

Misapplication of the *Tarasoff* Duty to Driving Cases: A Call for a Reframing of Theory

Roderick W. Pettis, J.D., M.D., and Thomas G. Gutheil, M.D.

In the years since the original *Tarasoff* cases created a new duty for psychotherapists toward third parties harmed by patients' violence, a series of cases nationwide—so called “driving cases”—have applied *Tarasoff*-like reasoning to situations where a patient injured others while driving a car. Our thesis in this paper is that such application is inappropriate since it represents an unjustified and largely unexamined assumption that driving injury is an expression of the mental-illness-derived intended violence that justifies the *Tarasoff* duty and its inevitable associated breach of confidentiality. We suggest to the contrary that driving cases almost invariably result from a patient's negligent driving rather than intentional violence stemming from mental illness; that clinicians in most instances have almost no capacity, training, or clinical bases on which to predict a patient's future negligence, violence aside; and that the theory of driving cases should be revised.

Although therapists in the mid-seventies were surprised and appalled at the duty to protect third parties established by the newly minted *Tarasoff* decisions,¹ most present day practitioners are aware of, if not enthusiastic about, this duty and its numerous local variants.² The present state of the duty may be chaotic, unpredictable, and capriciously variable³, but, despite the well-established problems with prediction of dangerousness,⁴ clinicians now practice as though some

version of the *Tarasoff* duty applied to them, even where no specific case law has established the fact.⁵

For review, note that the 1974 decision⁶ established a duty to warn potential victims about patient's violent acts. The unprecedented decision by the California Supreme Court to rehear its own case, in apparent reaction to the outcry that followed the first ruling, produced the definitive *Tarasoff* in 1976⁷ and yielded the following language defining the duty for clinicians:

When a psychotherapist determines, or pursuant to the standard of his profession should determine, that his patient represents a serious danger of *violence* to another, he incurs an obligation to use reasonable care to protect the *intended* victim against such danger. The discharge of such duty, depending on the nature of the case, may call for the therapist to warn

From the Program in Psychiatry and the Law, Massachusetts Mental Health Center, Harvard Medical School and the Charles C. Gaughan Fellowship in Forensic and Correctional Psychiatry, Bridgewater State Hospital, Bridgewater, MA. Reprint request to Dr. Gutheil at 74 Fenwood Road, Boston, MA 02115. The authors acknowledge their indebtedness to members of the Program for critical review and comments and to Debra Morley, M.A., and Ellen Rubin, M.M.H.S., for assistance in the preparation of this manuscript.

the *intended* victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances⁸ [emphasis added].

Note that the language emphasizes violence and intent, about which the therapist might be presumed to have direct knowledge from the patient's confidences; therapy was interpreted as a "special relationship" that had a defined legal meaning⁹ and associated duties. Note also the presumption of a relevant professional standard. The *Tarasoff* duty was presumed to justify the attendant breach of confidentiality on a public policy basis, namely, decreasing social risk.

In an apparently related development, a series of cases began to appear on the scene in which a patient in treatment, an ex-patient or a discharged patient injured certain persons while driving a car. These "driving cases" attempted, and usually succeeded, to fix liability for the injury to negligence by the treating clinicians. These cases have received an excellent review elsewhere.¹⁰

In this article we will review the cases according to non-*Tarasoff* principles, specifically the prediction of negligence, and suggest that a *Tarasoff*-type interpretation of the issues is erroneous and inappropriate to driving cases. We will then offer an alternative model, focusing on substantial departures from standard care, that is more realistic and more fair to the involved parties and to the aims of social justice. Our thesis is that driving cases rarely involve violent intent based on mental illness, but instead almost always represent a patient's negligence in driving. A violence prediction model

would therefore be irrelevant since the core issue would be the clinician's ability to predict a patient's future negligence.

Prediction of Negligence

Can therapists predict negligence? To our knowledge there exists no formal training in medical school or in residency that addresses the prediction of a patient's future negligence. Our review of the forensic literature finds little mention of and no research into this unlikely skill. The limited literature and research on the related notion of prediction of dangerousness cites therapists' exceedingly poor performance in predicting future dangerousness—that is, dangerous *intent*.¹¹

Even assessment of a patient's competence to drive is limited to the specifics of the moment and to the particulars of a given situation. The experienced clinician's assessment of present competence would bear little or no relation to the *future* competence of the patient and even less to that patient's future likelihood of dangerousness or negligence. Moreover, what criterion should the therapist consider in evaluating the likelihood that a patient may someday become a dangerous driver? Specifically, how is the clinician, faced with the patient who is not committable as imminently dangerous to self or others, to decide what threshold issues must exist before a *Tarasoff* duty to protect an unknowable victim against the potentially dangerous driver arises? In short, how does one go about predicting the possibility of future negligence? What, for example, would constitute clearance to

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drive or, conversely, an obligation to notify the bureau of motor vehicles?

Mental Illness and Driving

The *Tarasoff* case, as outlined above, yields the implicit assumption that the relevant duty is to protect third parties against intentional violence deriving from mental illness. One would not, for example, expect a *Tarasoff* duty to issue from psychiatric treatment of a "hit-man," soldier, or mercenary who, in the ordinary performance of their respective professions, might well repeatedly and intentionally endanger another's life. The extension of *Tarasoff* to driving cases becomes an implausible stretch when no connection can be demonstrated between the dangerous driving and the patients' mental illness. When a mental patient negligently operates a motor vehicle, where does this extension end? Does *Tarasoff*, for example apply for substance abuse-related driving accidents? Reviewing the current disturbing trend among fact finders toward assigning liability for any bad outcome, it is not inconceivable that rationales can be found for imposing liability on a *Tarasoff* theory (e.g., the therapist knew or should have known that the patient would negligently consume alcohol and become a dangerous threat to society behind the wheel of an automobile). This is particularly possible when the "severely substandard care" context described below is applicable.

The Issue in Court

In *Schuster v. Altenberg*¹² the court was faced squarely with the issue of liability for alleged negligence on the part

of a treating psychiatrist in his management and care of a patient. The plaintiffs, in this case, were the spouse and paralyzed daughter of the patient who had been treated by Dr. Altenberg.

The plaintiffs alleged that Dr. Altenberg was negligent in his management and care for Edith Schuster when despite her psychotic condition, he failed to seek her commitment, to modify her medications or to warn the patient or her family of her condition and its dangerous implications. Dr. Altenberg's negligence was alleged as the substantial contributing factor causing the automobile accident in which his patient's daughter was rendered paralyzed and in which the patient, the driver, was killed. The lower court granted Dr. Altenberg's motion for judgment on the pleadings, a legal finding that the Schusters had failed to state a legally sufficient complaint holding that "absent a readily identifiable victim, there exists no duty on the part of a psychiatrist to warn third parties of, or protect third parties from the conduct of the patient."¹³ The Schusters appealed.

The Wisconsin Supreme Court reversed the lower court and remanded the case holding that appellants' original complaint did allege legally cognizable claims suitable for the jury. The court relied upon extensive case law which established that liability could attach despite absence of privity.¹⁴

This case is particularly important because the court was specifically asked by the parties to examine the policy issues involved in holding a psychotherapist liable to third parties. Specifically, the court was asked to determine whether

public policy would generally preclude the imposition of liability in all cases in which allegations of a psychotherapist's negligent treatment and diagnosis, failure to warn third parties, or failure to seek commitment are made. After an extensive review of the literature and relevant case law beginning with the *Tarasoff* case the court held:

... there most assuredly exist meritorious public policy concerns regarding the imposition of liability upon psychotherapists for harm resulting from dangerous acts of their patients. These arguments, including confidentiality, unpredictability of dangerousness of patients, concerns that patients are assured the least restrictive treatment and that imposition of liability will discourage physicians from treatment of dangerous patients, present significant issues of public policy. However, neither the possible impact that limited intrusion upon confidentiality might have upon psychotherapist-patient relations, nor the potential impact that the imposition of liability may have upon the medical community with respect to treatment decisions, warrants the certain preclusion of recovery in all cases by patients and by the victims of dangerous patients whose harm has resulted directly from the negligence of a psychotherapist.¹⁵

In a concurring opinion by Justice Steinmetz our thesis is most elegantly expressed. While Justice Steinmetz agreed with the majority that the case raised factual issues as to whether Dr. Altemberg was negligent in diagnosing and treating Edith Schuster and, if so, whether the misdiagnosis and improper treatment were substantial factors in causing the accident and consequential injuries, he felt the court went too far in considering the case under the theory of a duty to warn or protect:

I believe that the majority goes too far in its holding, at least under the limited facts pre-

sented in the pleadings of this case, that a claim for relief was stated in the allegations that Dr. Altemberg negligently failed to warn the patient's family of her condition and that he failed to institute commitment proceedings for Edith Schuster. Contrary to the majority's assertion, the current law of negligence in Wisconsin is not so broad as to automatically encompass these claims. I firmly believe that this court is ill-advised to broaden the basis for a psychotherapist's liability to third parties under the concededly "sparse" facts alleged in the complaint. [Note, of course, that most car accidents and some car accident cases are equally fact-poor, and the facts are often in the hands of self-serving witnesses; note also the allusion to the issue of intent vs. negligence].

Justice Steinmetz specifically took issue with the majority's willingness to render policy determinations on the basis of what he felt were "inadequate and factually incomplete" pleadings. However, he expressed his own position as follows:

It may well be that the legal issues with respect to failure to warn and failure to confine become moot as the facts become known. That is, if all that is shown on discovery or at trial is that Mrs. Schuster was negligent in causing her daughter's injuries, then I would hold that there was no duty on the part of the doctor regarding failure to warn others and failure to seek the patient's confinement. The complaint sues for injuries sustained in a automobile accident and *there is no duty to predict negligent conduct* [emphasis added].

... Moreover, were I tempted to apply the public policy considerations as was done by the majority, I would resolve them in favor of the defendant, Dr. Altemberg. What we have here is a plaintiff injured through an ordinary car accident. There is no allegation or even an intimation in the complaint that Edith Schuster was homicidal, suicidal, or otherwise intended or desired to harm her daughter or herself [emphasis added]. Any discussion about a psychotherapists' liability for failure to protect third parties from a dangerous patient by its very nature implies that the claim is predicated upon the patient's *intentional acts* [emphasis added]. The *Tarasoff* decision and

its progeny all dealt with dangerous patients who intentionally harmed victims. This complaint, under the most liberal construction possible, does not even remotely suggest that there was any intentional behavior on the part of Edith Schuster, a voluntary outpatient in therapy, from which the plaintiff or any one in the world needed protection. The majority would apparently hold psychotherapists to the duty of assessing a patient's potential for negligent behavior as well as for dangerousness.

Contextual Issues

A number of issues not deriving from *Tarasoff* principles may also attend the driving cases and may thus cloud our analysis of the actual reasoning in the cases. We here describe these contextual issues and distinguish them from those cases which will constitute the "true" pool for our analysis.

Strict Liability Strict liability is a legal principle whereby liability is assigned for damages regardless of negligence. Strict liability reasoning, if applied to malpractice cases, would find the physician liable whenever injury occurs. Whereas this legal model initially applied to cases involving what were considered inherently dangerous activities (e.g., dynamite manufacture) and later cases involving the negligent manufacture and distribution of products, several cases¹² seem to portend a trend by the courts toward finding the physician liable for any bad outcomes, particularly where the claim is made that the aims of social justice override the outcome that might obtain under a common law negligence analysis. Occasionally, strict liability reasoning is disguised by the fact finder under a superficial negligence paradigm; the disguise is usu-

ally exposed by the decision's unrealistic assignment of foreseeability to the accident.

Application of this legal model to malpractice cases and in particular to cases requiring the ability to predict dangerousness leads to significant problems. The therapist is put in the impossible position of taking responsibility for any bad outcome that issues from the patient. In driving cases the therapist has no better instruments with which to undertake this responsibility than the application of the inexact science of danger prediction¹³ or the ability to predict negligence, which we will shortly argue is nonexistent.

The physician would by necessity have as his primary objective protection from liability rather than clinical benefit to the patient. The natural response to this risk would be to avoid any and all situations where patients have a history of violence or, since the extension of *Tarasoff* duties to the dangerous driver, where the patient has a bad driving history. This is not likely the intention of the courts and warrants careful scrutiny and consideration before the current trend reaches this undesirable result.

The "Severely Substandard Care" Model Another contextual issue that bears scrutiny in regard to its effect on the outcome of these cases is what we refer to as the "severely substandard care" model of legal decision making. It appears to occur when the court perceives before it cases of such gross negligence that the legal requirements of causation are stretched in order to compensate the victim, regardless of the vi-

olence done to rationality and empirical reality. We believe this scenario has contributed considerably toward expansion of the *Tarasoff* duties to include these driving cases. An example of this principle can be seen in the case of *Naidu v. Laird*¹⁴ in which a wrongful death action was brought against a state hospital psychiatrist (Naidu) alleging that he was negligent in the release of a mental patient who, *five and one half months after discharge*, killed the plaintiff's husband in an automobile accident.

The patient, Mr. Putney, had a long psychiatric history beginning in 1959 when he was discharged from the Army with a diagnosis of severe and chronic paranoid schizophrenia. Starting in June 1965, Mr. Putney underwent serial commitments to mental health facilities. Many of the commitments were for attempted suicide as well as disorderly conduct and on one occasion threatening to rape his landlord's wife. His fifth admission in 1972 followed his intentionally ramming a police vehicle with his automobile at which time he was found to be grossly psychotic and dangerous. During the admission at issue in the case, Mr. Putney was brought in by police after, having again failed to take his medication, he locked himself in his hotel room. He signed a voluntary hospitalization application obviating the need for court action to commit him. However, two weeks later, one day after being transferred to Dr. Naidu's care, he submitted a request for release.

In considering whether to honor this request, the treatment team under Dr. Naidu reviewed a summary of Putney's

medical records that had been created by the admission team. The complete records were not reviewed (an omission that left Dr. Naidu unaware of a note on a March 7 admission that indicated that Mr. Putney may have been spitting out his medication). It is worth noting that six of Mr. Putney's prior admissions were to this same facility making substantial record review quite simple. Mr. Putney was released with a 30-day supply of medication and a follow-up appointment at a local VA hospital. Immediately after he was released Putney stopped taking his medication and failed to keep his appointment. Five and a half months after discharge, Mr. Putney drove his car into that driven by Mr. Laird, resulting in Mr. Laird's death. The lower court jury, relying heavily on plaintiff's expert testimony that Dr. Naidu was grossly negligent in treatment and discharge of Putney, awarded plaintiff 1.4 million dollars.

The court—no doubt impressed with Dr. Naidu's failure adequately to review Mr. Putney's records that amply demonstrated his propensity to fail to comply with unsupervised treatment plans, to then decompensate, and to become violent—affirmed the lower court's holding on appeal. The court applied *Tarasoff* principles, first finding that the requisite special relationship applied, and specifically mentioned the rectitude of the superior court's holding that Dr. Naidu was chargeable with knowledge of Putney's prior automobile accident while in a psychotic state as well as the fact that he possessed a driver's license at the time of his release and could be

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expected to drive a motor vehicle on public roadways. The court further concurred with plaintiff's expert that it was foreseeable that Putney would fail to take his medication after release and, true to his recorded history, once again become psychotic. Although one may see the wisdom in holding Dr. Naidu liable under a professional negligence standard, the court chose instead to specifically address the issue of driving, thus expanding the therapist duty to this area.

While this incident certainly merited scrutiny under a professional negligence malpractice analysis, we suggest that the court was actually swayed by the *degree* of negligence in this case and—in refuting Dr. Naidu's claim that he owed no duty to the plaintiffs or that his treatment was not the proximate cause of Mr. Laird's death—unnecessarily extended *Tarasoff* to include the dangerous operation of a motor vehicle by a patient negligently discharged five months earlier. Though the *earlier* incident of ramming the car while psychotic could well be construed as meeting the criterion of mental-illness-derived violence, there is no unambiguous evidence in the record that Mr. Putney intentionally rather than negligently drove his vehicle into Mr. Laird's vehicle, nor, for that matter, that the latter incident flowed at all from his mental illness. In this regard the appeals court summarized: "Putney, who has a long history of mental illness, *apparently* drove his automobile deliberately into Mr. Laird's vehicle. At the time of the accident, Putney was in a psychotic state" [emphasis added]. Ironically, this portrayal raises

the question of insanity exculpation, rendering dubious even the "apparent" intentionality.

Note also, conversely, that—since the *pre-admission* car ramming was clearly *intentional*—that act offers no guidance in predicting future *negligence*.

In rejecting Dr. Naidu's contention that his treatment was not the proximate cause of Mr. Laird's death, the court suggested that the burden was on Dr. Naidu to establish some other intervening cause in the five and one-half month period that followed his discharge from Dr. Putney's care, during which time, of course, the patient was not under observation or evaluation by any clinician. Again, it seems to us that the court, persuaded by the degree of negligence, was more inclined to endorse the trial court's findings, even at the cost of placing this curious burden on Dr. Naidu.

There is also no discussion recorded as to whether possible intervening causal factors were examined. Rather, it is likely in finding that some negligence existed at the time of discharge, the court covertly shifted from a professional negligence standard to a strict liability standard under the rubric of the *Tarasoff* duty to protect.

If, for the sake of argument, one accepts that Dr. Naidu's discharge was inappropriate, (and this case can be distinguished by the fact that *some* driving history was contained in the record, in contrast to the patient who has not been involved in automobile accidents) are we to accept a five and one-half months interval as reasonable? Could a commitment petition on Mr. Putney succeed,

based on a danger five months in the future, or even on the premise that someday he might drive and, if so, might then be dangerous? Are we to accept, without thorough investigation, an absolute causal link between a patient's mental illness and an automobile accident? Even assuming a driver can be found to be suffering from a mental illness at the time of an accident, what threshold should exist to establish that the accident resulted from an intentional act by a mentally ill patient rather than from the patient's negligence? Should therapists be the absolute guarantors of their patients' behaviors, including their negligence?

Bad cases simply do not make good law and this is what occurs when careful consideration is not given to the policy implications of court rulings—here, that negligent driving occurring five and a half months after last contact is foreseeable. Was the court afraid that, under a common law negligence analysis, investigation and discussion of intervening factors would have reduced or vitiated any causal link to negligence extant at the time Dr. Naidu discharged Mr. Putney? The court's policy on this issue has special significance with regard to appropriate jury instructions on the issue of proximate cause.

Three Representative Driving Cases

Petersen v. State,¹⁹ a 1983 Washington State case, was among the first to broaden the ambit of the "duty to protect doctrine." The case is significant as it marked the extension of a psychia-

trist's liability for unintentional remote harm of an unforeseeable person. In *Petersen*, the court found a psychiatrist of a state hospital had a duty to take reasonable precautions to protect any person who might foreseeably be endangered by the patient's drug-related mental problems.

The plaintiff, Cynthia Petersen, was injured in an automobile accident when her car was struck in an intersection by a vehicle driven by Larry Knox who had run the traffic light at a speed of approximately 50 to 60 miles per hour. Knox had been released from a state psychiatric facility five days prior to the accident. Mr. Knox had been admitted to the mental health facility after he took a knife to himself and cut out his left testicle. Mr. Knox was known to have an extensive history of drug abuse, which included frequent use of the drug "angel dust" throughout the previous year. The psychiatrist in charge of Mr. Knox's care diagnosed him as having a schizophrenic reaction, paranoid type with depressive features and felt the patient's symptomatology was due primarily to the use of "angel dust." Mr. Knox was treated with Navane. One day prior to his discharge, he was apprehended driving his car in a reckless manner on the hospital grounds. Mr. Knox was discharged, when an opportunity for recommitment lapsed, the following morning and five days later, while under the influence of drugs ingested subsequent to discharge, drove through a traffic light at high speed, killing the plaintiff's husband.

It was established at trial that Mr.

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Knox had flushed his Navane down the toilet and, in fact, had a pattern of non-compliance coupled with a worsening of his drug abuse when not on neuroleptics. In holding that the treating psychiatrist owed a duty to take precautions to protect the plaintiff, the court cited *Tarasoff*, among other cases, as establishing, based on the special relationship that exists between a therapist and a patient, a duty to protect third parties.²⁰ The court specifically stated that the duty may include warning foreseeable third parties, calling relevant authorities, or involuntary commitment of the dangerous patient.²¹ In its discussion of the issue of foreseeability as a criterion for imposition of a duty to protect, the court recognized that—although *Tarasoff* did not specifically limit the scope of duty to identifiable victims—later California cases limited the scope of the therapist's duty to readily identifiable victims.²² However, the court cited and followed the approach taken by the court in *Lipari v. Sears Roebuck & Co.*,²³ which found the defendant therapist had a duty to protect plaintiffs or the class of persons to which the plaintiffs belonged.

The court's reliance on *Lipari* is especially significant in that the court in *Lipari* rejected limiting the duty to the identifiable victim and hence the case was a harbinger of the trend toward strict liability. The court actually considered these cases analogous to the product liability cases where the focus is on the reasonable likelihood of injury rather than the identity of the victim.²⁴ It is this perception that we believe is erroneous and reflects the improper application of

the strict liability context described above. The practice of psychotherapy is neither an inherently dangerous activity nor should patients be considered as analogous to products for whose actions, the "manufacturer" (therapist) should be held strictly liable.

In assessing dangerousness with regard to the patient's operation of a motor vehicle, the therapist here can be said to have been on notice given the patient's behavior on the day prior to discharge. There the patient was discovered in the parking lot of the hospital on return from pass spinning his car in circles. Is this, however, a function of his mental illness, or simply negligent behavior and is the therapist to be charged with the ability to predict which of his patients may in the future drive in a negligent manner? Moreover, if one is charged with such an omnipotent responsibility, what criterion should be used? Should one episode of aberrant driving such as occurred in this case be sufficient to predict future episodes or justify involuntary commitment each time the patient is in the hospital?

Moreover, if the therapist saw this behavior as some sort of predictor by whatever standard and applied for the patient's commitment on the basis of dangerousness, have we any reason to expect that such commitment would succeed? The behavior itself is only ambiguously endangering as it occurred and might well be seen by a court as only a symptom, insufficient to meet the test of clear and convincing evidence of dangerousness.

In *Cain v. Rijken*²⁵ a wrongful death

action was brought against a community mental health provider. Representative for the plaintiff filed the action after Cain was killed when his automobile collided with an automobile driven by Paul Rijken. At the time of the accident, Rijken was on conditional release by the Psychiatric Security Review Board (PSRB) to a day treatment at a CMHC (Providence) that accepted him under a contract with the county. Rijken was under the PSRB's authority after having been found NGRI for involvement in a high speed chase with local police during which he struck and damaged cars and drove into incoming traffic at 80 miles an hour. He was diagnosed as schizoaffective, subject to episodes of manic type activity and hallucinations, and showing poor judgment. When Rijken was released to Providence, the discharge summary described Rijken as being able to drive, an explicit assessment not usually present in driving cases.

Plaintiff alleged that defendant, Providence, negligently failed to supervise or control Rijken and failed to warn the PSRB that Rijken was incompetent to drive a motor vehicle and therefore Providence's negligence caused Cain's death. The lower court held that Providence did not owe a legal duty to plaintiff and granted summary judgment to the defendant. The court of appeals reversed, holding that Providence did, indeed, have such a duty. The Oregon Supreme Court granted review to decide the issue of whether an action could be brought against a community mental health center for failing to protect plaintiff from patient's unintentional acts.

The court, in reversing and remanding for trial on the merits, held that Providence "had a duty of reasonable care in treating its patients and controlling its patients' acts, that a breach of this duty would entail potential liability to persons foreseeably endangered thereby and that whether Rijken's acts and the risk to members of the public were foreseeable is a question of fact to be decided [by the trier]." ²⁵ In addressing the issue of foreseeability, the court further stated "... Providence had a duty to control Rijken, not just for Rijken's sake, but for the peace and safety of the general public. ... Thus the fact that Cain was not identified does not mean that Rijken's acts in harming Cain as an unidentified member of the public were not foreseeable." ²⁶

This case can again possibly be distinguished in that Providence was in possession both of knowledge of an example of Mr. Rijken's dangerous operation of a motor vehicle and of an affirmative assessment of the patient's fitness to drive. In fact, as stated is the facts of the case, Mr. Rijken only came under the supervision of the PSRB after having been found not guilty by reason of mental disease or defect from having been involved in dangerous operation of a motor vehicle. In this case we have an criminal charge that confirms for all practical purposes that Mr. Rijken's actions flowed from his mental illness (hence the NGRI). On discharge, however, his driving competence is asserted. However, here again, we contend that the duty to protect is erroneously applied. Although a psychotherapist may

or may not have been aware of patient's previous acts, a duty to warn or protect analysis assumes an ability to predict negligence. The only tenable exception is if the complaint alleges or evidence establishes that the accident in which the plaintiff or relative was injured was the result of an intentional act by a mentally ill patient.

A recent case in Georgia this year, *Ermutlu v. McCorkle et al.*,²⁸ strikingly combines and contrasts the points made so far. Camille Watkins was an outpatient of psychiatrist Ilhan Ermutlu and—despite her almost 30-year history of mental illness and recurrent hospitalizations—had never had a car accident or traffic ticket. After a manic episode treated with a dosage increase, Watkins was driving at excessive speed and rear-ended a car, killing herself and the 21-year-old driver, Lisa McCorkle. This tragedy was preceded by an apparent hit and run by Ms. Watkins. No one could explain “what caused Ms. Watkins’ behavior or whether the fatal accident was caused by or even related to her mental illness” (p. 794). The court found the evidence lacking for Ms. Watkins’ committability and noted:

The record is devoid of any evidence indicating the accident was caused by Ms. Watkins’ mental condition . . . the causal connection between Dr. Ermutlu’s conduct and plaintiffs’ injury is too remote for the law to allow a recovery. Mrs. Watkins had been driving . . . during the entire period of her mental illness (approximately 26 years) without being involved in a traffic accident . . . or displaying behavior which would in any way indicate her mental condition impaired her driving skills.

The court then opined that the doctor could not have foreseen that the pa-

tients’ illness would have caused the death. The court’s language conveys that an action in negligence requires such a causal connection. The court’s emphasis on the absence of a positive driving history as relevant to foreseeability illustrates the use of such history taking. The case is further distinguished by the court’s vision of *impairment*, rather than intentionality, as the critical issue.

Discussion

The driving cases reviewed above present different versions of the motor vehicle accident. Some reveal intent, others negligence. Some of the patients have a “positive driving history” and others do not. When the car is used intentionally as a weapon to inflict predictable violence stemming from a mental illness, clinicians might accept some responsibility in preventing this harm. But all too many cases of liability for a patient’s driving fail to meet the reasonableness of this last model.

According to the growing literature (see Appelbaum¹⁶), courts find therapists professionally liable for what appear to be policy reasons, whether or not professional negligence was a factor in the harm to the victim. The driving cases have raised several contextual issues that we believe have contributed to this trend. We have attempted to show this result in the courts’ inappropriate application of a *Tarasoff* duty to a patient’s operation of a motor vehicle.

Tarasoff and its progeny created new burdens for therapists. A number of cases have held that a therapist is liable to the unforeseeable victim for negligent

release of a dangerous patient—that is, a patient intentionally violent from a mental illness. We believe, however, that to hold a therapist liable for a patient's negligent operation of a motor vehicle is too far a departure, for the reasons we have cited, from the accepted duty to protect.

Whereas it has long been established that a physician has the responsibility of discussing the side effects of a medication that might impair driving, it has never been the physician's responsibility to ensure that the patient does not drive at all. Not only does the court appear to require this level of responsibility but also to require that the therapist predict future negligence. The courts have here clearly expanded the therapist's duty far beyond abilities for which therapists can be trained.

When, as in *Naidu v. Laird* and *Schuster v. Altenberg*, there exists no evidence in the record that the acts of the discharged patients were intentional or, more importantly, a direct result of the patient's mental illness, the court in imposing liability is setting a strict liability standard at best, or—perhaps worse—a nebulous and ultimately unfulfillable requirement that the therapist predict future negligence. In either case, the consequences for practicing therapists appear both unfortunate and inappropriate as burdens on a social policy basis. Moreover, if either standard is accepted, there will exist no impediment to promiscuous assignment of liability whenever injury occurs.

One conceptualization that may counter the trend evidenced in the driv-

ing cases was first proffered by the U.S. Supreme Court in *Youngberg v. Romeo*.²⁹ The court proposed adoption of a "substantial departure" test in the majority of cases that involve psychiatric negligence. Rather than hold a therapist to the standard of care established by the plaintiff's expert, the "substantial departure" test would ask whether a therapist's treatment and diagnosis substantially departed from that which therapists ordinarily provide. Clearly such an approach would prevent the arbitrary assignment of increasing responsibility to therapists in areas in which they have neither training nor experience. It is unlikely that prediction of negligence will ever become established as a skill and integral part of the care and treatment of patients to the extent that failing to predict it would constitute a substantial departure. More importantly, the application of this test would keep the focus of attention appropriately on the therapists' behavior rather than on the victim's injury thereby avoiding both the hindsight bias and other contextual pitfalls outlined above.

A final question remains, should every therapist routinely take a driving history? The above discussion might seem to support that approach but at least one scholar (Appelbaum PS, personal communication) has cautioned against doing so lest clinicians set an artificially high standard of care that requires this step for all practitioners. Clearly, a routine inquiry about violence belongs in every standard examination ("Have you ever in any situation caused death or serious injury to another human being?"); a

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query that turns up driving accidents should trigger further inquiry and the inclusion of those data into the clinical decision making. In any case we offer our analysis in the hope that clinicians may use it as a defense against inappropriate imposition of an impossible standard on their care of patients.

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8. *Tarasoff v. Regents of the University of California* 529 (Cal 1974) P2d 553 at 345
9. Restatement (second) of Torts §315 (1965)
10. See Felthous *supra* at note 3
11. See Monahan at note 4
12. *Schuster v. Altenberg* 424 NW 2d 159 (Wis.1988)
13. *Id* at 164
14. The court cited such cases as *A.E. Investment v. Link Builders Inc.*, 214 NW 2d 764 (Wis 1974) and *Gooden v. Tips* 651 SW 2d 364, 369 (Tex. Ct. App. 1983)
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17. Monahan at note 4
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20. See note on Restatement of Torts
21. *Petersen v. State*, 671 P2d 230 (Wash 1983) at 237
22. The court cited *Mavroudis v. Superior Court for the County of San Mateo*, 162 Cal Rptr 724 (Cal. Ct. App 1980)
23. *Lipari v. Sears Roebuck & Co.* 497 F. Supp. 185 (D. Neb. 1980)
24. *Id* at 194. The Nebraska court in this case cited as precedent for holding that the therapist should be liable to those persons foreseeably endangered, its own holding in a products liability case
25. *Cain v. Rijken*, 717 P2d 140 (Or. 1986) at 142
26. *Id*
27. *Id* at 148
28. *Ermutlu v. McCorkle*, 416 SE 2d 792 (Ga.App. 1992)
29. *Youngberg v. Romero* 457 U.S. 307 (1982).