(3) surrogacy clinics, see Huddleston vs. Infertility Ctr. of Am., 700 A.2d 453 (Pa. Super. Ct. 1997) (surrogacy clinic has special relationship with prospective-parent patrons and with child born as a result of clinic's services). For a court expressing reluctance about recognizing additional special relationships, see Patton v. United States of America Rugby Football Union, 851 A.2d 566 (Md. 2004).

The Prosser treatise has been predicting for nearly five decades that courts would recognize family members as a special relationship. See William L. Prosser, The Law of Torts § 54, at 338 (3d ed. 1964). Prosser's prognostication has not been borne out. The only case that squarely addresses whether a family member owes an affirmative duty to other family members held an aunt did not owe an affirmative duty to her nephew. Chastain v. Fuqua Indus., Inc., 275 S.E.2d 679 (Ga. Ct. App. 1980). Several cases recognize the duty of custodial parents to their children. See Delgado v. Lohmar, 289 N.W.2d 479, 483–484 (Minn. 1979); Lundman v. McKown, 530 N.W.2d 807, 820–821 (Minn. Ct. App. 1995) ("we believe there also is a presumption that 'custodial' stepparents (and 'visitation' stepparents during visitation) assume special-relationship duties to stepchildren"). However, a number of these courts do not view the parent's duty to the child as an affirmative one. Thus, in Broadbent v. Broadbent, 907 P.2d 43 (Ariz. 1995), in the course of holding that parental immunity does not prevent a child from suing a parent for negligent supervision, the court observed that, had the plaintiff been a neighbor child, the defendant would be liable. See also Bang v. Tran, 1997 Mass. App. Div. 122 (Dist. Ct. 1997). But see Holodook v. Spencer, 324 N.E.2d 338 (N.Y. 1974) (declining to recognize tort action by child against parent for negligent supervision; parent can only be liable to child when legal obligation arises outside the family relationship). Hence, these cases are not strong support for recognition of family as a special relationship imposing an affirmative duty. As well, courts in many of these cases primarily focus on whether parental immunity should be abolished and, if so, the scope of liability that remains for parents, thereby distracting attention from whether a parent has a special relationship with a child that imposes affirmative duties that go beyond providing necessary care, supervision, and provision for an unemancipated minor. See Foldi v. Jeffries, 461 A.2d 1145 (N.J. 1983); Cole v. Sears Roebuck & Co., 177 N.W.2d 866 (Wis. 1970).

Beyond these cases, there has been almost no judicial consideration of the affirmative duties of family members to each other. A sparse body of cases addresses the affirmative duty of family members to third parties for risks posed by another member of the family. See, e.g., Bicknell v. Dakota GM, Inc., 2009 WL 799613 (D. Minn. 2009) (concluding that wife did not have special relationship with husband such that an affirmative duty was owed); Touchette v. Ganal, 922 P.2d 347 (Haw. 1996).

§ 41. Duty to Third Parties Based on Special Relationship with Person Posing Risks

(a) An actor in a special relationship with another owes a duty of reasonable care to third parties with

regard to risks posed by the other that arise within the scope of the relationship.

(b) Special relationships giving rise to the duty provided in Subsection (a) include:

(1) a parent with dependent children,

(2) a custodian with those in its custody,

(3) an employer with employees when the employment facilitates the employee's causing harm to third parties, and

(4) a mental-health professional with patients.

Comment:

a. History. Section 315 of the Second Restatement of Torts stated the general proposition that there is no affirmative duty to control the conduct of a third party so as to prevent the third party from causing harm to another. Subsection (a) provided an exception to that general rule based on a special relationship between the actor and the third party. Subsequent Sections elaborated on the relationships that were sufficient to impose such a duty: § 316 imposed a duty of reasonable care on parents to control the conduct of their minor children; § 317 imposed a duty of reasonable care on employers to control the conduct of their employees acting outside the scope of employment; and § 319 imposed a duty of reasonable care on those who take charge of persons known to be likely to cause bodily harm to others. This Section replaces §§ 315(a), 316, 317, and 319 and includes an additional relationship creating an affirmative duty, that of mental-health professional and patient. Section 318 of the Second Restatement, which imposed a duty of reasonable care on possessors of land to control the conduct of their licensees, has been replaced by § 51 of this Restatement.

b. Court determinations of no duty based on special problems of principle or policy. Even though an affirmative duty might exist pursuant to this Section, a court may decide, based on special problems of principle or policy, that no duty or a duty other than reasonable care exists. See § 7(b).

c. Duty of reasonable care. The duty imposed by this Section is to exercise reasonable care under the circumstances. It is not to ensure that the other person is controlled. If the other person poses a risk of harm to third parties, the actor must take reasonable steps, in light of the foreseeable probability and magnitude of any harm, to prevent it from occurring. In addition, the relationships identified in this Section are ones in which the actor has some degree of control

even though these decisions arise in a custodial relationship. Imposing such a duty, thereby creating concern about potential liability, might detrimentally affect the decisionmaking of parole boards and others making similar determinations. By contrast, those who supervise parolees, probationers, or others in prerelease programs engage in more ministerial functions, and they are held to an affirmative duty of reasonable care. The extent of control exercised by the custodian—parole and probation officers have limited control over those whom they supervise—is a factor in determining whether the custodian has breached the duty of reasonable care. Even when an affirmative duty under this Section exists, significant questions about factual causation may arise in suits against supervisors of persons conditionally released from incarceration.

g. Duty of mental-health professionals. The seminal case of Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976), recognized a special relationship between a psychotherapist and an outpatient, and a corresponding duty of care on the part of the psychotherapist to third parties whom the patient might harm. The court in *Tarasoff* acknowledged the importance of confidentiality to the psychotherapist–patient relationship but concluded that the protection of third parties outweighed these concerns. Notably, in *Tarasoff*, the psychotherapists had already compromised confidentiality by contacting the police to have the patient detained so that he could be committed because of the dangers that he posed. The core holding of *Tarasoff* has been widely embraced, but courts often disagree about specifics. The primary points of contention are the content of the duty and to whom the duty is owed.

Consistent with the general approach of this Chapter, the duty imposed by Subsection (b)(4) on mental-health professionals is one of reasonable care under the circumstances. A mental-health professional has a duty to use customary care in determining whether a patient poses a risk of harm. Once such a patient is identified, the duty imposed by reasonable care depends on the circumstances: reasonable care may require providing appropriate treatment, warning others of the risks posed by the patient, seeking the patient's agreement to a voluntary commitment, making efforts to commit the patient involuntarily, or taking other steps to ameliorate the risk posed by the patient. In some cases, reasonable care may require a warning to someone other than the potential victim, such as parents, law-enforcement officials, or other appropriate government officials.

In some cases, one or more of these options may be clearly inappropriate, and courts appropriately rule as a matter of law that there has been no negligence for failing to pursue that course of action. In addition, some deference to the judgment of a psychotherapist acting in good faith is appropriate. The psychotherapy profession has been attentive to the duty imposed on it; students are routinely taught about their obligations to protect others from dangerous patients. Providing more certain guidelines than "reasonable care" to this attentive audience may be appropriate, especially where profit or other self-interest motivations are not significant. A standard of deference to the good-faith choices made by mental-health professionals would alleviate some tension prompted by the uncertainty of a reasonable-care standard. This deference might be effected by permitting argument on the subject, by an instruction to the jury explaining why it should give some deference to conscious and good-faith judgments of the defendant, or by crafting a good-faith rule roughly analogous to the business-judgment rule employed for corporate directors. Some legislatures have responded to this concern for greater certainty by enacting more inflexible rules limiting the scope of psychotherapists' duties.

The rule stated in this Section sets no limit on those to whom the duty is owed. Many courts and legislatures have limited the duty to warning third parties who are reasonably identifiable. Reasonable care itself does not require warning individuals who cannot be identified, so such a limitation is properly a question of reasonable care, not a question of the existence of a duty. However, when reasonable care requires confining a patient who poses a real risk of harm to the community, the duty of the mental-health professional ordinarily extends to those members of the community who are put at risk by the patient.

The duty imposed by this Section is limited to steps that are reasonably available to the mental-health professional. Patients who are not in custody cannot be "controlled" in the classic sense, and the duty imposed is only one of reasonable care. Yet a health-care professional can pursue, and may have a statutory obligation to seek, involuntary commitment of patients who are dangerous to themselves or others. Other less intrusive measures may be available and appropriate depending on the circumstances.

Illustrations:

2. Dr. Jones, a psychiatrist, sees a patient, Todd. During the course of therapy, Todd expresses a desire to harm his former girlfriend, Caroline, who had severed their relationship. Dr. Jones concludes that Todd poses a real risk of acting on his threat. Although Todd does not name his girlfriend in his sessions with Dr. Jones, her name was in Todd's medical records based on an initial history completed when Todd first became a patient of Dr. Jones. Dr. Jones does nothing to notify Caroline or otherwise take

steps to protect her. Todd physically harms Caroline, who sues Dr. Jones. Dr. Jones owes Caroline a duty of reasonable care and is subject to liability for Caroline's harm.

3. Steve, a 14-year-old having adolescent adjustment difficulties, is referred to Dr. Cress, a psychologist. Dr. Cress treats Steve for several months, concluding that Steve suffers from mild depression and deficits in peer social skills. Steve occasionally expresses generalized anger at his circumstances in life but never blames others or gives any other indication that he might act violently, and Dr. Cress has no reason to think that Steve poses a risk of harm to others. Steve hacks his parents to death with a scythe. Dr. Cress had no duty to Steve's parents and is not subject to liability to the administrators of their estates.

4. Dr. Strand, a clinical psychologist, becomes aware, during the course of counseling, that a patient, Lester, is sexually abusing his eight-year-old stepdaughter, Kelly. Dr. Strand does not communicate this information to Kelly's mother or to appropriate officials of the state Department of Social Services, or take any other steps to prevent Lester from continuing his sexual assaults on Kelly. Dr. Strand owes a duty of reasonable care to Kelly and is subject to liability for the harm due to Lester's continuing abuse of her.

5. Perrin suffers from schizophrenia, which can generally be controlled with medication. However, Perrin intermittently, with no apparent pattern, stops taking his medication. On these occasions he suffers severe delusions and frequently believes that he is under attack by various inanimate objects. Several of these episodes are punctuated by aggressive and threatening behavior that leads Dr. Hillsley, his treating psychotherapist, to believe that Perrin cannot live on his own and poses a significant danger to others unless he continues taking his medication. Dr. Hillsley receives a call from Perrin one Saturday morning, during which it becomes clear that he is not taking his medicine. Perrin requests an immediate office visit and tells Dr. Hillsley that pedestrians on the street are carrying surgical instruments with which to investigate Perrin's brain; Perrin assures Dr. Hillsley that he will retaliate in kind at the first provocation. Dr. Hillsley, not wanting to be bothered on the weekend, declines to meet with Perrin to evaluate whether he should be involuntarily committed or to recommend that Perrin seek an evaluation at the local psychiatric hospital. Instead, he suggests that Perrin go home and call his office on a weekday to make an appointment to see him during regular hours. Instead of going home, Perrin grabs Jake, a passerby on the street, and stabs him in the neck. Dr. Hillsley has

a special relationship with Perrin and a duty of reasonable care to Jake and others put at risk by Perrin. Dr. Hillsley is subject to liability for Jake's harm.

Even when a duty exists pursuant to Subsection (b)(4) and an actor breaches it, factual causation must exist for the actor to be subject to liability. Thus, when the actor's breach consists of failing to warn third parties who suffer harm, the actor is not subject to liability unless the warning would have prevented the harm. When those third parties are already aware of all the material information that would have been provided by the mental-health professional, any warning would not have made a difference and, hence, the actor is not subject to liability. Courts often express the reason for this outcome in duty terms: there is no duty to warn when the information is already known. It would be more accurate, however, to characterize the reason as the absence of factual causation.

Mental-health professionals subject to the duty imposed by Subsection (b)(4) include psychiatrists, psychologists, social workers, and others who have a relationship with a mental patient and provide professional psychotherapeutic services to the patient.

In addition to the affirmative duty to third parties imposed by Subsection (b)(4), mental-health professionals, like other health-care professionals, have a duty of care to their patients once they enter into a professional–patient relationship. A mental-health professional may fail to exercise the appropriate standard of care in treating a patient. When professional malpractice causes harm to the patient or to others, the professional is subject to liability. The source of such duty is not contained in this Chapter, but in the general principles regarding the duty of professionals not to harm others by failing to exercise appropriate care.

h. Duty of non-mental-health physicians to third parties. The duty of mental-health physicians to third parties for risks posed by the physician's patient's dangerousness is addressed in Subsection (b)(4) and Comment *g*. Although no black-letter provision in this Restatement imposes an affirmative duty on non-mental-health physicians to third parties, this Comment addresses that question. There are times when a medical patient's condition, such as a contagious disease, might pose a risk to others. In that event, the duty of the treating physician would be appropriately assessed based on the considerations contained in this Comment. This Comment's reference to "physicians" is to instances in which the rule contained in Subsection (b)(4) imposing a duty on mental-health professionals is inapplicable.

Unlike most duties, the physician's duty to the patient is explicitly relational: physicians owe a duty of care to *patients*. That duty

encompasses both the ordinary duty not to harm the patient through negligent conduct and an affirmative duty to use appropriate care to help the patient.

In some cases, care provided to a patient may create risks to others. This may occur because of negligent treatment, such as prescribing an inappropriate medication that impairs the patient. It can also occur because of appropriate care of the patient, such as properly prescribing medication that impairs the patient. In these instances, the physician's duty to third parties is governed by § 7, not by this Chapter. In other cases, however, a physician may have no role in creating the risk. An example is a physician who treats a patient with a communicable disease. In those cases, any duty of the physician is an affirmative one that arises under this Section and Comment.

The physician–patient relationship is not among the relationships listed in this Section as creating an affirmative duty. That does not mean that physicians have no affirmative duty to third parties. Some of the obligations of physicians to third parties, such as with patients who are HIV-infected, have been addressed by legislatures. In other areas, the case law is sufficiently mixed, the factual circumstances sufficiently varied, and the policies sufficiently balanced, that this Restatement leaves to further development the question of when physicians have a duty to use reasonable care or some more limited duty—such as to warn only the patient—to protect third parties. In support of a duty is the fact that an affirmative duty for physicians would be analogous to the affirmative duty imposed on mental-health professionals. See Comment *g*. In fact, the burden on a physician might be less than that imposed on a mental-health practitioner, because the costs of breaching confidentiality may be lower. Additionally, diagnostic techniques may be more reliable for physical disease and the risks that it poses than for mental disease and its risks.

Many courts have been influenced by the patient's preferences regarding warnings or other precautions to benefit family members or others with whom the patient has a relationship. The case for an affirmative duty to be imposed on a physician is stronger when the patient would prefer protective measures for the third party. This is similar to the intended third-party-beneficiary rule that courts have used in other professional contexts. Courts generally have held physicians liable to nonpatient family members for failing to provide the patient with information about a communicable disease. On the other hand, some courts are concerned that any precaution a physician might take would have little or no effect in reducing the risk, especially for warnings to patients about risks of which they were already aware. These courts may lack confidence in their ability to address factual causation in these cases. They may also be concerned with the

administrative costs of identifying the few cases in which causation exists. This Restatement takes no position on how these competing concerns should be resolved.

If a court does impose an affirmative duty on physicians to nonpatients, it must address both the content of the duty and the question of who can recover. For example, a court might limit the scope of a physician's duty to warning the patient of risks that the patient poses to others. A court might then hold that the physician's liability extends to any person harmed by the patient's condition or to a more limited class based on relationship with the patient, time, or place.

i. Nonexclusivity of relationships. As with § 40, the list of special relationships provided in this Section is not exclusive. Courts may decide that additional relationships justify exceptions to the no-duty rule contained in § 37. Indeed, the addition of the duty of mental-health professionals to third parties for risks posed by patients that is provided in Subsection (b)(4) is a relationship that courts have developed since the Second Restatement.

REPORTERS' NOTE

Comment c. Duty of reasonable care. The Second Restatement imposed a duty on parents and employers to control the conduct of minor children and employees only if they knew or had reason to know of their ability to control and knew or had reason to know of the necessity of and opportunity for control. See Restatement Second, Torts §§ 316–317. In this Restatement, those conditions are subsumed within the analysis of reasonable care; they are not prerequisites for the existence of a duty. See § 3. Similarly, whether reasonable care requires controlling the conduct of another or merely providing a warning is a question of breach (and governed by Chapter 3), not the existence of a duty.

As the North Carolina Supreme Court explained, after discussing the requirements of Restatement Second of Torts § 316 (duty of parent to control child), "[t]he issue in the final analysis is whether the particular parent exercised reasonable care under all of the circumstances." Moore v. Crumpton, 295 S.E.2d 436, 440 (N.C. 1982).

Comment d. Duty of parent of dependent children. For cases affirming the existence of an affirmative duty to third parties based on the parent–child relationship, see Parsons v. Smithey, 504 P.2d 1272 (Ariz. 1973); Linder v. Bidner, 270 N.Y.S.2d 427 (Sup. Ct. 1966); Moore v. Crumpton, 295 S.E.2d 436 (N.C. 1982); Isbell v. Ryan, 983 S.W.2d 335 (Tex. App. 1998); Nieuwendorp v. Am. Family Ins. Co., 529 N.W.2d 594 (Wis. 1995).

It is often said that parents are not vicariously liable for the torts of their children. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 123, at 913 (5th ed. 1984). This Section is not contrary to that proposition. Before liability may be

Cir. 1976); Sterling v. Bloom, 723 P.2d 755 (Idaho 1986); A.L. v. Commonwealth, 521 N.E.2d 1017 (Mass. 1988); Starkenburg v. State, 934 P.2d 1018 (Mont. 1997); Faile v. S.C. Dep't of Juvenile Justice, 566 S.E.2d 536 (S.C. 2002); Hertog v. City of Seattle, 979 P.2d 400 (Wash. 1999) (prerelease counselor); Bishop v. Miche, 973 P.2d 465 (Wash. 1999); Taggart v. State, 822 P.2d 243 (Wash. 1992) (parole officer). The Supreme Court of Alaska explained the basis for an affirmative duty despite lack of complete control:

> Although the state was required to release Nukapigak, he remained under state supervision as a parolee. It could regulate his movements within the state, require him to report to a parole officer under conditions set by that officer or a prison counselor, require him to undergo treatment for alcoholism, and impose and enforce special conditions of parole including requirements that he refrain from the use of alcohol, participate in an alcohol rehabilitation program, and that he consent to a search of his residence to see if he possessed firearms. It could revoke his parole and reincarcerate him if he violated these conditions. While the state could not completely control Nukapigak's conduct, it was hardly in the position of a stranger who (at least according to the traditional rule) cannot be expected to interfere with the conduct of a third person.

Div. of Corr. v. Neakok, 721 P.2d 1121, 1126 (Alaska 1986); see also E.P. v. Riley, 604 N.W.2d 7 (S.D. 1999) (department of social services had affirmative duty with regard to foster child in its legal, but not physical, custody). Thus, this Section rejects the reasoning of courts like Seibel v. City of Honolulu, 602 P.2d 532 (Haw. 1979), which declined to impose an affirmative duty on a prosecutor who had modest supervisory responsibilities for a person who had been acquitted of multiple rapes on the grounds of insanity and who subsequently obtained a conditional release from incarceration. The court reasoned that the prosecutor's custody pursuant to the court order of conditional release was insufficient to impose a duty pursuant to § 319 of the Restatement Second of Torts. See also Schmidt v. HTG, Inc., 961 P.2d 677 (Kan. 1998) (parole officer does not have control over released inmate and hence, has no affirmative duty); Lamb v. Hopkins, 492 A.2d 1297 (Md. 1985) (probation officers did not have sufficient charge for affirmative duty to arise); Bartunek v. State, 666 N.W.2d 435 (Neb. 2003); Small v. McKennan Hosp., 403 N.W.2d 410, 413–414 (S.D. 1987); Fox v. Custis, 372 S.E.2d 373, 376 (Va. 1988) ("The applicable statute [regarding a parole officer's supervision of a parolee] does not contemplate continuing hourly or daily dominance and dominion by a parole officer over the activities of a parolee."); cf. Bailey v. Town of Forks, 737 P.2d 1257 (Wash. 1987) (defendant, whose police officer had statutory duty to take custody of intoxicated driver but did not, is subject to liability to plaintiff who was injured by intoxicated driver).

Comment g. Duty of mental-health professionals. Virtually all courts confronting the issue have decided that mental-health professionals owe some affirmative duty to third parties with regard to patients who are recognized as posing dangers. See Currie v. United States, 644 F. Supp. 1074,

1078 (M.D.N.C. 1986) (stating that the "vast majority of courts that have considered the issue have accepted the *Tarasoff* analysis"), aff'd, 836 F.2d 209 (4th Cir. 1987); Munstermann v. Alegent Health-Immanuel Med. Ctr., 716 N.W.2d 73, 81 (Neb. 2006) ("The vast majority of courts that have considered this issue have accepted the *Tarasoff* analysis."); Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 98 (1994) (reporting that *Tarasoff* is "widely accepted (and rarely rejected) by courts and legislatures in the United States as a foundation for establishing duties of reasonable care upon psychotherapists to warn, control, and/or protect potential victims of their patients who have expressed violent intentions."); see also Bradley v. Ray, 904 S.W.2d 302, 307–309 (Mo. Ct. App. 1995) (providing survey of jurisdictions' response to *Tarasoff* and reporting that only one state had declined to adopt a *Tarasoff* duty). Some courts, while not adopting a *Tarasoff* duty, have spoken in terms that suggest a favorable disposition in a future case that squarely poses the issue. See, e.g., Anthony v. State, 374 N.W.2d 662 (Iowa 1985). The vast majority of such states in which a *Tarasoff* duty has been judicially imposed have subsequently enacted statutes that codify the duty, often in response to efforts by mental-health associations and the American Psychological Association to provide greater clarity or limits to the judicially imposed duty. See Fillmore Buckner & Marvin Firestone, *Where the Public Peril Begins: 25 Years After* Tarasoff, 21 J. LEGAL MED. 187 (2000); Damon M. Walcott et al., *Current Analysis of the* Tarasoff *Duty*, 19 BEHAV. SCI. & L. 325, 339 (2001). See generally Bradley v. Ray, 904 S.W.2d 302, 309 (Mo. Ct. App. 1995); Paul B. Herbert & Kathryn A. Young, Tarasoff *at Twenty-Five*, 30 J. AM. ACAD. PSYCHIATRY L. 275 (2002).

The *Tarasoff* duty is widely taught to therapist students; texts and clinical guidelines provide guidance on how to comply, professional ethical codes take account of it, and the mental-health professional who does not know of the general concept is unusual. See GERALD COREY ET AL., ISSUES AND ETHICS IN THE HELPING PROFESSIONS 224–232 (7th ed. 2007) ("Most counseling centers and community health agencies now have developed guidelines regarding the duty to warn and protect when the welfare of others is at stake."); GERALD COREY ET AL., PROFESSIONAL AND ETHICAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 123–124 (1979) (therapists are "obliged to exercise reasonable care to protect the would-be victims"); DEAN HEPWORTH, ET AL., DIRECT SOCIAL WORK PRACTICE: THEORY & SKILLS 69 (7th ed. 2006) ("In certain instances, the client's right to confidentiality may be less compelling than the rights of other people who could be severely harmed or damaged by actions planned by the client and confided to the practitioner."); DAVID G. MARTIN & ALLAN D. MOORE, FIRST STEPS IN THE ART OF INTERVENTION 364 (1995) ("It is hard to imagine a mental-health professional who has not heard of the now infamous *Tarasoff* case . . . ."). Indeed, even in states in which there is no definitive case adopting a *Tarasoff* duty, clinicians practice as if there were. Lawson R. Wulsin et al., *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty to Warn,"* 140 AM. J. PSYCHIATRY 601 (1983) ("Massachusetts has had no specific case 'on point' for this issue, clinicians generally act as

though the reasoning in *Tarasoff* applied here.").

For courts endorsing a general duty of reasonable care similar to that adopted in this Section, see Currie v. United States, 644 F. Supp. 1074, 1080–1083 (M.D.N.C. 1986), aff'd, 836 F.2d 209 (4th Cir. 1987); Perreira v. State, 768 P.2d 1198 (Colo. 1989); Naidu v. Laird, 539 A.2d 1064 (Del. 1988); Davis v. Lihm, 335 N.W.2d 481 (Mich. Ct. App. 1983); McIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979); Estate of Morgan v. Fairfield Family Counseling Ctr., 673 N.E.2d 1311 (Ohio 1997); Schuster v. Altenberg, 424 N.W.2d 159, 161–162 (Wis. 1988). Indeed, the initial opinion in *Tarasoff* was limited to imposing a duty to warn. Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553 (Cal. 1974). That opinion was withdrawn for rehearing, and the second and governing *Tarasoff* opinion expanded the duty of psychotherapists to require the exercise of reasonable care. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976). The California Supreme Court relied heavily on an article that found support in prior cases for a duty, by those caring for inpatients, owed to third parties. The article also confronted the trade-off between preserving confidentiality and protection of third parties. See John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025 (1974).

Some courts have declined to adopt a duty beyond that of warning. A substantial number of courts, and legislatures enacting statutes, limit the duty to warning the potential victim. See, e.g., Bradley v. Ray, 904 S.W.2d 302, 312 n.7 (Mo. Ct. App. 1995). A number of the cases declining to extend the duty beyond warning involve factual circumstances in which efforts other than warnings would not have been reasonable. See Fraser v. United States, 674 A.2d 811 (Conn. 1996) (no basis on which to believe patient posed a risk of harm to others); Boulanger v. Pol, 900 P.2d 823, 835 (Kan. 1995) (no reason existed for seeking involuntary commitment where warning to individual threatened by patient would have been adequate). Curiously, North Carolina recognizes a duty to control patients but does not recognize a duty to warn. See Gregory v. Kilbride, 565 S.E.2d 685 (N.C. Ct. App. 2002). See generally Alan R. Felthous & Claudia Kachigian, *To Warn and to Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?*, 19 BEHAV. SCI. & L. 355 (2001).

One good reason for employing a duty of reasonable care rather than limiting the duty to one of warning is that new developments may provide additional means for curbing the risks posed by violent psychotherapy patients. See John Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 515–518 (2006) (explaining development of involuntary outpatient programs).

Some courts and statutes require a specific threat by the patient or actual knowledge by the mental-health professional of the patient's danger to another. See, e.g., Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980); Emerich v. Phila. Ctr. for Human Dev., 720 A.2d 1032, 1036, 1041 (Pa. 1998) (duty of mental-health professional to warn third person where patient communicates a "specific and immediate threat of serious bodily injury"); Doe v. Marion, 645 S.E.2d 245 (S.C. 2007) (requiring specific threat

of harm for duty to be imposed; generalized danger of child abuse insufficient to support existence of an affirmative duty). Such requirements are rejected by Subsection (b)(4). If a mental-health professional should, in the exercise of the care ordinarily provided by similar professionals, know that a patient poses a risk of harm, such knowledge is sufficient to impose a duty of care. Likewise, while a specific threat may be a strong indication of danger, other facts in the context of mental-health treatment may also lead a professional to the judgment that the patient poses a danger to others or to self. See Estate of Morgan v. Fairfield Family Counseling Ctr., 673 N.E.2d 1311 (Ohio 1997).

Some courts and statutes have limited any warning obligation to those who are specifically identified by the patient. Others couch the limitation as those who are "readily identifiable." See, e.g., Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983); Jenks v. Brown, 415, 557 N.W.2d 114, 117 (Mich. Ct. App. 1996) ("reasonably identifiable" third parties); Munstermann v. Alegent Health-Immanuel Med. Ctr., 716 N.W.2d 73, 85 (Neb. 2006); Emerich v. Phila. Ctr. for Human Dev., 720 A.2d 1032 (Pa. 1998). Mental-health professionals should take reasonable steps to identify those who are at risk due to a dangerous patient. The greater the danger posed by the patient, the greater the efforts required to identify a potential victim, and a psychotherapist may not ignore a substantial risk to a third person merely because the individual's identity has not been supplied by the patient. The failure of the patient to name a specific victim may bear on whether there is a real risk of danger or on whether there is a specific person at risk. In that respect, lack of identification of the potential victim may be relevant to whether there is any duty and, if so, whether there is a breach. Nevertheless, the lack of identification does not, by itself, obviate any duty to warn. In any case, the threat must be one to an individual or small number of individuals. There is no duty to warn the public generally when no individual is identifiable. See Thompson v. Cnty. of Alameda, 614 P.2d 728 (Cal. 1980). On the other hand, reasonable care may require steps beyond a warning, such as commitment. No limitation with regard to victims, other than the ordinary scope-of-liability limits, applies to such cases. See Currie v. United States, 644 F. Supp. 1074, 1079 (M.D.N.C. 1986) ("The court does not believe that it is wise to limit any duty to commit according to the victim. Arguably, the patient who will kill wildly (rather than specifically identifiable victims) is the one *most* in need of confinement."), aff'd, 836 F.2d 209 (4th Cir. 1987).

The duty imposed by Subsection (b)(4) is applicable to all mental-health professionals who act in a relationship with a mental patient. In *Tarasoff*, the court held that the affirmative duty extended to both the treating psychologist and to several other psychiatrists who were involved in the care of the patient, so long as they had a psychotherapist–patient relationship. *Tarasoff*, supra, 551 P.2d at 344 n.6. Courts since *Tarasoff* have applied this duty to psychiatrists, see, e.g., Jablonski v. United States, 712 F.2d 391 (9th Cir. 1984); Rivera v. N.Y. City Health & Hosp. Corp., 191 F. Supp. 2d 412 (S.D.N.Y. 2002); Hamman v. Cnty. of Maricopa, 775 P.2d 1122 (Ariz. 1989); Davis v.

Lhim, 335 N.W.2d 481 (Mich. Ct. App. 1983); MacIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979); Schrempf v. State, 487 N.E.2d 883 (N.Y. 1985) (recognizing a duty but finding no liability where psychiatrist acted reasonably in the absence of any warning signs of potentially violent behavior by patient); and to psychologists, see, e.g., White v. United States, 780 F.2d 97 (D.C. Cir. 1986); Hedlund v. Superior Court, 669 P.2d 41 (Cal. 1983); Weigold v. Patel, 2000 WL 1056643 (Conn. Super. Ct. 2000) (finding duty existed for both a treating psychiatrist and psychologist); see also Durflinger v. Artiles, 727 F.2d 888, 890 (10th Cir. 1984) (stating that the duty involves "psychological rather than medical inquiry"). A number of state statutes enacted since *Tarasoff* contain broad definitions of the professionals to whom the statute is applicable. See, e.g., COLO. REV. STAT. § 13-21-117 (imposing duty on any "physician, social worker, psychiatric nurse, psychologist, or other mental health professional . . . where the patient has communicated to the mental health care provider a serious threat of imminent physical violence against a specific person or persons"); LA. REV. STAT. ANN. § 9:2800.2 (applying duty to "treating psychologist or psychiatrist, or board-certified social worker"); MICH. COMP. LAWS § 330.1946(4) (providing duty is imposed on "mental health professionals," including psychiatrists, psychologists, social workers, licensed professional counselors, marriage and family therapists, and music therapists); NEB. REV. STAT. § 38-2137 (providing duty applicable to licensed or certified mental-health practitioners); N.J. STAT. ANN. § 2A:62A-16 (West) (affecting any person licensed "to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling"); see also Emerich v. Phila. Ctr. for Human Dev., 720 A.2d 1032 (Pa. 1998) (imposing duty on mental-health professionals). So long as persons act in a mental-health-professional role, they are subject to the duty imposed by Subsection (b)(4). A Louisiana court declined to extend *Tarasoff* to religious counselors in Miller v. Everett, 576 So. 2d 1162 (La. Ct. App. 1991). The court in *Miller* relied on the lack of a special relationship between the counselor and the plaintiffs, rather than addressing the relationship between the counselor and the counseled.

Among the objections to imposing a duty that includes steps to "control" a patient is that psychotherapists do not have custody of their outpatients and therefore do not have the ability or right to limit their activities. See Boynton v. Burglass, 590 So. 2d 446 (Fla. Dist. Ct. App. 1991). This objection fails to appreciate that mental-health professionals have a variety of options available that may reduce the risk posed by a dangerous patient. See John Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497 (2006) (explaining four options available to psychotherapist with a dangerous patient). That a psychotherapist does not have complete control of a patient does not obviate a duty to take those steps that are available to control the risk that the patient will harm someone. See Estate of Morgan v. Fairfield Family Counseling Ctr., 673 N.E.2d 1311, 1323 (Ohio 1997) ("Although the outpatient setting affords the psychotherapist a lesser degree of control over the patient than does the hospital setting, it nevertheless embodies sufficient elements of control to warrant a corresponding duty to control."). But see Santana v. Rainbow Cleaners, 969 A.2d 653, 665-667 (R.I. 2009) (holding that outpatient clinic did not have an affirmative duty to control patient).

Only four jurisdictions have decided against a *Tarasoff*-like duty, and one of those was by an intermediate appellate court. See Boynton v. Burglass, 590 So. 2d 446 (Fla. Dist. Ct. App. 1991) (en banc); Tedrick v. Cmty. Res. Ctr., Inc., 920 N.E.2d 220, 228-229 (Ill. 2009); Thapar v. Zezulka, 994 S.W.2d 635 (Tex. 1999) (declining to adopt a duty to warn because such a duty would have conflicted with confidentiality statute that barred disclosure; distinguishing victims of child and sexual abuse, where reporting is statutorily mandated); Nasser v. Parker, 455 S.E.2d 502 (Va. 1995) (no special relationship exists unless defendant has "taken charge" of other; relationship between psychiatrist and patient admitted voluntarily to hospital because of history of violence toward women whose condition had recently deteriorated entailed insufficient control for special relationship to exist); see also Evans v. United States, 883 F. Supp. 124 (S.D. Miss. 1995) (Federal Tort Claims Act case in which court predicted that Mississippi would not adopt *Tarasoff*); Gregory v. Kilbride, 565 S.E.2d 685, 692 (N.C. Ct. App. 2002) (acknowledging a duty to control patients, but stating that "North Carolina does not recognize a psychiatrist's duty to warn third parties" without further explanation or citation (emphasis omitted)).

The concerns of courts and commentators about imposing a duty on psychotherapists are not without merit. They include: (1) the difficulty of making accurate predictions of dangerousness; (2) the necessity of incursions on professional obligations of confidentiality; (3) the impact of breaches of confidentiality on the therapist-patient relationship and the concomitant costs to effective therapy; (4) deterring mental-health professionals from treating potential patients who are dangerous; (5) the risk that therapists will employ more restrictive means than appropriate or will otherwise practice defensively, to the detriment of the patient because of liability concerns; (6) the substantial liability that could be imposed on mental-health professionals for either a modest professional mistake or because of an erroneous court determination; and, related to the prior two concerns, (7) the uncertainty created by a general reasonable-care standard for mental-health professionals. See generally Michael L. Perlin, Tarasoff *and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29, 35-39 (1992) (summarizing criticisms of *Tarasoff*); D.L. Rosenhan et al., *Warning Third Parties: The Ripple Effects of* Tarasoff, 24 PAC. L.J. 1165, 1185-1189 (1993) (also reviewing criticisms of *Tarasoff*). Dr. Alan Stone was the earliest and most vehement critic of *Tarasoff*. Alan A. Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

The court in Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983), captured many of these concerns in its observation that:

> The treating physicians, in their evaluation of the case, well might believe that [the patient] could be allowed to leave the institution for a prescribed period and that his release on pass might contribute to his treatment and

recovery. We do not believe that they should have to function under the threat of civil liability to members of the general public when making decisions about passes and releases. The plaintiff could undoubtedly find qualified psychiatrists who would testify that the treating physicians exercised negligent judgment, especially when they are fortified by hindsight. The effect would be fairly predictable. The treating physicians would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest.

These observations may explain cases, such as Morton v. Prescott, 564 So. 2d 913 (Ala. 1990), in which the court limited the duty of a psychotherapist, with regard to controlling a voluntarily-admitted patient in custody, to those against whom the patient had made a specific threat. The concern of the impact of liability and of narrowly confining affirmative duties appears to be the basis for this decision, rather than any inability to protect a broader class of potential victims by imposing a broader duty.

Developments since *Tarasoff* suggest that some of these concerns are not as serious as some critics and a few jurists thought. The best (and perhaps only feasible) method of exploring the impact of *Tarasoff*-like rules on care for mental patients is through survey methodology. While such surveys are subject to a number of potential biases that may skew results, they should be capable of identifying significant changes or problems.

(1) In the largest survey of mental-health professionals, Givelber et al. found that their respondents generally thought that they were able to predict, with some degree of accuracy, outpatient dangerousness, with less than 10 percent expressing the view that it was impossible to predict. Respondents also believed that there was a fair amount of reliability, i.e., agreement among others, for their judgments. See Daniel J. Givelber et al., Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 462–464. A survey conducted a decade after the Givelber study obtained similar results. Rosenhan, supra, at 1207–1208.

Most nonsurvey research on the accuracy of predictions of dangerousness has focused on the needs of criminal law. Thus, investigations address predicting dangerousness over a lengthy period. Moreover, empirical studies are more readily conducted of inpatients, rather than of outpatients. Those studies have not been heartening about the ability of psychotherapists to predict dangerousness. See, e.g., JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981) (finding that only one in three predictions of long-term dangerousness among institutionalized population were correct). Even with relatively sensitive tests for dangerousness, a substantial number of false positives occur because of the low base rate of dangerousness among the patient population. See Joseph M. Livermore, Carl P. Malmquist & Paul E. Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 84 (1968) (using criminal convictions as the measure for dangerousness biases (by understating) the incidence of dangerousness). Subsequent research has found somewhat better accuracy, partially as a result of better research methodology in identifying subsequent violence and partially due to improved predictive techniques. See Randy K. Otto, *On the Ability of Mental-Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 LAW & PSYCHOL. REV. 43 (1994); Rosenhan, supra, at 1186 n.140 ("[R]ecent evidence, however, suggests that while predicting dangerous behavior is clearly a difficult matter, there are circumstances when it can be predicted better than others."). Advances in knowledge about risk factors and predictive methodology should improve future accuracy. See Randy Borum, *Improving the Clinical Practice of Violence Risk Assessment*, 51 AM. PSYCHOL. 945, 954 (1996). At the time of *Tarasoff*, Professor John Monahan wrote that psychotherapists' predictions of violence were sufficiently inaccurate to be unpromising for use in the legal system. Thirty years later, he revised that assessment and commented: "What a difference three decades make: the field of violence risk assessment has burgeoned and is now a vast and vibrant area of interdisciplinary scholarship." See John Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 497 (2006).

False negatives are apparently not as prevalent as false positives because of the perception that they are more costly than false positives and because of the low base rate of dangerousness. See ALAN A. STONE, MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION 35 (1975) (explaining forces at work in the psychotherapy profession that produce low rate of false negatives); Michael Petrunik, *The Politics of Dangerousness*, 5 INT'L J.L. & PSYCHIATRY 225, 243–246 (1982).

(2) Before *Tarasoff*, mental-health professionals believed that professional ethical obligations required them to breach confidentiality and issue warnings in certain circumstances, including when a patient posed a risk to the community. Judith Beren Leonard, *A Therapist's Duty to Potential Victims: A Nonthreatening View of* Tarasoff, 1 LAW & HUM. BEHAV. 309, 317 (1977) ("*Tarasoff* represents no greater burden than the profession would be likely to impose upon itself."); R. Little & E. Strecker, *Moot Questions in Psychiatric Ethics*, 113 AM. J. PSYCHIATRY 455 (1956) (two-thirds of responding psychotherapists stated that they would breach confidentiality and warn others if they believed a minor patient was homicidal or suicidal and parents refused to take action); Toni Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 176 (1978) (70% of survey respondents reported that confidentiality could be breached under appropriate circumstances). Thus, the idea that *Tarasoff* required breach of an absolute curtain of confidentiality was false; indeed, in the *Tarasoff* case, the psychotherapist contacted law-enforcement officials and had his patient detained because of the psychotherapist's concern about the potential for violence by the patient. However, by including potential victims among those required to be warned, *Tarasoff* expanded the universe of persons to be provided confidential information. Even after *Tarasoff*, a substantial proportion of mental-health professionals believe that their ethical, rather than legal, obligations require warnings. James

C. Beck, *Violent Patients and the* Tarasoff *Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361, 365 (1985) (only 12% of respondents believed *Tarasoff* duty was due solely to legal requirements); Givelber, supra, at 474 (between 48 and 77% of respondents believed professional ethics and 75 to 85% believed personal ethics required taking some action to protect third party).

(3) Two small studies of psychotherapists reveal that, in a small percentage of *Tarasoff* cases, there is an adverse effect on therapy, such as a patient ceasing further therapy. Beck, supra, at 373 (reporting on two studies that included 40 cases in which confidentiality was breached, three of which resulted in adverse impact on therapy). Rosenhan et al. found, in a survey of California therapists, that half of them felt they had lost a patient as a result of discussing the need to breach confidentiality when that patient threatened harm. Rosenhan, supra, at 1215.

Other assessments of the impact of *Tarasoff* on the mental-health profession suggest even more modest or no adverse effects. See Renee Binder & Dale McNeil, *Application of the* Tarasoff *Ruling and Its Effect on the Victim and the Therapeutic Relationship*, 47 PSYCHIATRIC SERVS. 1212 (1996) (reporting that 3/4 of patients had a minimal or positive reaction to breaches of confidentiality by their therapist and concluding that "[m]any of the anticipated negative effects of the *Tarasoff* decision have not materialized"); Dale McNeil et al., *Management of Threats of Violence Under California's Duty-to-Protect Statute*, 155 AM. J. PSYCHIATRY 1097 (1998) (notification of family members who were potential victims assisted in family therapy). Some researchers believe that therapists can, by discussing the need for a warning with their patients, actually improve the therapeutic relationship and its benefit for patients. One therapist has theorized that *Tarasoff* obligations enhance the ability of psychotherapists to help their patients with better decisionmaking. L.R. Wulsin et al., *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty to Warn,"* 40 AM. J. PSYCHIATRY 601 (1983). James Beck reports that:

> A warning that is discussed strengthens an alliance because the therapist demonstrates to the patient the ability to retain his therapeutic concern even in the face of imminent danger.... By making clear to the patient that the therapist proposes to prevent violence if he or she can, the therapist dramatically demonstrates to the patient an alliance with the healthier, more socially constructive aspects of the patient's personality.

James C. Beck, *When the Patient Threatens Violence: An Empirical Study of Clinical Practice after* Tarasoff, 10 BULL. AM. ACAD. PSYCHIATRY & L. 189, 199 (1982); see also Judith Treadway, Tarasoff *in the Therapeutic Setting*, 41 HOSP. & CMTY. PSYCHIATRY 88, 88–89 (1990) (reporting on case in which patient was relieved that therapist brought spouse, who had been threatened by patient, into therapy session); David B. Wexler, *Patients, Therapists, and Third Parties: The Victimological Virtues of* Tarasoff, 2 INT'L J.L. & PSYCHIATRY 1 (1979).

(4) Surveys reveal little or no abandonment of potentially dangerous patients after *Tarasoff*. Givelber, supra, at 478–489; Beck, supra, at 366 (5%

of private psychiatrist respondents report avoiding potentially violent patients and another 5% report referring patients who become violent for public treatment); Rosenhan et al., supra, at 1209–1210 (18% of therapists report avoiding counseling dangerous patients, at least in part, because of *Tarasoff*). Mental-health professionals might be reluctant to self-report such behavior, lending concern about bias to this outcome. Yet, if the obligations imposed by *Tarasoff* are unpopular in the psychotherapist community, a contrary bias might result in overreporting of abandonment.

(5) Despite much theorizing about the adverse effects that defensive practices might produce, the only effort to examine this hypothesis found little to support it. See Jeffrey R. Wilbert & Solomon M. Fulero, *Impact of Malpractice on Professional Psychology: Survey of Practitioners*, 19 PROF. PSYCHOL.: RES. & PRAC. 379, 381 (1988) ("Overall, our data turned up little evidence of an epidemic of litigaphobia among practicing Ohio psychologists.").

(6) Some of the concerns about erroneous judgments can be cabined by courts ensuring that there are facts supporting a professional judgment that the patient posed a risk, that there were reasonable steps available to the professional to ameliorate that risk, and that adoption of those steps would have avoided or ameliorated the harm suffered by the plaintiff. See Boynton v. Burglass, 590 So. 2d 446 (Fla. Dist. Ct. App. 1991).

(7) The reasonable-care standard does create uncertainty for a population that is acutely aware of the *Tarasoff* decision. See Peter H. Schuck & Daniel J. Givelber, Tarasoff v. Regents of the University of California: *The Therapist's Dilemma*, *in* TORTS STORIES 99, 114–116 (Robert L. Rabin & Stephen D. Sugarman eds., 2003) (explaining extent of familiarity of therapist community with *Tarasoff* generally). Giving greater deference to reasonable choices made by therapists in protecting potential victims, when unsuccessful, could rectify this concern. Cf. Currie v. United States, 644 F. Supp. 1074, 1083 (M.D.N.C. 1986) (providing good-faith professional-judgment defense to therapist who made judgment not to commit patient), aff'd, 836 F.2d 209 (4th Cir. 1987). Many of the statutes enacted by legislatures that codify therapists' obligations provide greater certainty, but at the cost of eliminating some claims that might be valid.

(8) Beyond assessing quality of care, a recent unpublished empirical investigation found that *Tarasoff* duties have increased homicides by five percent. See Griffin Sims Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of* Tarasoff v. Regents *on Homicidal Activity*, Emory University, Department of Economics January 29, 2010. Emory Law and Economics Research Paper No. 10-61.

In sum, *Tarasoff's* duty of care is not without costs, although they appear in retrospect to be considerably more confined than was initially predicted by the therapeutic community. More difficult to determine, as is always the case with events that are prevented from occurring, are its benefits in terms of protecting third parties from violence. Survey evidence does suggest that another benefit of *Tarasoff* is greater attention by therapists in their counseling relationships to potential violence. Indeed, one of the earliest and harshest critics of *Tarasoff*, an academic psy-

chiatrist who also teaches law, subsequently confessed that "the duty to warn is not as unmitigated a disaster for the enterprise of psychotherapy as it once seemed to critics like myself." ALAN A. STONE, LAW, PSYCHIATRY AND MORALITY: ESSAYS AND ANALYSIS 181 (1984).

That a defendant is subject to a duty under Subsection (b)(4) does not preclude an affirmative duty existing due to some other provision in this Chapter. See Estate of Long v. Broadlawns Med. Ctr., 656 N.W.2d 71 (Iowa 2002) (duty imposed based on undertaking by defendant). For cases imposing a duty on mental-health professionals based on their custody of those who are being treated as inpatients, see Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982) (mental-health hospital subject to duty of reasonable care to identified third party with regard to voluntarily committed patient who was provided a weekend pass after he stated that, if given the opportunity, he would hurt his wife); Leonard v. State, 491 N.W.2d 508 (Iowa 1992) (psychotherapist has special relationship with involuntarily committed patient, but duty is limited to reasonably foreseeable victims); Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983) (affirmative duty of reasonable care owed to third parties for dangerous patient who was involuntarily committed); Gregory v. Kilbride, 565 S.E.2d 685 (N.C. Ct. App. 2002) (affirmative duty exists to take care to protect third parties from risks posed by the release of a mental patient who is involuntarily committed). But see Boulanger v. Pol, 900 P.2d 823 (Kan. 1995) (no affirmative duty and no liability for negligent release of voluntary patient).

A mental-health professional may commit malpractice in treating a patient. All health-care professionals owe a duty of care upon entering into a physician–patient relationship. Such malpractice, if it poses a risk of harm to a third party, may be the basis for a duty and liability pursuant to the ordinary duty of care imposed on professionals not based on an affirmative duty under this Section. See Comment *h*. Thus, a psychotherapist who ceases prescribing medication to a schizophrenic patient with violent tendencies, who then harms others, may be subject to liability if removing the patient's medication were contrary to the applicable professional standard of care. See Estate of Morgan v. Fairfield Family Counseling Ctr., 673 N.E.2d 1311 (Ohio 1997); Schuster v. Altenberg, 424 N.W.2d 159, 161–162 (Wis. 1988).

For cases in which courts have employed no duty to explain why the defendant is not liable for failure to warn plaintiffs of information they already possessed, see, e.g., Boulanger v. Pol, 900 P.2d 823, 835 (Kan. 1995); Wagshall v. Wagshall, 538 N.Y.S.2d 597 (App. Div. 1989). Judge Calabresi explains the misuse of no duty in warnings cases in which the danger is known in Burke v. Spartanics Ltd., 252 F.3d 131 (2d Cir. 2001).

Illustration 2 is based loosely on Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976). Illustration 4 is based on Bradley v. Ray, 904 S.W.2d 302 (Mo. Ct. App. 1995).

Comment h. Duty of non-mental-health physicians to third parties. For courts distinguishing between cases in which the physician's conduct in the case created a risk of harm and those involving an affirmative duty, see Taylor v. Smith, 892 So. 2d 887, 893 (Ala. 2004) (Physician-defendant

continued to supply methadone to a clinic patient despite drug tests that showed that she was continuing to abuse other drugs. The combination of methadone and other drugs created serious risks and the patient caused an automobile crash that injured plaintiff. The court recognizes this case as one falling within the general duty of care: "[E]very person owes every other person a duty imposed by law to be careful not to hurt him."); Cheeks v. Dorsey, 846 So. 2d 1169 (Fla. Dist. Ct. App. 2003); McKenzie v. Haw. Permanente Med. Grp., Inc., 47 P.3d 1209 (Haw. 2002); McNulty v. City of New York, 792 N.E.2d 162 (N.Y. 2003); Bradshaw v. Daniel, 854 S.W.2d 865 (Tenn. 1993); Flynn v. Houston Emergicare, Inc., 869 S.W.2d 403 (Tex. App. 1994); Gooden v. Tips, 651 S.W.2d 364 (Tex. App. 1983). For a case in which the plaintiff's allegations encompassed both the creation of risk and affirmative duties, see Schmidt v. Mahoney, 659 N.W.2d 552 (Iowa 2003).

For courts that have found an affirmative duty on the part of physicians to nonpatients, see Myers v. Quesenberry, 193 Cal. Rptr. 733 (Ct. App. 1983); Pate v. Threlkel, 661 So. 2d 278 (Fla. 1995) (physician owed a duty of care to child of patient to warn patient of genetic condition that could affect child); Hoffman v. Backmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (physician has a duty to warn family members of patient with tuberculosis); DiMarco v. Lynch Homes-Chester Cnty., Inc., 583 A.2d 422 (Pa. 1990) (physician had duty based on § 324A to tell patient that hepatitis could be transmitted through sexual intercourse; physician also incorrectly told patient that, if she was symptom-free six weeks after exposure to virus, she was not infected); Troxel v. A.I. DuPont Inst., 675 A.2d 314 (Pa. Super. Ct. 1996) (physician who diagnosed infant with contagious disease, but failed to tell family, owed duty to friend of family who was later infected with the virus); Bradshaw v. Daniel, 854 S.W.2d 865 (Tenn. 1993) (physician had duty to warn family members of patient who contracted Rocky Mountain spotted fever about common sources of infection to which they might be exposed). Indeed, the California Supreme Court in *Tarasoff* relied on non-mental-health physicians' duty to third parties to justify the affirmative duty it adopted for mental-health professionals. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 343 & n.8 (Cal. 1976).

Among courts that have imposed a duty to nonpatients, a number have been cautious about extending it so broadly as to encompass all persons foreseeably put at risk. See, e.g., Tenuto v. Lederle Labs., 687 N.E.2d 1300 (N.Y. 1997) (duty to warn limited to patient's family); Matharu v. Muir, 29 A.3d 375 (Pa. Super. Ct. 2011) (imposing affirmative duty on mother's physician to unborn child to attend to Rh sensitization in mother that threatened health of fetus). Other courts, in denying a duty to nonpatients, have emphasized that the plaintiff was an unidentified and unknown member of the public. Those courts reason that, if a duty to nonpatients were recognized, it would have to extend to all such persons. See Werner v. Varner, Stafford & Seaman, P.A., 659 So. 2d 1308 (Fla. 1995); Webb v. Jarvis, 575 N.E.2d 992 (Ind. 1991); Kolbe v. State, 661 N.W.2d 142 (Iowa 2003); McNulty v. City of New York, 792 N.E.2d 162 (N.Y. 2003). These cases seem to be influenced by concerns similar to

those raised by Judge Cardozo in Ultramares Corp. v. Touche, 174 N.E. 441 (N.Y. 1931), of the possibility of virtually limitless liability. Yet, these cases, unlike the economic loss in *Ultramares*, involve liability that, in all likelihood, is limited to a single accident. Physical harm simply does not travel as widely as economic loss.

Courts that have declined to impose an affirmative duty on physicians have expressed concern about the improbability that intervention would provide any real risk reduction. See Praesel v. Johnson, 967 S.W.2d 391 (Tex. 1998); see also Myers v. Quesenberry, 193 Cal. Rptr. 733 (Ct. App. 1983) (emphasizing the burden of plaintiff to establish causation in order to succeed in the suit); McKenzie v. Haw. Permanente Med. Grp., Inc., 47 P.3d 1209, 1220 (Haw. 2002) ("Thus, the scope of the physician's duty may be limited in situations where the danger is obvious, a warning would be futile, or the patient is already aware of the risk through other means."); Lester v. Hall, 970 P.2d 590 (N.M. 1998).

In Praesel v. Johnson, 967 S.W.2d 391 (Tex. 1998), the court expressed concern about the efficacy of any warning by a physician in reducing the risk posed by a patient. The court proceeded to balance the benefit of any warning in risk reduction with the burden of liability being imposed on the physician. The court thus balanced the *ex ante* benefit with the *ex post* burden, determined by the cost of the accident, an inappropriate comparison for purposes of identifying appropriate incentives for safety.

Courts frequently discuss the scope of a duty, and limitations on who can recover, by employing the duty rubric without differentiation. A statement that "there is no duty to third parties," may mean that third parties may not recover from a negligent physician, or that a physician has no obligation to warn or to take other measures to protect third parties in meeting the legal standard of care. See Kirk v. Michael Reese Hosp. & Med. Ctr., 513 N.E.2d 387, 399 (Ill. 1987); Kolbe v. State, 661 N.W.2d 142 (Iowa 2003); Zavalas v. State, 861 P.2d 1026 (Or. Ct. App. 1993) (explaining defendant's argument that he could not be held liable to nonpatients as he had no duty to them; his only duty was the standard of care owed to patients).

Some courts have reasoned that, because a physician does not have control over the patient, no special relationship exists. See Shortnacy v. N. Atlanta Internal Med., P.C., 556 S.E.2d 209 (Ga. 2001); Kirk v. Michael Reese Hosp. & Med. Ctr., 513 N.E.2d 387 (Ill. 1987). That reasoning is most persuasive when the plaintiff claims the defendant's negligence is in failing to control the patient. It is unpersuasive when, as in the psychotherapist-patient situation, see Subsection (b)(4), the plaintiff claims that the physician should have provided a warning to the potential victim. The court in *Shortnacy* was obscure about the specifications of negligence by the plaintiff.

Physicians' reporting obligations for patients who are HIV-positive have been addressed by statute in virtually all states. See Robin Sheridan, Comment, *Public Health Versus Civil Liberties: Washington State Imposes HIV Surveillance and Strikes the Proper Balance*, 24 SEATTLE U. L. REV. 941, 945 (2001) (all 50 states have either statutes or regulations addressing HIV reporting); The Henry J. Kaiser Family Foundation, HIV Name Reporting (April 2008), http://www.statehealthfacts.kff.org/comparetable.jsp?ind=559 & cat=11 (last visited May 3, 2012). There is substantial variation among these statutes, but only a handful have provisions that address the liability *vel non* of a person who complies with the statutory requirements. See Bobbi Bernstein, *Solving the Physician's Dilemma: An HIV-partner Notification Plan: Is the Public Interest in Stemming the Spread of HIV Better Served by Protecting an HIV-positive Patient's Privacy at All Costs, or by Notifying a Person Who Might Have Been Exposed?*, 6 STAN. L. & POL'Y REV. 127 (1995). Thus, most do not resolve the question of whether a physician has an affirmative duty to third parties who are at risk because of an HIV-infected patient.

For a detailed analysis of whether differences between psychotherapists and other physicians justifies a difference in whether an affirmative duty is imposed on them with regard to risks to third parties, see W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties*, 44 WAKE FOREST L. REV. 877 (2009). The author also concludes that a majority of courts do recognize a duty to third parties to warn the patient of the risk of contagion and a duty of reasonable care to warn third parties who are foreseeably at risk due to the condition of the physician's patient. Id. at 799–800.

Comment i. Nonexclusivity of relationships. In Biscan v. Brown, 160 S.W.3d 462 (Tenn. 2005), parents who hosted a party at which minors consumed alcohol, but did not provide the alcohol, were held to have an affirmative duty to those at the party and third parties for the risks associated with minors' drinking. Ironically, the provider of the alcohol was not subject to liability because of a statute declaring the furnishing of alcohol not to be the proximate cause of harm. The court's opinion includes a discussion of the relevant factors in recognizing an affirmative duty, although its heavy reliance on foreseeability should be viewed as a makeweight. See § 37, Comment *f*.

§ 42. Duty Based on Undertaking

An actor who undertakes to render services to another and who knows or should know that the services will reduce the risk of physical harm to the other has a duty of reasonable care to the other in conducting the undertaking if:

(a) the failure to exercise such care increases the risk of harm beyond that which existed without the undertaking, or

(b) the person to whom the services are rendered or another relies on the actor's exercising reasonable care in the undertaking.

Comment:

a. History. Liability for negligently conducting a gratuitous undertaking has a history that dates back to the early 18th century.