinicians. An exceptional approach was taken in Ohio, where statutory immunity exists for failure to protect under all circumstances (SB 156, Department of Mental Health Reorganization Bill, p 143, 1988 [Ohio]).

After the United States Court of Appeals, 10th Circuit, embraced the specificity rule in Colorado (Brady v Hopper, 751 F2d 329 [10th Cir 1984]), and after the Colorado Legislature enacted protective disclosure law wherein the duty to warn or protect does not arise unless the patient makes a specific threat (HB 1201 [Colo 1986]), the

Colorado Supreme Court (Pereira v Colorado, 768 P2d 1198 [1989]) defined the duty in such a way that a specific threat was not always necessary for the duty to arise. Did the court overrule the statutory law? No, but Colorado clinicians would have been misled if they had assumed that absence of a specific threat provided immunity from liability in all situations.

The Colorado statutory duty and immunity provision pertained to outpatients, not inpatients. The Pereira case involved an inpatient who was thought to have been violent when discharged. The protective disclosure statute in Colorado explicitly leaves the door open to liability when a dangerous patient is mistakenly discharged. This law did . . .

not apply to the negligent release of a mental hospital or ward or to the negligent failure to initiate involuntary 72-hour treatment and evaluation after a personal patient evaluation determining that the person appears to be mentally ill, and as a result of such mental illness, appears to be an imminent danger to others (Pereira v Colorado, 768 P2d 1198 [1989]).

Even without such exception to the limited liability provided by the specificity rule, courts can be expected to make decisions in the face of statutory law. Hopefully, they will turn to codified law for guidance more than to the confusing jurisprudence spawned by courts in other jurisdictions. Thus the legislative approach should comple-

ment, not compete with, legitimate judicial functions.

A CLINICAL VIEW

Today's psychiatrist must give thought to how to warn or protect in a manner consistent with sound clinical practices. Every psychiatrist should reflect on the moral implications and become familiar with the professional code of ethics, statutory measures in the state where the psychiatrist practices, and court decisions—both landmark cases like Tarasoff and Lipari and germane court decisions in the jurisdiction of practice. Here I will share pertinent considerations and some advice, but without suggesting that a clinical standard has been established for accurately predicting future violence or for effective prevention without confinement.

Of utmost importance in preventing violence, within the scope of the psychiatrist's acknowledged skills, is simply the provision of competent and conscientious clinical care. A thorough and accurate diagnostic assessment is fundamental. Prudent decisions regarding timely hospitalization can result in effective intervention in the immediate future and provide opportunity for a more careful evaluation.

In addition to providing competent and conscientious clinical care, focused attention must be given to the question of future violence. Paul Appelbaum advocates a three-step model for dealing with the potentially violent patient:

- assessment of dangerousness;
- selecting a course of action; and
- implementation.5

This is a nice, simple, and logical sequence to bear in mind and follow; and it allows consideration of the unique complexities involved in different cases.

Although psychiatrists are generally experienced in evaluating a patient's present suicide potential, assessment of violent potential is probably not accomplished with the same consistency and thoroughness. Male sex, black racial
grouping, youth, and low socioeconomic status may have a high statistical correlation with violence, but, like demographic correlates of suicide, such factors help the clinician little in determining whether a given patient presents a foreseeable danger.

To assess the risk of violence, the psychiatrist should inquire about predisposing factors such as violence in the family of origin. Check for presence of recurrent violent and impulsive behaviors. Give focused attention to aspects of the patient's current mental status that are conducive to violence (eg, agitation, specific threats, aggressive ideation). Especially look for absolutist thinking wherein violence is regarded as the only recourse. And finally, assess the situational and enabling variables that complete the picture of an untoward event: availability of weapon and victim.

I like to begin with questions about the patient's subjective, affective experience, and lead stepwise toward more specific ideation. For example, after hearing of the patient's subjective distress, I will ask the patient about desperate thoughts. This allows the patient to volunteer thoughts of suicide, homicide, and other extreme responses. After this open-ended approach, where concern exists, I will become more specific and concrete in exploring the actions the patient has considered.

The psychiatrist should attempt to weigh the risks and benefits of disclosure versus nondisclosing alternative interventions. If the risk of serious harm seems certain and imminent, hospitalization may be more protective than warnings alone. If because of serious mental illness, many people are endan-

gered, not just a single "writable" individual, this too would argue in favor of hospitalization. A number of duty to warn/protect lawsuits might not have occurred if the patient had been hospitalized or if the patient's hospitalization had been extended. Since hospital confinement provides better immediate protection of the public, this measure could be overused as a form of "defensive" psychiatry. Given the legal limitations to involuntary hospitalization, this is not likely a serious and prevalent form of abuse.

Though much emphasis has been placed on warnings and reports, preventive disclosures are not the only extraliminary measure for preventing violence. After assessing the nature of the risk, for example, the psychiatrist may be prudent to enlist the cooperation of the patient or the patient's family in neutralizing the deadly weapon of choice.

For further discussion on effective treatment and management of the patient who presents a danger to others, the reader is referred to several book chapters7,8 as well as the book recently edited by James Beck.9 Whenever the psychiatrist has doubts about safe management of a dangerous patient, the psychiatrist should obtain earlier psychiatric records on the patient and consult with an experienced colleague.

CONCLUSION

The psychiatrist of the 1990s has no simple rule to follow. In each case, where the patient presents a serious threat, the psychiatrist must weigh competing moral considerations. The psychiatrist should be familiar with the ethical code of the APA, a few landmark cases including Tarasoff, relevant court decisions by federal or appellate courts where the psychiatrist practices, and state statutory law including confidential and privileged communication, the mental health code for involuntary hospitalization, and protective disclosure law, if applicable. Most important, the psychotherapist should make every effort to practice competently, carefully, and prudently, giving attention to accurate diagnosis, effective treatment, and safe management in patient care.

REFERENCES