Liability of Treaters for Injuries to Others: Erosion of Three Immunities

Alan R. Felthous, MD

For years treaters of mental patients who harmed other persons were largely protected by three doctrines: the common law rule of nonresponsibility, sovereign immunity, and the "honest error" rule. The present paper examines the erosion of these immunities that has occurred over the last 30 years. As the strength and breadth of these protections have lessened, claims of negligence have expanded. Failure to properly diagnose includes failure to foresee violent acts. Failure to properly treat includes failure to restrain a violent patient. The recently asserted failure to protect others is not necessarily based on failure to diagnose or to treat, or, for that matter, on medical malpractice law.

Liability of treaters for harm that their patients inflict on third persons is largely a recent phenomenon. For years treaters were protected from such liability claims by virtue of three doctrines.

Under English common law, a person had no duty to prevent a second person from causing harm to a third. Thus, except where a custodial relationship existed between a hospital treater and an inpatient, a treater could not be held liable if a patient physically injured someone else.

Secondly, according to the doctrine of sovereign immunity, a citizen could not bring legal action against the government. Because individuals thought to be dangerous were generally confined in federal or state institutions, sovereign immunity provided liability protection for treaters whose patients were most apt to harm others.

Finally, for many years courts held that physicians should not be held liable for an honest error in professional judgment.[1-9] As claims involving harm to third persons gained entry into courts in increasing numbers in the 1960s, courts generally held that the decision of whether to discharge a hospital patient[5] or whether to place a patient on less restrictive status[8] must be left to sound medical judgment.

Today these three protections for treaters of high-risk patients have been substantially eroded.

Common Law Rule That a Person Is Not Liable for Injuries That a Second Person Inflicts upon a Third Person

According to the common law rule of nonresponsibility, one person has no

Dr. Felthous is chief of forensic services and associate professor, Department of Psychiatry and Behavioral Sciences, The University of Texas Medical Branch, Galveston, TX 77550. Presented at the Sixteenth Annual Meeting of the American Academy of Psychiatry and the Law, Albuquerque, New Mexico, October 11, 1985.

duty to protect a second from harming a third.[10] For many years the special relation exception to common law immunity was an important doctrine in American law. Examples of exceptional relations included parent-child and master-servant. Application of this exception to treaters, however, generally occurred only for those with absolute control over their patients such as superintendents of insane asylums. Treaters could be held liable for inadequate supervision, allowing a dangerous patient to escape,[10–13] or wrongful discharge, but they generally remained immune when an outpatient injured another, until the *Restatement (Second) of Torts* and the *Tarasoff* decision.

Founded in 1923, the American Law Institute (ALI), an organization of jurists, legal scholars, and legal practitioners, has endeavored to restate the law in clear and simple language and to formulate model statutes suitable for societal needs. The ALI's restatements of tort law are regarded by courts as highly respected formulations of considerable legal authority. Consequently, courts not uncommonly cite ALI restatements that apply to case law.

Published in 1965, the ALI's *Restatement (Second) of Torts* articulated the special relation exception to the common law rule that a person has no duty to prevent a second person from harming a third. The restatement[14] declared that a person has a duty to control another person's behavior and to prevent that person from harming another if:

> (a) A special relation exists between the actor and the [second] person which imposes a duty upon the actor to control the [second] person's conduct, or
> (b) A special relation exists between the actor and the [third person] which gives the [third person] a right to protection (p. 122).

Note that this rule does not explicitly require custodial control for the duty to control behavior to occur. However, of the various relations specified in subsequent sections (parent-child, master-servant, etc.), the category that would appear to apply to the treater-patient relation is the one involving custodial control.[15]

> One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or to subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of [these] persons as to prevent them from intentionally harming the other or so conducting themselves as to create an unreasonable risk of harm to him, if the actor
> (a) Knows or has reason to know that he has the ability to control the conduct of the [other] person, and
> (b) Knows or should know of the necessity and opportunity for exercising such control.

So, what is the custodian's duty? "One who takes charge of a . . . person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the . . . person to prevent him from doing such harm."[16] Thus, in the *Restatement (Second) of Torts*, nothing suggested an outpatient psychotherapeutic relationship alone creates a duty to control another person's conduct, and there certainly was no mention of any method of preventing violence, other than controlling the person's conduct. Neither did this formu-

lation articulate the vague duty to protect, even though protection was the aim of the duty to control behavior.

To mental health professionals, the special relation exception to the common law rule was only an obscure legalism until *Tarasoff*.[17,18] Citing the second restatement, the Supreme Court of California found the relation between treater (psychotherapist) and patient, regardless whether an inpatient or outpatient relationship, to qualify as the first special relation exception to the old common law rule of immunity. Thus, *Tarasoff* allowed imposition of liability without requiring the treater to have had custody of the person in a total institution. For the first time treaters of strictly outpatients could be held liable for their patients' acts of personal violence. Since *Tarasoff*, the California court has reaffirmed the special relation exception[19] and other courts followed suit in acknowledging a duty for treaters to protect others from harm caused by outpatients.[20]

What will the ALI's next restatement of torts bring? The next edition can be expected to take into account the *Tarasoff*-like case law that has developed since the second restatement in 1965. It is difficult to imagine how a custodial relationship can be extended to a noncustodial relationship. The "takes charge" relationship is sufficiently vague that it could conceivably be applied to outpatient psychotherapy. Nonetheless, the duty would have to be broadened from controlling the subject to more clearly permit other means of protection. Then courts which consider future cases will be able to cite the ALI's restatement with logic that is more consistent.

Sovereign Immunity

In accordance with the doctrine of sovereign immunity, state and federal law provide immunity from liability for governmental agents who make a policy or discretionary decision that results in some damage.[21,22] Tort claims acts were enacted by state and federal governments to allow recovery in litigation against governments under specified circumstances. In lawsuits initiated based on such acts, defendants who were employed by the government claimed that decisions regarding treatment, management, release, or restraint of patients were immune from such liability claims, because the acts fell within the discretionary exception to liability.

Because the purpose of the Federal Tort Claims Act[23] was to compensate victims of negligence by governmental agencies and employees, several courts held that determination of liability could be measured by the same standards that local law applied to private employers. Sovereign immunity was thus rejected where circumstances compared with liability in the private sector for negligence with resultant harm to a member of the general public. Some courts ruled that a decision involving release from confinement or placement in a less restrictive setting amounted to an "implementation" of rules or policies, and therefore did not fall within the exemption of discretionary functions.[24–27]

Arguments for and against sovereign immunity of the states were essentially the same as those of the federal government. Courts that did not find state stat-

utes to be protective distinguished between planning or discretionary policies on the one hand and operational or ministerial functions on the other. States' hospital release standards could qualify as discretionary policies, but the actual decision to release was ministerial and subject to claims of liability.

As we acknowledge that sovereign immunity is no longer as uniformly protective of treaters as it once was, we must stress that this doctrine continues to serve as a strong defense in a number of jurisdictions.[28–30] Discretionary immunity provides a stronger defense, if the issue is releasing a prisoner or an incarcerated delinquent.[31] This is interesting, because although mental illness is not necessarily involved, the inmate's future violence may be "statistically foreseeable" in some cases based on the individual's criminal record to a greater extent than that of a mental patient who has never violated the law.

Honest Error in Medical Judgment Rule

Thirty years ago medical judgment was difficult to attack in litigation. In an early case, *St. George v. State*,[1] the appellate court judge stated, "Are the doctors, or is the state which employs them, legally responsible in damages for an honest error of professional judgment made by qualified and competent persons? We think this question must be answered in the negative. It has been so held in malpractice cases of all types for years." *St. George* was commonly cited in subsequent court decisions that favored the medical defendant based on an honest error in medical judgment.[2,3] For liability to arise, there must be some error in addition to a good faith misjudgment.

By 1976 court decisions made it clear that the honest error in medical judgment rule no longer provided absolute immunity in practice, if it still did in principle. If a violent act is "foreseeable" and if treaters could have taken reasonable care to prevent violence but did not, then treaters can be found liable for negligence.[17,18,32–34] What evidence makes a violent act foreseeable? And, what constitutes reasonable care? Later court decisions addressed these questions in a manner that further dismantled the formerly protective cloak of the honest error rule.

Various courts broadened the nature of duties, the breach of which amounted to negligence by treaters of potentially violent patients. Because courts were not always specific and in accord regarding the nature of these duties, our discussion here outlines plaintiff claims that may or may not be successful, but that collectively have been accepted by enough courts to result in a substantial erosion of the honest error rule. Here we group claims of negligence as failure to diagnose, failure to treat, and failure to protect.

In some recent cases, courts found ordinary negligence instead of medical malpractice.[35] This obviated the plaintiff's need to establish deviation from proper medical practice, and the honest error rule simply did not apply. Applebaum[36] suggested that some courts virtually abandoned the requirement for

negligence and adopted a standard that approached strict liability.

Claims of Negligence

Failure to Properly Diagnose (Dangerousness) Usually the claim of failure to conduct a sufficiently thorough examination is coupled with the claim that proper treatment was not provided. A more comprehensive assessment would have established the patient's dangerousness, but because his dangerousness went unnoticed appropriate treatment or management was not afforded the patient. Related claims are failure to obtain prior medical records, failure to follow up on clues that should have suggested dangerousness, failure to monitor a patient's condition closely enough, and failure to record and attend to aggressive behaviors.

What seems to be meant by failure to properly diagnose is the failure to establish presence not of a specific mental disorder, but rather of dangerousness.

The treater's duty to protect arises only if violence is foreseeable,[18–20] so one defense to a negligence claim is that violence was not foreseeable (e.g., the patient manifested no recent signs of dangerousness).[37,38] The plaintiff may claim that signs of dangerousness were not observed because the diagnosis was inadequate. Had the patient been evaluated more carefully, his violence would have been foreseeable. Hence, the patient's violence was "reasonably foreseeable" or "should have been foreseeable," even though the treater's evaluation revealed no signs of dangerousness. A more effective defense than mere absence of signs of violence is that inquiry regarding violence had been made, but the patient and family members denied that the patient had behaved aggressively. A well-established and well-documented period of nonviolence can also serve the defendant.

Defendant treaters have attempted to negate the claim of foreseeability by asserting that violent behaviors cannot be predicted accurately. Acts of violence are not foreseeable in a scientific or absolute sense. Courts have considered the prediction of dangerousness as a "professional judgment" that met the honest error rule of immunity. Curiously, courts seemed more impressed by limitations in treaters' abilities to predict violence before their limitations were empirically demonstrated and widely promulgated.

While acknowledging treaters' limitations in predicting violence accurately or absolutely, courts are, nonetheless, increasingly basing their decisions on the assumption that violent threats, acts, or preparatory behaviors ought to cause treaters enough concern to take preventive measures.[18–20, 33, 39–44] Treaters have a duty to guard against a patient's dangerous mental condition when the condition is discoverable by means of reasonable care.

What troubles treaters is the general lack of consistent guidance from the courts as to what signs of aggression are sufficient for violence to be reasonably foreseeable. Another concern of treaters is the tendency for some courts to conflate dangerousness and mental disorder into a single medically treatable condi-

tion.[45] This may be valid for some conditions, for example, a patient with bipolar disorder who is violent only during manic episodes. But if treaters are to be held liable for violent acts committed by their patients with personality disorders—and today sometimes they are[39,40]—there must be greater clarity and consistency in the law regarding what can and should be done to manage these patients.

In deciding whether a violent act should have been foreseeable and prevented by greater restriction of the patient, some courts weighed the risk of harm to other persons against the therapeutic value of the "open-door policy." By open-door policy, courts apparently referred to the revolution of the 1960s that resulted in fewer patients hospitalized for lengthy periods under restrictive conditions. Increasing numbers of patients were discharged into the community. Hospitalized patients were granted more liberties in the form of unlocked wards, ground privileges, convalescent leaves, and so on. Courts upheld the clinical justification for patients to have more freedoms and to become reintegrated into the community even in the face of possible but difficult-to-calibrate risk.

Ruling in favor of defendant treaters, several courts expressed concern in dicta that if treaters were to be held liable whenever their predictions of dangerousness were wrong, therapeutic progress would be hampered and few patients would be discharged. Courts expressed such concerns more frequently and forcefully in the 1960s, while the deinstitutionalization movement was gathering momentum.[2,3,7,46]

Failure to Properly Treat (or Restrain) Typically the plantiff's claim is that the patient was not adequately controlled or restrained. Proper treatment of a dangerous patient should involve enough control to prevent violence. Some court decisions have been criticized for suggesting that dangerousness, like a specific mental illness, ought to be "treated" and handled as a strictly medical problem.[45]

Under the general claim of failure to restrain can be listed more specific insufficiencies of control that have been advanced in particular cases. Examples include failure to hospitalize a dangerous patient,[40,41,47] failure to adequately supervise and control an inpatient's aggressive behaviors, failure to provide adequate security such that a dangerous patient is allowed to escape,[11–13] inappropriate transfer of a dangerous patient to a less restrictive status such as convalescent leave,[25] and premature or wrongful discharge of a dangerous patient.[39]

Failure to Protect A type of negligence that has expanded disarmingly in recent years is based on the premise that a treater has a duty to take appropriate actions to protect third persons from violent acts of patients under his treatment. Following *Tarasoff I* and *II* and subsequent decisions, the treater-patient relationship need not be custodial for the duty to protect to arise. This is conceived as a duty to the potential victim, not the patient. Aforementioned claims of negligence can be regarded more

broadly as a breach of the treater's duty to protect.

A related, more specific claim of negligence is the failure to convey information to individuals or agencies who, with such information, might have prevented injury or death. Plaintiffs have claimed negligence on the part of treaters because of a failure to adequately inform other treaters who assume responsibility for providing continuity of care,[41] the court that is empowered to restrain or release the patient,[42] law enforcement officers,[48] employers of the patient,[49] custodians of the patient, family members of the patient,[20] a detective agency retained to protect the victim,[24] and the victim himself or herself.[17-20]

According to several early decisions, the duty to warn others who might somehow act to prevent violence or to protect the victim arises only if the victim is *identifiable* by the treater.[17,18,20] In expanding the treater's duty to protect, the Supreme Court of California held that a young child whose mother had been threatened by a patient was also an identifiable victim because of the child's proximity to his endangered mother, and because, even if he were not physically harmed, observing his mother being shot with a firearm would likely cause him emotional trauma.[19]

A federal appeals court in California found the identity of a patient's victim to be evident, even if the patient did not explicitly target his victim in therapy sessions. According to the court, the patient's girlfriend should have been foreseeable as his likely victim, because of his history of acting violently against his previous wife and because his "psychological profile" indicated a likelihood of aggressing against women who were close to him.[43]

Other courts have held that the victim need not be identifiable for a duty to arise only that the treater reasonably foresee that the patient's condition can endanger others.[33,43,47] Thus, the case law is variable on the question of whether a specific victim must be identifiable for the violence to be foreseeable such that a duty to protect occurs.

Neither is there consistency in the law regarding when the privileged nature of certain information should prevent disclosures serving to warn others. Even in states with a physician-patient privilege statute that protects confidentiality of information, courts found this privilege insufficient reason to limit the duty to warn.[20] In contrast, a Maryland court ruled that if a psychiatrist had warned the intended victim of his patient's violent disposition, this disclosure would have violated the state law on privileged communication,[50] even though the statutory evidentiary privilege was limited to "judicial, legislative, or administrative proceedings." Beigler,[51] Roth and Meisel,[52] Stone,[53] and others have addressed the manifold ethical and clinical considerations in balancing confidentiality against warning disclosures. In-depth discussion of this issue would exceed the scope of this paper. The important point to be made here is that some treaters can be guided by local court rulings, but others must turn to court decisions that do not apply to the jurisdictions in which they practice. According to the

Supreme Court of California, "The protective privilege ends where the public peril begins."[18] Although several other courts accepted the California court's reasoning, when case law is considered collectively, there is not complete uniformity in decisions pertaining to the duty to protect, such as by warning, and the obligation to maintain confidentiality.

Some commentators criticized the duty to warn of *Tarasoff I* as too specific. Mills,[45] for example, questioned the preventive value of warning as a routine intervention and suggested various adverse effects from reliance on warnings alone. He argued, "Psychotherapists should do something when they believe that their patients are potentially violent," but therapists' actions "should be clinical, in contradistinction to warning the victim or notifying the police" (p. 257). The California "court's only concrete suggestions about discharging the duty to protect" (p. 249), i.e., warning victim and/or police, may not be the best measure in all circumstances. Dix[54] maintained that *Tarasoff* and progeny cases did not impose only a duty to warn. It would make little sense to protect potential victims by warning them, but to neglect other techniques that might also be effective.

On the other hand, the duty to protect is said to be too vague. After a violent act, one can always hypothesize that something else might have been done to prevent it. If *Tarasoff I* provided a legal prescription for medical treatment, *Tarasoff II* laid more legal groundwork for retrospective challenges to medical judgments in general.

Beck[55] observed that, outside of California, no court has applied the *Tarasoff* doctrine and found the psychotherapist of an outpatient to be liable. If there is no cause for alarm, neither should mental health professionals be lulled into complacency. Published court decisions do not reflect the number of *Tarasoff*-like cases that may have been settled out of court. A treater is more likely to be found liable if the patient was at some time under his custodial care. Finally, as should be evident from this present review, the expanding duties under *Tarasoff* constitute only part of a larger picture of diminishing immunity.

Comment

For many years treaters' limited abilities to predict and prevent violent acts of their patients posed little legal liability. Manifestly dangerous patients were hospitalized and under institutional control. When patients harmed other persons, treaters were generally protected from liability by the common law rule of nonresponsibility, by sovereign immunity, and/or by the honest error rule. Today this trilogy is no longer as strongly and uniformly protective as it once was.

Social changes have increased the risk of liability by increasing the likelihood that treaters will care for potentially dangerous outpatients who are not under custodial control. There are indications that the end point of the deinstitutionalization movement has not yet been reached. Decreasing hospital benefits from third-party payers will predictably result in some patients being treated on an outpatient basis despite the desirabil-

ity of hospitalization. Although the vast majority of emotionally disturbed individuals are not dangerous to others, some are. Decreased accessibility to hospital treatment should increase the total number of disturbed individuals in the community, including those with potential for harming others. Treaters in the community must have greater exposure to potentially dangerous patients than was the case when long-term hospitalization was a more widespread practice.

Hospital treaters are also faced with more risks of liability. Changes in civil commitment laws, together with other aspects of deinstitutionalization, result in shorter periods of hospitalization and increasing rates of discharge. Thus, there is a greater risk of postdischarge violence and wrongful discharge litigation.

From the perspective of tort law, the question is usually one of whether an individual treater caused violence by failing to take action that could have prevented a patient from harming another. From a broader perspective, deinstitutionalization and the increased emphasis on patients' rights, especially liberty, has restricted the treater's traditional approach for dealing with dangerous patients.

The question of what should be done to protect people from violent patients can be regarded as a multifaceted social issue, the resolution of which demands concerted attention from various professional disciplines, agencies, and systems. Our country is still experimenting with alternatives to institutional care for the mentally ill. Particularly while case law remains fluid, so-called negligence of individual treaters can be regarded more generally as evidence of continuing social adjustment in the wake of well-intended, partially successful, but clearly imperfect deinstitutionalization of long-term mental hospitals. If this view is valid, it would be a mistake to single out individual treaters to blame and then rest contented that nothing else need be done.

Greater use of the insanity defense and changes in commitment laws for insanity acquittees appear to have contributed to an image problem for mental health professionals, especially psychiatrists. Psychiatrists are perceived as promoting insanity acquittals by way of courtroom testimony and then discharging dangerous acquittees prematurely. Because psychiatrists collectively allowed the defendant to wreak tragedy a second time, it is reasoned, they should be held liable. Perhaps popular antipathy about this issue has become generalized to include perceived mismanagement of violent patients in general, not just insanity acquittees.

Today's treater faces a greater probability of caring for a dangerous patient without ongoing custodial control, and yet the treater's traditional legal protections against liability have been significantly diminished. Even a treater of an outpatient in various jurisdictions is considered to have a special relation with the patient and so is not protected by the common law rule that a person is not responsible for preventing a second person from harming a third person. In a number of jurisdictions, sovereign immunity is no longer protective. The honest error rule has been eroded by claims of a variety of errors of omission

and expanding duties of treaters. Not the least of these duties is the duty to protect, which is not invariably construed as a medical duty involving medical judgment. As treaters recognize the expanding claims of negligence involving injury to third persons, they must also appreciate the other half of the problem of increasing liability—decreasing immunity.

References

1. *St. George v. State*, 283 App Div 245, 127 NYS 2d 147 (1954)
2. *Taig v. State*, 19A.D. 2d 182, 241 NYS 2d 495 (1963)
3. *Seavy v. State*, 250 NYS 2d 877 (1964)
4. *Milano v. State*, 253 NYS 2d 662 (1964)
5. *Pernetti v. State*, 254 NYS 2d 332 (1964)
6. *Higgins v. State*, 265 NYS 2d 254 (1965)
7. *Hernandez v. State*, 9 Cal. Rptr. 205 (1970)
8. *Orman v. State*, 322 NYS 2d 914 (1971)
9. *Johnson v. United States*, 409 F Supp 1283 (M D Fla, 1976)
10. Prosser WL, Handbook of the Law of Torts, 4th ed, Chapter 9, West, St. Paul, 1971
11. *Jones v. State*, 45 NYS 2d 404 (1943)
12. *Weihs v. State*, 45 NYS 2d 542 (1943)
13. *Finkel v. State*, 237 NYS 2d 66 (1962)
14. *Restatement (Second) of Torts*, 315 (1965), p. 122
15. *Restatement (Second) of Torts*, 320 (1965), p. 130
16. *Restatement (Second) of Torts*, 319 (1965), p. 129
17. *Tarasoff v. Regents of University of California*, 13 Cal 3d 177, 188 Cal. Rptr. 129, 529P 2d 553 (Cal 1974)
18. *Tarasoff v. Regents of University of California*, 17 Cal 3d 425, 131 Cal. Rptr. 14 (Cal 1976)
19. *Hedlund v. Orange County*, 34 Cal. 3d 695, 669 P 2d 41 (1983)
20. *McIntosh v. Milano*, 168 NJ Super 466, 403A 2d 500 (1979)
21. *Thompson v. County of Alameda*, Supp 167 Cal Rptr 70 Cal 614 P 2d 728 (Cal, 1980)
22. *Kenndrick v. United States*, 82 F Supp 430 (1949)
23. Federal Tort Claims Act 23 USCA 1356, 2671 *et seq*
24. *Fair v. United States*, 234 F 2d 288 (1956)
25. *Merchants National Bank & Trust Co. of Fargo v. United States*, 272 F Supp 409, 417–419 (DND, 1967)
26. See *White v. United States*, 317 F 2d 13, 17–18 (4th Cir 1963)
27. *Underwood v. United States*, 356 F 2d 92 (1966)
28. *Kravitz v. State of California*, 8 CA 3d 301 87 Cal. Rptr. 352 (4th Dist Div 1, 1970)
29. *Sherrill v. Wilson*, 653 S W 2d 661 (1983)
30. *Cairl v. State of Minnesota*, 323 NW 2d 20 (1982)
31. *Martinez v. California*, 85 Cal App 3d 430, 149 Cal. Rptr. 519 (1978)
32. *Davis v. Lhim*, 335 NW 2d 487 (Mich App, 1983)
33. *Petersen v. State*, 100 Wn 2d 421, 671 P 2d 230 (1983)
34. *Peck v. Counseling Service of Addison County, Inc.*, No 83-062 (Vt Sup Ct June 14, 1985)
35. Felthous AR: Negligence without malpractice: broadening liability for psychiatrists who release dangerous mental patients. Med Law 4:453–62, 1985
36. Appelbaum PS: The expansion of liability for patients' violent acts. Hosp Community Psychiatry 35:13–4, 1984
37. *Brady v. Hopper*, 570 F Supp 1333 (D Colo 1983)
38. *Ross v. Central Louisiana State Hospital*, La App 392 So 2d 698 (1980)
39. Durflinger v. Artiles, 563 F Supp 322 (D Kan 1981)
40. *Bradley Center, Inc. v. Wessner*, Ga App 287 SE 2d 716 Ga 296 S E 2d 693 (1982)
41. *Greenberg v. Barbour*, 322 F Supp 745 (E D Pa 1971)
42. *Hicks v. United States*, 357 F Supp 434 (1973), 511 F 2d 407 (1975)
43. *Jablonski by Pahls v. United States*, 712 F 2d (1983)
44. *Semler v. Psychiatric Institute of Washington DC*, 538 F 2d 121 (1976)
45. Mills MJ: The so-called duty to warn: the psychotherapeutic duty to protect third parties from patients' violent acts. Behav Sci Law 2:237–57, 1984
46. *Eanes v. United States*, 407 F 2d 823 (1969)
47. *Lipari v. Sears, Roebuck & Co*, 497 F Supp 185 (1980)
48. *Williams v. United States*, 450 F Supp 1040 (1978)
49. *Eiseman v. New York*, 489 NYS 2d 957 (NY App Div 1985)
50. *Shaw v. Glickman*, 45 Md App 718, 415 A 2d 625 (1980)
51. Beigler, JS: *Tarasoff* decisions *v.* confidentiality. Behav Sci Law 2:273–89, 1984

52. Roth, LH, Meisel, A: Dangerousness, confidentiality and the duty to warn. Am J Psychiatry 134:508–11, 1977
53. Stone, AA: The *Tarasoff* decisions: suing psychotherapists to safeguard society. Harvard Law Rev 90:358–78, 1976.
54. Dix, GE: *Tarasoff* and the duty to warn potential victims, in Law and Ethics in the Practice of Psychiatry. Edited by Hofling CK. New York, Brunner/Mazel, 1981
55. Beck, JC: The psychotherapist and the violent patient: Recent case law, in The Potentially Violent Patient and the Tarasoff Decision. Edited by Beck JC. Washington, DC, American Psychiatric Press, 1985, pp 9–14