

# Tarasoff and the Dangerous Driver: A Look at the Driving Cases

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In three recent cases, hereinafter referred to as the driving cases, the courts have taken up the issue of whether a psychotherapist should be held liable for negligent diagnosis and treatment and failure to warn third parties of a patient's potential danger to others in the operation of an automobile. These cases will be discussed as (1) an extension of the *Tarasoff* decision, which established psychotherapists' duty to protect third parties from patients' violent acts, and (2) what some commentators regard as a move toward holding the mental health professions to a standard of strict liability. How far have the courts in these cases extended the *Tarasoff* duty to protect and is the specter of strict liability real or imagined? This review finds the court adhering to a professional negligence standard as altered by the *Tarasoff* case in which the court applied the Restatement of Torts (Second) §315 and held that the psychotherapist-patient relationship is a special relationship requiring a duty to protect or warn. And while a negligence standard ostensibly applies, the conclusions reached in these cases reveal an undeniable trend toward results one might expect to accrue under a strict liability standard.

The influence of the seminal *Tarasoff v. Regents of the University of California*<sup>1</sup> case is well established.<sup>2</sup> In *Tarasoff*, a therapist was informed by an outpatient that he intended to kill his former girlfriend. The therapist was not told the girlfriend's name but, under the circumstances in the case, a determination of the intended victim's identity would not have been difficult. The patient subse-

quently acted on his threat and killed Tatiana Tarasoff. The central issue for the court was whether the therapist was negligent in failing to warn Tatiana Tarasoff of the dangerous patient. The court, applying the Restatement of Torts (Second) §315 to the therapist-patient relationship,<sup>3</sup> held that the therapist did in fact have a duty to warn of the danger to Ms. Tarasoff and, for failure to do so, could be found negligent. After considerable effort on the part of the American Psychiatric Association, and others, *Tarasoff* was reargued. In the 1976 (*Tarasoff* II) opinion, the court broadened its earlier ruling, the duty to warn, to include the duty to protect.<sup>4</sup> The court, however,

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left it unclear how one was to discharge this new duty, other than to suggest that the method be "reasonable."

Some commentators have suggested that the trend since *Tarasoff* is toward a strict liability standard (i.e., liability without negligence) for mental health workers.<sup>5</sup> Whether this is in fact true may be a matter of interpretation. What is indisputable is that *Tarasoff* has indeed influenced many decisions in other jurisdictions. There has been an unmistakable evolution, from holding the psychotherapist narrowly responsible when the victim is foreseeable and readily identifiable, to establishing a broad duty to protect the public in general from potential foreseeable harm. The cases reviewed here all involve imposition of liability on a psychotherapist for failure to take precautions to protect unidentified third parties against negligent operation of a motor vehicle by a patient.

This paper will examine the issues raised by driving cases and will discuss the trend these cases represent specifically with regard to the legal standard being applied and the implications for psychotherapists.

#### **Four Representative Driving Cases**

*Petersen v. State*,<sup>6</sup> a 1983 Washington State case, was among the first to broaden the ambit of the "duty to protect doctrine." Included here as historical background, it marked the extension of a psychiatrist'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 a traffic light at a speed of approximately 50 to 60 miles per hour. Five days prior to the accident, Knox was released from a state psychiatric facility where he had been receiving treatment. Approximately one month 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 that included frequent use of the drug "angel dust" (PCP) 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 that 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 fashion on the hospital grounds. Mr. Knox was discharged, when an opportunity for recommitment lapsed, the following morning. Five days later, while under the influence of drugs ingested subsequent to discharge, he drove through a traffic light at high speed injuring the plaintiff.

It was established at trial that Mr. Knox had flushed his Navane and in fact had a pattern of noncompliance coupled with a worsening of 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.<sup>7</sup> That duty may include warning foreseeable third parties, calling relevant authorities, or involuntary commitment of the dangerous patient.<sup>8</sup> In its discussion of the issue of foreseeability as a criterion for imposition of a duty to protect, the court recognized that while *Tarasoff* did not specifically limit the scope of duty to an identifiable victim, later California cases had limited the scope of the therapist's duty to readily identifiable victims.<sup>9</sup> However, the court specifically cited and followed the approach taken by the court in *Lipari v. Sears, Roebuck & Co.*, which found the defendant therapist had a duty to protect plaintiffs or the class of persons to which the plaintiffs belonged.<sup>10</sup> The court's reliance on *Lipari* is especially significant as the court, in *Lipari* had rejected limiting the duty to the identifiable victim, and presaged the evolutionary trend toward strict liability by finding these cases analogous to products liability cases where the focus is on the reasonable likelihood of injury rather than the identity of the victim.

In the first of the three more recent driving cases, *Cain v. Rijken*,<sup>11</sup> 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, Mr. Rijken was on a conditional release by the Psychiatric Security Review Board (hereinafter PSRB) to a day treatment program at a community mental health facility (Providence) that accepted him under a contract with the county. Mr. Rijken was under the PSRB's authority after being found not responsible by reason of mental disease or defect for having been involved in a high speed chase with local police during which he struck and damaged cars and drove into oncoming traffic at 80 miles per hour. He was diagnosed as schizophrenic, schizo-affective type subject to episodes of manic activity and hallucinations and showing poor judgment. When Rijken was released to Providence, the discharge summary described Rijken as being able to drive.<sup>12</sup>

Plaintiff alleged that defendant, Providence Medical Center (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 plaintiff's death. The lower court held that Providence did not owe a legal duty to plaintiff and granted summary judgment to defendant. The Court of Appeals reversed the lower court holding that Providence did in fact 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 facility for failing to protect plaintiff from a patient's unintentional acts.

The court in reversing the lower court,

and remanding for trial on the merits held that Providence:

... having accepted Rijken as a mental health patient under ORS 161.390 (3)<sup>13</sup>; had a duty of reasonable care in treating its patients and controlling its patient's 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 a jury or a court sitting as fact finder.<sup>14</sup>

The court in considering the issue of foreseeability acknowledged the possible applicability of the *Tarasoff* line of cases to the fact situation presented in the case at bar; however, it distinguished this case from those common law cases and held that the duty to protect in this case flowed directly from the statute that established the authority of the PSRB and the community mental health facility to care for the defendant.<sup>15</sup> The court nevertheless found the common law principles of reasonable care and foreseeability of harm relevant even though the statute did not address these issues directly. The court acknowledged that the fact that Rijken did not threaten to harm any person or threaten to drive so as to injure persons reduced Providence's ability to foresee his harmful acts and specifically referred to a California case<sup>16</sup> that limited the duty of care in all cases to readily identifiable victims. However, upon review of the statute the court 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.<sup>17</sup>

In a 1988 case, *Naidu v. Laird*,<sup>18</sup> a wrongful death action was brought against a state hospital psychiatrist (Naidu) alleging that he was negligent in releasing a mental patient who, five and one half months after discharge, killed plaintiff's husband in an automobile accident. The lower court held for plaintiff and Dr. Naidu appealed.

The patient, Mr. Putney, had a long psychiatric history beginning as early as 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.<sup>19</sup> 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. He was found to be grossly psychotic and dangerous. Another admission followed his noncompliance with antipsychotic medication whereupon his violent behavior returned. On all admissions Mr. Putney was found to be difficult and uncooperative. Highlights of Mr. Putney's long psychiatric history are mentioned here as it was in part Dr. Naidu's failure to obtain and review this history for which he was found negligent.<sup>20</sup>

On Mr. Putney's last admission on March 7, 1977, he 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. However, two

weeks later, one day after being transferred to Dr. Naidu's care, he submitted a request for release.

In considering the discharge, the treatment team, under Dr. Naidu, reviewed a summary of Putney's medical records, which had been generated by the admission team. The complete records were not reviewed (an omission that left Dr. Naidu ignorant of a note on the 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 scheduled follow-up appointment at a local VA. Immediately after he was released, Putney stopped taking his medication and failed to keep his appointment. Five 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's testimony that Dr. Naidu was grossly negligent in treatment and discharge of Putney, awarded plaintiff 1.4 million dollars.

Dr. Naidu argued on appeal that he owed no duty to protect the public at large from patients' dangerous acts and, if such duty did obtain, as a matter of law, the links between his treatment of Putney and the fatal accident were so remote as to be legally insufficient to establish proximate cause.<sup>21</sup> He further submitted that as Putney posed no present danger to himself or others at the time of his discharge, he had no choice

under the law but to release him. The Delaware Supreme Court, in affirming the lower court, rejected Dr. Naidu contentions holding that:

... based on the special relationship that exists between a psychiatrist and a patient, a psychiatrist owes an affirmative duty to persons other than the patient to exercise reasonable care in the treatment and discharge of psychiatric patients. Reasonable care is that degree of care, skill, and diligence which a reasonably prudent psychiatrist engaged in a similar practice and in a similar community would ordinarily have exercised in like circumstances.<sup>22</sup>

With regard to Dr. Naidu's contention that proximate cause was not established, the court found no legal error on the issue in the lower court record and found the factual findings of the jury were supported by the evidence in the record. And with regard to Dr. Naidu's contention that he had no choice pursuant to statute but to release Putney, the court, citing plaintiff's expert's testimony, which fully disagreed with Dr. Naidu's assessment of patient's status as nondangerous, held that "whether Dr. Naidu breached his statutory duty under circumstances which demonstrated his gross negligence was an issue properly left to the jury."<sup>23</sup> The court, as in the above discussed cases, cited *Tarasoff* and its lineage and specifically the *Tarasoff* court's reliance on the Restatement of Torts (Second) in finding the special relationship precedent. The court specifically mentioned the rectitude of the Superior Court's holding that Dr. Naidu was chargeable with knowledge of Putney's prior automobile accidents 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 expected to drive a motor vehicle on public roadways. And the court 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.<sup>24</sup>

In the last case under review, *Schuster v. Altenberg*,<sup>25</sup> the court was again faced 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 medication, 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 in causing the automobile accident in which his patient's daughter was rendered paralyzed and in which the patient, who was driving, was killed.<sup>26</sup> 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."<sup>27</sup> The Schusters appealed. The Wisconsin Supreme court reversed and remanded the case

holding that appellants original complaint did allege legally cognizable claims suitable for the jury. The court specifically rejected the contention that liability should not attach in the absence of a readily identifiable victim. The court instead relied upon extensive case law which established that liability could attach despite absence of privity.<sup>28</sup> What is most significant about this case is that despite the fact that the record on appeal contained little more than the original complaint and answer, the court at the request of both parties agreed to examine the policy issues involved in the case. 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 the 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 treating dangerous patients, present significant issues of public policy. However, neither the possible impact that limited intrusions 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.<sup>29</sup>

Given this court's thorough review of the literature on these issues and its specific coverage of the issues most often raised by psychotherapists as defenses in these cases and in the literature, this case is likely to influence other courts to continue this trend toward imposition of liability in the absence of a foreseeable victim.

### **Discussion**

These cases raise new issues for psychotherapists. It may be clear that a patient judged dangerous to self or others or gravely disabled is committable. What, however, is the responsibility of the psychotherapists, with regard to the patient's operation of a motor vehicle, when faced with a patient who at the point of evaluation is judged not committable but who has a history of non-compliance with medications with resultant psychosis? Moreover, what is the applicable legal standard?

A review of case law since *Tarasoff* and these driving cases in particular yields a confusing array of decisions and rationales, making it particularly difficult to determine what coherent principles apply, if any. In the closely related negligent release cases, it has long been established that an ordinary negligence duty exists for harm caused by patients negligently allowed to escape or discharged from inpatient facilities. To the extent that the duty in negligent release cases is to the unidentified victim, neither *Tarasoff* nor the driving cases have broadened the scope of the duty. Rather,

*Tarasoff* is notable for extending the duty to outpatient circumstances in which the psychotherapist had never exercised physical control over the patient, and the driving cases evince a trend to include an ever-expanding scope of dangerous activity for which a therapist may be held liable irrespective of whether negligence existed at the time of discharge. Moreover, in a case such as *Naidu v. Laird*,<sup>30</sup> the court has added confusion to the issue of proximate cause by finding liability five and one half months after the patient was discharged. The trend clearly suggests that courts regard the protection of the public as superior to confidentiality when the two are in conflict.<sup>31</sup> And while common law negligence<sup>32</sup> standards were applied where relevant, the courts reach different conclusions regarding issues of foreseeability and whether liability attaches when no identifiable victim is known. The issue of foreseeability is particularly strained in these driving cases. And while the *Tarasoff* progeny receive credit for leading the trend toward holding a psychotherapist responsible to the unidentified victim, this is not new law nor is it a product only of *Tarasoff* or its lineage. Instead, this concept owes its genesis to the minority view in the seminal case on foreseeability, *Palsgraf v. Long Island R.R. Co.*<sup>33</sup> in which three judges first raised the issue of a duty to all injured victims of a negligent act or omission irrespective of their proximity to the negligent act. Applied to driving, this creates an impossible burden to the therapist who has no particular skill re-

lated to evaluating driving ability and even less ability to predict "dangerous driving."

The law defines negligence as "conduct which falls below the standard required by law for the protection of others against unreasonable risk of harm."<sup>34</sup> In professional negligence the therapist is held to a so-called community standard that has increasingly become a national standard. The standard in a particular suit is established by the expert testimony of members of the professional community presumably familiar with the applicable standard of care in the circumstances at issue. Mills,<sup>35</sup> in a well conceived article, endorses the "substantial departure from ordinary clinical practice" approach first suggested by the Supreme Court in *Youngberg*.<sup>36</sup> He proposes that the courts adopt the more flexible "substantial departure" test in the majority of cases that involve psychiatric negligence.<sup>37</sup> Rather than hold a therapist to the standard of care established by plaintiff's expert, the "substantial departure test" would ask whether a therapist's treatment and diagnosis substantially departed from that psychotherapists ordinarily provide. He concedes the rather fine distinction it entails but believes it offers the court greater latitude in determining whether a doctor deviated from conventional practice to an extent sufficient for liability to attach. He asserts "... the standard of substantial departure allows a defendant to avoid liability whenever he or she acted in reasonable good faith and where the literature and conventional practice does not suggest that he or she needed

to do a good deal more than was done".<sup>38</sup>

Whether or not courts will apply such a test remains to be seen, and it may be doubtful that under such a test results would differ given the policies that apparently drive many judicial decisions. Application of such a test is also not likely to obviate the court's dependence on experts who notoriously disagree on the standards at issue in individual cases. However, the application of such a test would shift the focus of attention to the therapist's behavior rather than the victim's injury, a seemingly appropriate focus in a negligence analysis. Such a shift in focus might also serve to diminish the contaminating effect of the "hindsight bias,"<sup>39</sup> which results from the inescapable retrospective refraction that accompanies injury cases. Moreover, Mills points out that such a shift in focus also seems particularly pertinent to cases involving the infant and unreliable science of danger prediction. The application of the "substantial departure test" merits serious consideration by the courts. However, the real forum for addressing the confusion that results from the current absence of meaningful standards may be the legislative. This seems particularly true given the threat of strict liability that could rightfully be construed as the specter on the horizon.

Felthous,<sup>40</sup> citing the confusing array of decisions in these cases, points out that it would more appropriately be the province of legislative bodies to decide the policy issues involved with this threatening evolution. He states, "If any type of warning or reporting is desired as a matter of public policy to prevent

automobile accidents caused by psychiatric patients, this ought to be addressed legislatively. Statutory law has the virtue of clarity and consistency not found in jurisprudence based on individual cases."

The legislative approach has indeed borne fruit in several jurisdictions. In response to the combined efforts of therapists from various disciplines as well as the recommendations of the American Psychiatric Association, states such as California, Michigan, and Massachusetts, among others, have passed legislation that limit the scope of the duty to protect imposed by *Tarasoff* and its progeny. These states have passed legislation that limit the liability in duty to protect cases to serious threats toward an identifiable victim. The states vary in what is required of the therapist before the duty to protect is discharged making it important for clinicians to be familiar with the language of the applicable statute.

It seems incumbent on the mental health professions to continue to establish appropriate standards and to take an active role in policy development in state and federal forums. It is clear that more solutions should be considered and proffered for, at the very least, heuristic value as the controversy over these issues continues and solutions are sought. Godard and Bloom,<sup>41</sup> in their review of these issues, reach similar conclusions and specifically admonish psychiatrists to actively resist the imposition of the responsibility for the prediction of driving ability. Until, however, there are more and better data on such issues as

ability to predict dangerousness and until courts and legislatures are persuaded by them, psychotherapists will have to rely on a reading of statutory and case law to determine what duties the courts might impose.

### **Conclusion**

While it may be that courts continue to apply a negligence analysis to these cases, they do not do so instructively; instead this analysis precipitates a major disappointment with the process. No clear standard of acceptable behavior on the part of a therapist emerges in a review of these cases. However, a few points do seem clear. First, the court is likely to continue the trend of seeking out ways to compensate unfortunate victims in these cases, whether or not the result approaches strict liability. Second, it should come as no surprise that attention to detail on the part of the therapist is paramount. Previous medical records should be carefully reviewed, and referring therapists or physicians should be contacted to complete a careful history. Second opinions will probably be helpful in establishing accord with applicable standards of care when deciding on privileges for outpatients that may include driving and when considering discharge planning. When there is no reason, other than the patient's potentially dangerous driving, for continued confinement and the decision is made to discharge, it may be necessary, in addition to warning the patient against driving, to contact the local Department of Motor Vehicles with information regarding the patient's potential danger to the public (analo-

gous to the option of warning the police when patient is potentially violent per *Tarasoff*).

Felthous<sup>42</sup> suggests that a trial of having the patient drive with a staff member be attempted before the patient is discharged when a clinician has reason for concern about an inpatient's safe driving. This solution is problematic given that staff are not typically trained to perform such a function and it would entail an additional burden on already severely limited resources. Moreover, it remains unclear what threshold should trigger such actions by the therapist. For now, consultation with colleagues and members of the treatment team provides the greatest protection against allegations of negligence, though uncertainty may remain ineradicable. Experts currently disagree whether a driving history should become an integral part of history taking. Some feel that routinely taking a driving history creates a practically unattainable standard of care. Others believe it a question of whether clear benefit to risk management approaches outweighs the risk of adding yet another hook on which to hang an assertion of negligence.

The driving cases reviewed here represent a significant stretch from the original *Tarasoff* duty. The disturbing trend toward imposing liability whenever there is injury can only generate counterproductive uncertainty and anxiety for therapists. As we contend with these uncertainties, we will develop further studies and analysis and continue our efforts to persuade decision makers, judges and legislators, that bad cases do

not make good law, and that social policy is properly the province of the legislature.

### References

1. *Tarasoff v. Regents of the University of California*, 529 P.2d 553 (Cal. 1974)
2. See such commentary as, Stone A: The *Tarasoff* decisions: suing psychotherapists to safeguard society. *Harv L Rev* 90:358-78, 1976; and Givelber DJ, Bowers WJ, Blitch CL: *Tarasoff*: Myth and reality: an empirical study of private law in action. *Wis L Rev* 443-90, 1984; where Stone sets out the concerns of psychotherapists and the Givelber articles counters several of the points made by Stone. See also Fleming JG, Maximov B: The patient or his victim: the therapist's dilemma. *Cal L Rev* 62:1025-68, 1974, which was discussed by the Court in its deliberations on *Tarasoff*
3. Restatement (Second) of Torts §315 (1965). Sets out the general rule regarding special relationships: "There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless (a) a special relation exists between the actor to control the third person's conduct or (b) a special relation exists between the actor and the other which gives to the other a right to protection."
4. *Tarasoff v. Regents of the University of California* 551 P.2d 334 (Cal. 1976)
5. See Appelbaum: The expansion of liability for patient's violent acts. *Hosp Community Psychiatry* 35:13-4, 1984; and generally Simon: The duty to warn and protect endangered third parties. *Clin Psychiatry Law* 308-13, 1987
6. *Petersen v. State*, 671 P.2d 230 (Wash. 1983)
7. See note 3
8. *Petersen v. State*, 671 P.2d 230, 237 (Wash. 1983)
9. The court cited *Mavroudis v. Superior Court*, 162 Cal. Rptr. 724 (1980) and *Thompson v. County of Alameda*, 614 P.2d 728, *Lipari v. Sears, Roebuck & Co.*
10. 497 F.Supp. 185. (D. Neb.) In *Lipari*, the victim was shot by a complete stranger who had been receiving outpatient psychiatric treatment from doctors at a veterans administration facility. Before the patient ended his treatment against doctor's advice, he had made no specific threats against any reasonably identifiable victim. However, approximately one month later, the patient discharged a shotgun in a crowded night club

## Tarasoff and the Dangerous Driver

- injuring plaintiff and killing plaintiff's husband
11. Cain v. Rijken, 717 P.2d 140 (Or. 1986)
  12. On the discharge summary the box "May Drive" was checked
  13. Subsection of the statute that established the Psychiatric Review Board's jurisdiction over persons found not responsible for crimes by reason of mental disease or defect
  14. Cain v. Rijken, 717 P.2d 140, 142 (Or. 1986)
  15. Id at 147
  16. Thompson v. County of Alameda, 614 P.2d 728 (Cal. 1980)
  17. Cain v. Rijken, 717 P.2d 140, 148 (Or. 1986)
  18. Naidu v. Laird, 539 A.2d 1064 (Del. 1988)
  19. Id at 1067-1068. The facts surrounding Mr. Putney's commitments are summarized by the court
  20. Id at 1073
  21. Id at 1066
  22. Id at 1072
  23. Id at 1071
  24. It is important to stress the lower court jury's reliance on the testimony of plaintiff's psychiatrist who testified to these facts and that the appeal court apparently found the testimony equally compelling evidence of Dr. Naidu's gross negligence
  25. Schuster v. Altenburg, 424 N.W. 2d 159 (Wis. 1988)
  26. Id at 160-161
  27. Id at 164
  28. The court cited such cases as A.E. Investment v. Link Builders, Inc., 214 N.W. 2d 764 (Wis. 1974) as establishing that a party is negligent if it was foreseeable that the party's act or omission to act could cause harm to someone. The court also cited Gooden v. Tips, 651 SW.2d 364, 369 (Tex. Ct. App. 1983), in which a physician was held to owe a duty to use reasonable care to protect the driving public where the physician's negligence in diagnosis or treatment of his patient contributes to plaintiff's injuries
  29. Schuster v. Altenburg, 424 N.W. 2d 159, 175 (Wis. 1988). In addition to the *Tarasoff* line of cases court cited such articles as Givelber *et al.*, *supra* note 2, as well as Fleming and Maximov, *supra* note 2, among others
  30. Naidu v. Laird, 539 A.2d 1064 (Del. 1988)
  31. Beigler JS: *Tarasoff v. confidentiality*. Behav Sci Law 2:272-88, 1984
  32. (i.e., the elements of common law negligence duty, breach, causation, and damages)
  33. Palsgraf v. Long Island R.R. Co., 162 N.E. 99 (N.Y. 1928) The minority view held that a defendant's duty is established if his act or omission caused foreseeable harm. Once negligence is established, the defendant is liable for unforeseeable harm and unforeseeable plaintiffs
  34. Restatement (Second) of Torts §282 (1965)
  35. Mills MJ: The so-called duty to warn: the psychotherapeutic duty to protect third parties from patient's violent acts. Behav Sci Law 2:237-58, 1984
  36. Youngberg v. Romeo, 457 U.S. 307 (1982)
  37. Mills credits the Supreme Court in dicta in Youngberg v. Romeo, 457 U.S. 307 (1982), for first suggesting such a legal standard
  38. Mills, *supra* note 35, at 249
  39. See Gutheil *et al.*: Decision Making in Psychiatry and the Law. Baltimore, William & Wilkins, 1991, p 199. In a study conducted by Gutheil *et al.*, it was demonstrated that when clinicians were presented with a case scenario and asked to predict the probability of suicide, a statistically significant hindsight bias was demonstrated by the higher estimated probability of suicide by those who knew the outcome to be suicide than by those who did not possess such retrospective information. The researchers defined "hindsight bias" as the tendency to overestimate the probability of suicide when one knows it has occurred
  40. Felthous AR: The duty to warn or protect to prevent automobile accidents. Rev Clin Psychiatry Law 1:221-38, 1991
  41. Godard SL, Bloom JD: Driving, mental illness, and the duty to protect, in Confidentiality Versus the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry. Edited by Beck JC. Washington, DC, American Psychiatric Press, 1990, pp 191-204
  42. See Felthous, *supra* note 40