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Tarasoff v. Regents of the University of California: Psychotherapist's Obligation of Confidentiality Versus the Duty to Warn

Nancy A. Nesbitt

TARASOFF v. REGENTS OF THE UNIVERSITY OF CALIFORNIA: PSYCHOTHERAPIST'S OBLIGATION OF CONFIDENTIALITY VERSUS THE DUTY TO WARN

What is the extent of the psychotherapist's[1] duty to protect third persons whose safety may be threatened by his patients? In *Tarasoff v. Regents of the University of California*,[2] the California Supreme Court held that psychotherapists, and presumably psychiatrists as well, have a duty to warn third parties of the possible dangers of bodily harm to which they are exposed by patients of the psychotherapist. This note will examine the traditional standards employed to impose the duty to protect third parties from unreasonable danger or harm, the alteration of these standards by *Tarasoff* and the conflict engendered by the *Tarasoff* holding between the psychotherapist's duty to warn and his duty of confidentiality to his patients.

Duty to Protect Third Persons

The psychotherapist's failure to protect persons endangered by a patient is an act of nonfeasance which, for the most part, is a very limited concept. It may, however, be characterized as follows:

> A previous course of action, not in itself creating risks to others, may have brought the actor into certain socially recognized relations with others which are of such a character as to require affirmative acts to protect them from risks which the person required to act had no part in creating. The failure to perform such an act is described as nonfeasance.

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1. Psychotherapy involves a
relationship which exists between two persons (or more, where marriage counseling or group therapy is involved) where one (or more) is seeking help in the solution of a mental problem caused by psychological and/or environmental pressures from another whose training and status are such as to warrant other persons confiding in him for the purpose of such help.
Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 617 (1964).

2. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). This case vacated the opinion in Tarasoff v. Regents of the Univ. of California, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

> The situation is more easily comprehended by treating [it] . . . as . . . one depending upon the relationship of the parties. The principle is thus ordinarily formulated that while an actor is always bound to prevent his acts from creating an unreasonable risk to others [misfeasance], he is under the affirmative duty to act to prevent another from sustaining harm only when certain socially recognized relations exist which constitute the basis for the legal duty.[3]

As a result of the narrowly defined social relationship which is required in nonfeasance cases, there is typically no duty to control the conduct of a person so as to prevent his harming third parties; however, there are exceptions to this rule where certain relationships exist. The special relationships that generally create this duty may be included within one of two classifications: (1) those in which the relationship between the actor and the party threatened with harm is such that the actor may be required to protect the party from harm and (2) those in which the relationship between the actor and the person threatening harm to the third party is such that the actor may be required to control the former's conduct.[4]

The psychotherapist's duty to third parties threatened, or potentially endangered, by his patients falls within the latter category.[5] Because of the psychotherapist's relationship with his patients or clients, the psychotherapist is deemed to be in a position to "control" his patient's conduct and may be legally required to do so in appropriate circumstances.[6]

Control in this area of negligence law has traditionally meant physical control over the person of the primary tortfeasor. The amount of physical control over another which is required for the imposition of tort liability is not a matter which can be mathematically ascertained. In cases involving emotionally or mentally ill patients, the degree of

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3.. Harper & Kime, *The Duty to Control the Conduct of Another*, 34 YALE L.J. 886, 887 (1934) [hereinafter cited as Harper & Kime]. *See* F. HARPER & F. JAMES, LAW OF TORTS, 1054 (1956); RESTATEMENT (SECOND) OF TORTS § 314, comment c (1965).

4. Harper & Kime, *supra* note 3, at 887-88. *See* W. PROSSSER, HANDBOOK OF THE LAW OF TORTS, 348-50 (4th ed. 1971) [hereinafter cited as PROSSER]; RESTATEMENT (SECOND) OF TORTS, §§ 314A-315 (1965).

5. PROSSER, *supra* note 4, at 349-50; RESTATEMENT (SECOND) OF TORTS, § 319, comment a (1965); Harper & Kime, *supra* note 3, at 897-98.

6. The relationship of psychotherapist and patient is necessarily a very close and confidential one. Naturally, the psychotherapist must have a certain degree of psychological control over the patient. However, it is not actual control that is definitive of the relationship, but rather the *ability* to control. See note 11 *infra* and accompanying text.

control possessed by professional personnel charged with their care and treatment has varied considerably.

On the one hand, liability has been imposed when authorities failed to adequately control a mental patient within the confines of a hospital.[7] Liability has also been predicated upon the negligent discharge of a mentally ill person from a psychiatric hospital.[8] Other courts have found liability for harm inflicted by mental patients who had been "temporarily released" from professional supervision.[9] On the other hand, sufficient control has been found to exist where hospital personnel refused admittance to an emotionally disturbed individual.[10]

It seems clear from the foregoing case law that physical control has a rather broad meaning and is not restricted to direct and immediate power over the actions of another. Instead, the term has been applied to situations in which hospital personnel, professionals and others charged with the care and treatment of a mental patient had the ability of denying the patient the opportunity to inflict harm on third persons.[11] It was this almost pervasive definition of control that the California court was presented with in the *Tarasoff* decision.

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7. University of Louisville v. Hammock, 127 Ky. 564, 106 S.W. 219 (1907).

8. Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); Underwood v. United States, 356 F.2d 92 (5th Cir. 1966); Austin W. Jones Co. v. State, 122 Me. 214, 119 A. 577 (1923); Homere v. State, 79 Misc. 2d 972, 361 N.Y.S.2d 820 (Ct. Cl. 1974), *aff'd* 48 App. Div. 2d 422, 370 N.Y.S.2d 246 (Sup. Ct. 1975). For an opposing viewpoint, *see* Kendrick v. United States, 82 F. Supp. 430 (N.D. Ala. 1949). Like *Hicks* and *Underwood, Kendrick* involved the release of a mental patient from a Veteran's Administration hospital. However, there the court found that the government psychiatrists were performing a discretionary act when they released the patient; thus, the United States was immune from liability under 28 U.S.C. § 2680(a) (1970). *See generally* St. George v. State, 203 Misc. 340, 118 N.Y.S.2d 596 (Ct. Cl. 1953), *rev'd on other grounds*, 283 App. Div. 245, 127 N.Y.S.2d 147 (Sup. Ct.), *aff'd mem.*, 308 N.Y. 681, 124 N.E.2d 320 (1954) (no liability found because defendant psychiatrists simply made an honest error in professional judgment).

9. Merchant's Nat'l Bank and Trust Co. v. United States, 272 F. Supp. 409 (D.N.D. 1967). *Cf.* Smart v. United States, 111 F. Supp. 907 (W.D. Okla. 1953) (no liability found because the acts involved were held to fall within the "discretionary function" exception to the Federal Tort Claims Act, 28 U.S.C. § 2680(a) (1970)).

10. *See* Greenberg v. Barbour, 322 F. Supp. 745 (E.D. Pa. 1971).

11. One author has proposed that "de facto" control is the only type of control creating a relationship falling within the second exception to the general rule discussed earlier. See note 4 *supra* and accompanying text; Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 365-66 (1976) [hereinafter cited as Stone]. But when other types of relationships falling within this exception are examined, it is clear that something less than "de facto" control will be sufficient to justify a departure from the general rule. *See* Harper & Kime, *supra* note 3, at 888-98. The *ability* to exercise control seems to be the definitive factor in qualifying relationships.

Tarasoff Decision

In *Tarasoff*, a mental patient was being treated by psychotherapists at a university hospital on a voluntary outpatient basis. During a treatment session, the patient confided to one of the attending therapists that he intended to kill a certain young woman. Believing that the patient should be institutionally committed, the defendants requested the assistance of the campus police in confining him. The patient was subsequently taken into custody, but released when he promised to stay away from the woman involved.[12]

In holding for the deceased's representatives in a subsequent wrongful death action, the California Supreme Court imposed a duty on the defendant therapists to warn third parties of their patients' announced intent to inflict harm upon them.[13] Finding this duty to be governed by a standard of reasonable care, the court stated:

> When a therapist 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 upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[14]

The foregoing standard of "reasonable care" in protecting third parties is not, however, required of the psychotherapist until activated by his initial determination as to the patient's violent tendencies. In this regard, the court in *Tarasoff* delineated a higher standard of care

12. The plaintiffs also sought to have the police officer involved held liable for a failure to confine the patient in *Tarasoff*. The officers were held to be immune from liability under CAL. WELF. & INST. CODE § 5154 (West 1972). *See* 17 Cal. 3d at 449, 551 P.2d at 352-53, 131 Cal. Rptr. at 32-33.

13. An additional allegation by the plaintiffs was that the defendant psychotherapists were liable for a failure to confine the mental patient. However, the court held that they were immune from this liablity under CAL. GOV'T. CODE § 856 (West Supp. 1977). This section grants immunity from liability to public employees charged with official responsibility for the confinement and release of mental patients for any injuries that might result from their determinations in these matters. However, the immunity only applies if determinations are made in accordance with statutory guidelines. If the determination is made in a wrongful or negligent manner, or if the employee wrongfully or negligently fails to make such determination, the immunity will not attach. *See* 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

14. *Id.* The court reiterated this same standard at a later point in the opinion. 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

which is required of the psychotherapist in making the initial determination of a patient's propensity for violence: "Obviously we do not require that the therapist . . . render a perfect performance; the therapist need only exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that profession] under similar circumstances.' "[15]

As the court in *Tarasoff* recognized in its analysis of the extent of the psychotherapist's duty to the intended victim of a patient, the duty to warn has previously been imposed under factual circumstances similar to those in the *Tarasoff* decision. In a line of medical malpractice cases, physicians were held to a duty to warn persons likely to come in contact with patients whom the physicians knew or should have known were suffering from contagious diseases.[16] Although these cases applied the higher professional standard of care to the diagnosis by physicians of contagiousness, they adopted a standard of "ordinary or reasonable care" in determining how physicians should act for the protection of third parties once the diagnosis was made.

Aside from this limited area of nonfeasance, there appears to be no duty to warn which is recognized as satisfying the actor's broader duty to protect the injured party.[17] This absence of recognition, however, cannot be taken as implying that such a duty cannot exist in the context of psychotherapy. Examination of the standard of care required for the protection of third parties threatened by others shows that a warning may, under some circumstances, be sufficient to satisfy this duty. Thus, whether or not a duty arises depends on the facts of each particular case. The question which should be asked in each case is whether, under all the circumstances, a warning to the injured

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

16. Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921); Hofmann v. Blackmen, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970); Skillings v. Allen, 143 Minn. 323, 173 N.W. 663 (1919); Edwards v. Lamb, 69 N.H. 599, 45 A. 480 (1899); Wojcik v. Aluminum Co., 18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup. Ct. 1959); Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (1928).

17. *See* Fair v. United States, 234 F.2d 288 (5th Cir. 1956), involving a duty to warn a third party previously threatened by a mental patient. There, however, the defendants had *affirmatively undertaken* the duty to notify this person when the mental patient was released from the hospital.

A duty to warn is also recognized as an alternative to a duty to affirmatively act for the protection of others where the relationship involves an invitee. The owner or occupier of land is generally held to a duty to see that the land is reasonably safe for the invitee or to use reasonable care to warn the invitee of any unreasonably dangerous condition. This duty includes an obligation to protect the invitee from the dangerous activities of third persons upon the property. Harper & Kime, *supra* note 3, at 903. *See* RESTATEMENT (SECOND) OF TORTS §§ 314A, 315 (1965).

party would have satisfied the standard of "reasonable care for the prevention of harm to others."[18] In resolving this question, the contagious disease cases have consistently recognized a warning as satisfying the standard of ordinary care.[19]

Apart from the standard of care imposed by *Tarasoff* regarding the duty to warn, studies conducted by prominent psychotherapists cast doubt on the standard of care imposed by the *Tarasoff* decision on psychotherapists in determining the potential for violence by their patients. In one such study, Professor Bernard L. Diamond of the University of California concluded that psychotherapists cannot predict the propensity for violence with any reasonable degree of accuracy.[20] Professor Diamond's study also discussed other clinical studies that have attempted to formulate criteria by which violent tendencies may be diagnosed. Diamond found that many of the personality traits utilized as criteria are similarly prevalent in nonviolent individuals.

Moreover, the criteria utilized in these studies are inconsistent from study to study.[21] Similarly, the Diamond report referred to several statistical studies which demonstrate the tendency by therapists to grossly overpredict dangerousness in patients and clients.[22] Finally, other studies have concluded that no correlation exists between mental

18. Harper & Kime, *supra* note 3, at 888. *See* F. HARPER & F. JAMES, LAW OF TORTS 1054-55 (1956); PROSSER, *supra* note 4, at 350.

19. *See* cases at note 16 *supra*. Dean Prosser has said, in describing that fictitious person who establishes the standard of care, that phrases such as "reasonable man" or "prudent man" or "man of ordinary sense using ordinary care and skill" are all intended to mean much the same thing. PROSSER, *supra* note 4, at 150.

20. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 PA. L. REV. 439, 440, 451-52 (1974) [hereinafter cited as Diamond]. *See* People v. Burnick, 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974).

21. Diamond, *supra* note 20, at 440-44.

22. *Id.* at 444-47. In these studies, it was estimated that dangerousness was overpredicted between ten and one hundred times its actual incidence. Likewise, Dr. Stone is of the view that imposing liability for a failure to predict violence will result in an increase of overprediction. Stone, *supra* note 11, at 372.

A new study that is particularly graphic was concerned with the so-called Baxstrom patients. In a decision of the United States Supreme Court, Baxstrom v. Herold, 383 U.S. 107 (1966), 967 patients in New York maximum security hospitals for the criminally insane were ordered transferred to ordinary mental hospitals because the statute under which they were originally committed to these hospitals was held violative of the equal protection clause of the fourteenth amendment. Four and one-half years after this decision, one-third of these patients were back in the community. This is a higher release rate than for mental patients generally. Only 26 of the 967, or 2.7 percent, had been returned either civilly or criminally to hospitals for the criminally insane. Dr. Henry J. Steadman, a research sociologist for the New York Department of Mental Hygiene, who performed extensive research on the Baxstrom patients, examined factors

illness and the propensity for violence.[23] Recognizing the problems concerning the diagnosis of dangerousness, Professor Diamond concluded his study by warning that psychiatrists and others concerned with human behavior should acknowledge their inability to predict violence in patients and should not volunteer such predictions.[24]

The federal judiciary has also recognized the inherent difficulty in predicting an individual's disposition toward violence. Mr. Justice Douglas, in his dissent from the dismissal of certiorari in *Murel v. Baltimore City Criminal Court*,[25] referred to the following testimony before a congressional subcommittee:

> A diagnosis of mental illness tells us nothing about whether the person so diagnosed is or is not dangerous. Some mental patients are dangerous, some are not. Perhaps the psychiatrist is an expert at deciding whether a person is mentally ill, but is he an expert at predicting which of the persons so diagnosed are dangerous? Sane people, too, are dangerous, and it may legitimately be inquired whether there is anything in the education, training or experience of psychiatrists which renders them particularly adept at predicting dangerous behavior. Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate, and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals.[26]

Because of the recognized difficulty in predicting dangerous behavior, the standard of care imposed by *Tarasoff* as to the initial determination of violence is too strict a standard. Such a standard would require psychotherapists to possess a degree of skill that simply does

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differentiating the returnees from the rest of the group. He found no reason to explain why the returnees should act any more violently than the others, thus necessitating their return. Steadman, *Follow-Up on Baxstrom Patients Returned to Hospitals for the Criminally Insane*, 130 AM. J. PSYCH. 317 (1973) (cited in Diamond, *supra* note 20, at 446-47).

23. Diamond, *supra* note 20, at 447-50.

24. *Id.* at 452.

25. 407 U.S. 355 (1972). Other cases recognizing this difficulty in prediction include Drope v. Missouri, 420 U.S. 162 (1975); Greenwood v. United States, 350 U.S. 366 (1956); Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); People v. Burnick, 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975); St. George v. State, 203 Misc. 340, 118 N.Y.S.2d 596 (Ct. Cl. 1953), *rev'd on other grounds*, 283 App. Div. 245, 127 N.Y.S.2d 147 (Sup. Ct.), *aff'd mem.*, 308 N.Y. 681, 124 N.E.2d 320 (1954).

26. 407 U.S. at 364-65, no.2. This quote is taken from the testimony of Bruce J. Ennis, Staff Attorney of the New York Civil Liberties Union and Director of the Civil Liberties and Mental Illness Project, before the *Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2nd Sess., 277-78 (1969-70).

not exist.[27] Psychotherapists should only be held to the general standard of acting reasonably for the protection of the third parties.

It should be emphasized that the ability to predict violent tendencies is synonymous with the ability to foresee the risk of such danger and therefore is closely related to the concept of proximate cause.

While *Tarasoff* did not deal with proximate cause,[28] it is certainly an issue that should have been considered. When the psychotherapist has negligently failed to control his patient, or has failed to warn the intended victim and injury has resulted, a question is raised as to whether the psychotherapist's negligence is the proximate cause of the injury or whether the intentional act of the patient is an intervening cause of the injury. When a defendant's negligence creates a condition whereby the commission of an intentionally harmful act by another becomes more likely, it seems clear that the intentional act cuts off the effect of the defendant's negligence unless the defendant knew or should have known that his negligence would create such a condition and opportunity.[29] Therefore, even though the psychotherapist may have a duty to act reasonably to prevent harm to third parties threatened by his patients, establishing proximate cause would seem to present a difficult task for plaintiffs in light of the inability on the part of psychotherapists to predict violence in their patients and foresee the risks posed to others.

Duty to Warn Versus Confidential Communications

Thus far this discussion has centered upon the psychotherapist's duty to protect third parties from the violent acts of his patients. But what of the psychotherapist's professional duty to his patients? Another criticism of *Tarasoff* is that imposing a duty on psychotherapists to warn persons threatened by their patients requires a revelation of a patient's confidential communications made to his therapist.

27. The court in *Tarasoff* apparently recognized the problems involved in predicting violence. However, it did not take these into consideration when it formulated a standard for the preliminary determination of violence based upon the professional skill of psychotherapists generally. 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

28. Proximate cause was dealt with in both the majority and dissenting opinions of the court of appeals decision in *Tarasoff*. Tarasoff v. Regents of the Univer. of California, 33 Cal. App. 3d 275, 108 Cal. Rptr. 878, 883-84, 900-01 (1973).

29. *See* Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); Underwood v. United States, 356 F.2d 92, 99 (5th Cir. 1966); PROSSER, *supra* note 4, at 275; RESTATEMENT (SECOND) OF TORTS, §§ 302B, 448-449 (1965).

The physician's ethical duty of confidentiality goes back to the time of Hippocrates[30] and is embodied in the ethics of the American Medical Association:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, *unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.*[31]

Where psychotherapy is concerned, however, confidentiality is more than just an ethical obligation. Ideally, psychotherapy involves complete candor and openness between patient and therapist. To a large extent, the success of psychotherapy is dependent on the patient's revelation of his inner feelings and thoughts. Every bit of information obtained by the psychotherapist in this manner is vital to the treatment of the patient. "Saying all is the desideratum."[32] Accordingly, it is recognized that confidentiality is vital to effective psychotherapeutic treatment and is a necessary inducement to the patient's seeking psychotherapeutic help.[33]

Even those who strongly support the preservation of confidentiality, however, recognized that the revelation of a confidence is justifiable in preventing the commission of a crime or a tort.[34] The instances where this is proper must, of course, lie within the discretion of the therapist, using his own good judgment and relying upon his conscience

30. "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about." L. EDELSTEIN, THE HIPPOCRATIC OATH 3 (1943).

31. A.M.A. PRINCIPLES OF MEDICAL ETHICS § 9 (1957) (emphasis added). Among the ranks of psychotherapists, psychiatrists are specializing physicians, so they, at least, would be bound by this principle.

32. Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 186 (1960) [hereinafter cited as Slovenko]. *See* Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955); Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 618-20 (1964) [hereinafter cited as Fisher]; Fleming & Moximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1031-32 (1974).

33. *See* Fisher, *supra* note 32, at 618; Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175, 178-79 (1962); Slovenko, *supra* note 32, at 187-88. It has been questioned whether confidentiality is necessary to protect these interests of the patient. It is felt that the patient's interests in his constitutional rights of due process, privacy, and liberty are the most important interests to be protected by preserving confidentiality between psychotherapist and patient. Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1039-64 (1974).

34. *See* Fisher, *supra* note 32, at 633; Slovenko, *supra* note 32, at 197-98. This exception is in accord with the AMA PRINCIPLES OF MEDICAL ETHICS § 9 (1957).

to assure effective treatment of his patients.[35] It is arguable that *Tarasoff's* sanction of possible tort liability for a failure to reveal confidences by way of warning, may inhibit the psychotherapist's judgment.

Of course, other repercussions may be felt by the psychotherapist who is forced to reveal the confidences of his patients. Not only may patients be discouraged from seeking help and treatment, but liability may be imposed for improper revelation of a confidence. There are basically four types of actions that are available for wrongful disclosure of a confidence: (1) an action for breach of the contractual relationship between doctor and patient based upon an implied term of confidentiality; (2) an action for denial of the patient's right of privacy; (3) an action for the breach of the physician's fiduciary duty of confidentiality; and (4) an action based upon doctor-patient privilege statutes which have been construed as embodying a remedy for breach of confidence.[36] Of great importance to this discussion, however, are the psychotherapist's possible defenses. Basically, the defenses are the same as those for right of privacy and defamation actions.[37]

Berry v. Moench[38] involved a libel suit initiated by a patient against his former psychiatrist. After learning that his daughter was contemplating marriage to the patient, the girl's father, a personal friend of the defendant psychiatrist, solicited information from the doctor about his patient. The psychiatrist replied, warning the father that his daughter should "run as fast and as far as she possibly could in any direction away from [the plaintiff]."[39] The court held that a conditional privilege arose under the circumstances protecting the defendant from liability. In describing the circumstances which gave rise to the psychiatrist's conditional privilege, the court stated:

> [T]he privilege is not something which arises automatically and becomes absolute merely because there is an interest to protect. It has its origin in, and it is governed by, the rules of good sense and customary conduct of people motivated by good will and proper consideration for others. . . .
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> . . . One purveying such information about one person to protect another is obliged to consider the likelihood and the extent of benefit to the recipient, if the matter is true,

35. *See* Fisher, *supra* note 32, at 633; Slovenko, *supra* note 32, at 198.

36. Comment, *Physicians and Surgeons: Civil Liability for a Physician Who Discloses Medical Information Obtained Within the Doctor-Patient Relationship, in a Nonlitigation Setting*, 28 OKLA. L. REV. 658, 662-69 (1975).

37. *Id.* at 669.

38. 8 Utah 2d 191, 331 P.2d 814 (1958).

39. *Id.* at —, 331 P.2d at 816.

> as compared with the likelihood of injury and the extent thereof to the subject, if it proves false, or improper to reveal. Whether the privilege exists, depends upon generally accepted standards of decent conduct. Applying that standard, it exists if the recipient has the type of interest in the matter, and the publisher stands in such a relation to him, that it would reasonably be considered the duty of the publisher to give the information.[40]

The court's observation would appear to correlate with the standard of care which creates the duty to act for the protection of third parties.[41] Thus, a psychotherapist avoids liability to both his patient and third parties if he warns others of the potential dangerous behavior that a patient may exhibit, provided that a warning is a reasonable method of satisfying his duty to act for the protection of others.

Conclusion

The concern in *Tarasoff* focused on protecting the public from the violence of the mentally ill. Whether the court has provided sufficient protection by imposing a duty on psychotherapists to warn prospective victims and others is questionable in light of the extreme difficulty in accurately predicting violent behavior. The alternative to a warning would seem to be physical commitment of potentially violent mental patients.[42] Such an alternative not only suffers from the problem of accurately predicting the likelihood of violence, but also unduly limits the ability of psychotherapists to use a variety of techniques to treat mental illness.

For the ultimate protection of society, the psychotherapist must be free to weigh the advantages and disadvantages of any course of treatment. Because of the variable and delicate nature of the situations the psychotherapist may face, he cannot be bound by rigid standards of care. To the extent that *Tarasoff* restricts the flexibility of responses by imposing a duty to warn, an impediment to effective treatment of the mentally ill has been imposed which may add little, if any, support to the arsenal presently employed for the protection of society.

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40. *Id.* at —, 331 P.2d at 818 (footnote omitted).
41. See notes 7-17 *supra* and accompanying text.
42. *See* Stone, *supra* note 11, at 374.