

## A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties

W. Jonathan Cardi<sup>1</sup>

Following *Tarasoff v. Regents of the Univ. of California*<sup>2</sup> and a majority of jurisdictions,<sup>3</sup> § 41 of the Restatement (Third) of Torts (hereinafter, “R3”) imposes a duty on mental healthcare professionals (hereinafter, “therapists”) to warn foreseeable victims of a risk posed by one of the therapist’s patients.<sup>4</sup> The R3 “takes no position,” however, as to whether a non-mental-health physician owes a similar duty to warn foreseeable third parties of a risk (e.g., of communicating disease) posed by one of the physician’s patients.<sup>5</sup> This brief article explores both the accuracy and the viability of this distinction and its theoretical underpinnings. Specifically, the article takes three positions: (1) as a purely descriptive matter, the R3 ought to recognize a physician duty to warn foreseeable third parties; (2) as a normative matter, the question is more nuanced perhaps even than the courts and the R3 recognize; and (3) that the courts’ (and the R3’s) analysis of the issue is best captured by a pluralistic understanding of tort law.

### I. Evaluating the Descriptive Accuracy of § 41

Suppose that during the course of treatment, a patient tells his therapist that he intends to harm his ex-girlfriend. Should the therapist have a duty of reasonable care to warn the ex-girlfriend? This was the question in the *Tarasoff* case, and the California Supreme Court answered that a therapist does owe a duty to use reasonable care to protect foreseeable victims, including the duty to warn them directly.<sup>6</sup> As the R3 correctly notes, since *Tarasoff* a majority of jurisdictions have adopted some version of its holding,<sup>7</sup> although some have narrowed it, for example, by limiting the duty to cases in which the patient has made an explicit threat to an identified third party.<sup>8</sup>

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<sup>1</sup> Dorothy Salmon Chair and Associate Professor of Law, University of Kentucky. I would like to thank Mike Green, Bill Powers, and the Wake Forest Law School for bringing together such an auspicious group, and for including even the inauspicious.

<sup>2</sup> 551 P.2d 334, 342 (Cal. 1976) .

<sup>3</sup> See Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 98 (1994) (reporting that *Tarasoff* is “widely accepted (and rarely rejected) by courts and legislatures in the United States as a foundation for establishing duties of reasonable care upon psychotherapists to warn, control, and/or protect potential victims of their patients who have expressed violent intentions.”).

<sup>4</sup> RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM (BASIC PRINCIPLES) § 41(b)(4) (Proposed Final Draft No. 1, 2005) [hereinafter PROPOSED FINAL DRAFT NO. 1].

<sup>5</sup> *Id.* at §41, Reporters’ Note to cmt. *h*.

<sup>6</sup> *Tarasoff*, 551 P.2d at 340.

<sup>7</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41 & Reporters’ Notes at --. Four jurisdictions have rejected a *Tarasoff*-like duty. See *Boynton v. Burglass*, 590 So. 2d 446 (Fla. Dist. Ct. App. 1991) (en banc); *Thapar v. Zezulka*, 994 S.W.2d 635 (Tex. 1999) (declining to adopt a duty to warn because it would conflict with confidentiality statute); *Nasser v. Parker*, 455 S.E.2d 502 (Va. 1995) (holding that no special relationship can exist unless defendant has “taken charge” of other; typical psychologist-patient relationship is insufficient); see also *Gregory v. Kilbride*, 565 S.E.2d 685, 692 (N.C. Ct. App. 2002) (acknowledging a duty to control patients, but stating that “North Carolina does not recognize a psychiatrist’s duty to warn third persons” (emphasis omitted)).

<sup>8</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, Reporters’ Notes at --; *Leonard v. Latrobe Area Hosp.*, 625 A.2d 1228 (Pa. Super. Ct. 1993) (narrowing *Tarasoff* to cases involving a specific threat to a specific person). *But see Hamman v. County of Maricopa*, 775 P.2d 1122, 1128 (Ariz. 1989) (imposing a duty on therapists to warn any victim who is foreseeably “within the zone of danger, that is, subject to probable risk of the patient’s violent conduct”).

Now suppose that a person receiving treatment by a physician for HIV-AIDS confides in the physician that he intends to have unprotected sex with his girlfriend. Should the physician owe a tort duty of reasonable care to warn the girlfriend? The R3 essentially punts on this question, explaining in § 41, Comment *h* that “the case law is sufficiently mixed, the factual circumstances sufficiently varied, and the policies sufficiently balanced that this Restatement leaves to further development the question of when physicians have a duty to use reasonable care or some more limited duty — such as to warn only the patient—to protect third persons.”<sup>9</sup> It is my view that as a re-statement of the law, the R3 gets this wrong.

It is true that cases involving physician’s duty to third parties arise in a whole host of fact patterns. For example, they involve different risks—hepatitis,<sup>10</sup> tuberculosis,<sup>11</sup> genetic conditions,<sup>12</sup> even Rocky Mountain Spotted Fever<sup>13</sup>—and a variety of wrongdoing—failure to diagnose or properly treat the patient,<sup>14</sup> failure to warn the patient of the risk of transmission of disease, or failure to warn third parties of the risk of transmission. The R3 is also correct in noting that courts’ treatment of these cases sometimes varies according to the particular facts involved. For instance, courts’ duty determinations occasionally turn on the perceived magnitude of the relevant risk.<sup>15</sup> Despite the differences among cases, however, the case law reveals much more consensus than the R3 indicates. In fact, most courts have endorsed suits by a foreseeably-harmed third party against a physician for the failure to warn the physician’s patient of the risks of spreading disease.<sup>16</sup> And an even greater majority has imposed on

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<sup>9</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. *h*.

<sup>10</sup> *See, e.g.,* Candelario v. Teperman, 789 N.Y.S.2d 133, 134 (N.Y. App. Div. 2005) (denying duty to warn patient’s daughter of risks of transmission of Hepatitis C).

<sup>11</sup> *See, e.g.,* Hoffman v. Backmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (imposing duty on physician to warn family members of tuberculosis patient).

<sup>12</sup> *See, e.g.,* Safer v. Pack, 677 A.2d 1188 (N.J. 1996) (imposing duty on physician to warn patient’s daughter of risk of genetic predisposition to cancer).

<sup>13</sup> *See, e.g.,* Bradshaw v. Daniel, 845 S.W.2d 865 (Tenn. 1993) (holding that physician had duty to warn family of Rock Mountain Spotted Fever patient of risks of common environmental risk factors).

<sup>14</sup> *See, e.g.,* Britton v Soltes, 563 NE2d 910 (Ill App. 1990) (refusing to hold physician liable to family not living with patient for failure to diagnose disease). The R3 correctly characterizes some of these cases—cases in which the physician created or enhanced the risk to the third party—as properly falling under the purview of § 7. PROPOSED FINAL DRAFT NO. 1, §41, cmt. *h*. The failure to diagnose cases may be particularly hard to categorize in this regard.

<sup>15</sup> *Compare, e.g.,* Jones v. Stanko, 160 N.E. 456, 456 (Ohio 1928) (recognizing physician’s duty to warn foreseeable persons of communicability of smallpox) *with* D’Amico v. Delliquadri, 683 N.E.2d 814, 816 (Ohio App. 1996) (implicitly distinguishing *Jones* as a case involving a fatal infectious disease and dismissing suit by patient’s girlfriend against physician for failing to warn patient of risks of transmission of genital warts).

<sup>16</sup> *See, e.g.,* Myers v. Quesenberry, 193 Cal. Rptr. 733 (Ct. App. 1983) (allowing suit by third party for physician’s failure to warn patient against driving in an uncontrolled diabetic condition complicated by a missed abortion); Reisner v. Regents of the University of California, 37 Cal. Rptr. 2d 518, 523 (1995) (allowing suit by third party for failure to warn patient of communicability disease); Lemon v. Stewart, 682 A.2d 1177 (Md. 1995) (denying fear of infection claim by relatives of HIV patient because no foreseeable risk, but stating that “had any of the appellants been a sexual partner or needle-sharing partner of [patient], an arguable claim could be made that they were foreseeably potential victims of any breach of the duty to [patient] and ought to have a cause of action for that breach, to the extent they could prove injury.”); Pate v. Threlkel, 661 So. 2d 278 (Fla. 1995) (holding that physician owed a duty of care to child of patient to warn patient of genetic condition that could affect child); DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422 (Pa. 1990) (holding that physician’s duty to warn patient of risks of communicability of Hepatitis B ran to patient’s sexual partner); C.W. v. Cooper Health System, 906 A.2d 440 (N.J. App. 2006) (imposing physician duty to warn patient of risks of transmission of HIV and extending duty to patient’s sexual partner). *But see* Praesel v. Johnson, 967 S.W.2d 391 (Tex. 1998) (declining to impose duty by physicians to third parties to warn epileptic patients not to drive); D’Amico v. Delliquadri, 683 N.E.2d 814, 816 (Ohio App. 1996) (implicitly distinguishing *Jones v. Stanko, supra*, as a case involving a fatal infectious disease,

physicians a *Tarasoff*-like duty of reasonable care to warn those foreseeably at risk of infection by the patient.<sup>17</sup>

In the face of relatively clear majority rules, why might the R3 recognize a duty on the part of therapists, yet refuse to take a position on an analogous duty by physicians? First, the R3's description of the current state of the law is not entirely without merit. As with *Tarasoff*, there do exist dissenting jurisdictions in physician cases,<sup>18</sup> and (somewhat confoundingly) many jurisdictions have yet to address the question directly. Furthermore, even among courts

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and dismissing suit by patient's girlfriend against physician for failing to warn patient of risks of transmission of genital warts because state physician-patient privilege statute would bar physician from testifying in his own defense).

<sup>17</sup> See *Hoffman v. Backmon*, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (holding that physician has duty to warn patient's family about risks of patient's tuberculosis); *Gill v Hartford Acci. & Indem. Co.*, 337 So. 2d 420, 421 (Fla. App. 1976) (imposing duty on physician to warn patient's hospital roommate of patient's highly contagious infection); *Troxel v. A.I. DuPont Inst.*, 675 A.2d 314 (Pa. Super. Ct. 1996) (holding that physician owed duty to friend of patient child's family, who was infected by child's cytomegalovirus, to warn family of risks of communicability); *Bradshaw v. Daniel*, 854 S.W.2d 865 (Tenn. 1993) (holding that physician had duty to warn family members of patient who contracted Rocky Mountain spotted fever about common sources of infection); *Safer v. Pack*, 677 A.2d 1188 (N.J. 1996) (imposing duty on physician to warn patient's daughter of risk of genetic predisposition to cancer and defining duty as "to require that reasonable steps be taken to assure that the information reaches those likely to be affected or is made available for their benefit"); *Wojcik v Aluminum Co. of America*, 183 N.Y.S.2d 351, 358 (1959) (imposing duty to warn patient of communicability of tuberculosis and affirming, in dicta, the duty to warn the patient's wife); *Davis v Rodman* 227 S.W. 612, 614 (Ark. 1921) (acknowledging physicians' "duty to exercise reasonable care to advise members of the family and others, who are liable to be exposed thereto, of the nature of the disease and the danger of exposure"); *Gammill v. U.S.*, 727 F.2d 950, 954 (10th Cir. 1984) (applying Colorado law and noting that "A physician may be found liable for failing to warn a patient's family, treating attendants, or other persons likely to be exposed to the patient, of the nature of the disease and the danger of exposure."); *Shepard v. Redford Community Hosp.*, 390 N.W.2d 239, 241 (Mich. 1986) appeal denied 430 N.W.2d 458 (1988) (stating that physician has a duty to warn a patient's family members of the possibility of infection of spinal meningitis); *Jones v. Stanko*, 160 N.E. 456, 456 (Ohio 1928) ("It is the duty of a physician who is treating a patient afflicted with smallpox to exercise ordinary care in giving notice of the existence of the contagious disease to other persons who are known by the physician to be in dangerous proximity to such patient. . . ."); see also *Heigert v Reidel*, 565 N.E.2d 60, (Ill. App. 1990) (discussing with approval decisions from other jurisdictions imposing a physician duty to warn third parties, but declining to impose duty on physicians to warn nurse of infectious patient because there existed neither a physician-patient relationship nor a patient-plaintiff relationship). See generally Tracey A. Bateman, *Liability of Doctor or Other Health Practitioner to Third Party Contracting Contagious Disease from Doctor's Patient*, 3 A.L.R.5th 370 (1992) ("Courts found liability to a family member living with the patient supportable where the doctor failed . . . to inform the family member of the nature of the disease or that it was contagious."); Gregory G. Sarno, *Physician's Failure To Protect Third Party From Harm By Nonpsychiatric Patient*, 43 AM. JUR. PROOF OF FACTS 2D 657 (Updated July 2008) ("Depending on the particular circumstances, a physician who treats a patient for a communicable disease may be under a duty to diagnose the disease's contagious and infectious nature and to relay such diagnosis to those who are ignorant of the communicable nature of the disease and who, by reason of family ties or otherwise, are reasonably likely to come into contact with the patient.").

<sup>18</sup> See *Candelario v. Teperman*, 789 N.Y.S.2d 133, 134 (N.Y. App. Div. 2005) (holding, in context of suit by patient's daughter who contracted Hepatitis C while caring for patient, that "a physician does not owe a duty of care to a nonpatient, even if the physician knows that the nonpatient is caring for the physician's patient, unless the physician's treatment of the patient is the cause of the injury to the nonpatient"); *Pate v. Threlkel*, 661 So. 2d 278 (Fla. 1995) (holding that physician owed a duty of care to child of patient to warn patient of genetic condition that could affect child, but distinguishing inheritable disease from prior communicable disease cases in Florida and refusing to impose duty to warn patient's family because it would violate Florida confidentiality statute and would put too great a burden on the physician); see also *Reisner v. Regents of the University of California*, 37 Cal. Rptr. 2d 518, 523 (1995) (allowing suit by third party for failure to warn patient of communicability disease, but stating that "Once the physician warns the patient of the risk to others and advises the patient how to prevent the spread of the disease, the physician has fulfilled his duty-and no more (but no less) is required.").

generally in favor of imposing third-party duties on physicians, the boundaries of the duty sometimes differ—for example, some courts extend the duty to all foreseeable parties, whereas others limit the duty to those with whom either the physician or patient has some special relationship.<sup>19</sup> The increasing enactment of statutes involving physician-patient confidentiality only muddies the picture further.<sup>20</sup> Nonetheless, a consensus in favor of imposing a duty to warn third parties seems to have been accepted by the courts, and possibly even by the medical community, for decades.<sup>21</sup> At the very least, the case law is in no more disarray than other areas of negligence—therapists’ duties included—in which the R3 takes a firm position.

With all of this in mind, the R3’s strongest rationale lies in its statement that the policies underlying physician-third-party duty questions are “sufficiently balanced” that no position warrants the ALI’s endorsement.<sup>22</sup> In other words, despite strong support in the case law in favor of imposing a physician duty, the *normative* weight for no-duty counsels awaiting further development in the law. Part III of this article compares the viability of a distinction between physician and therapist duties and explores the issue’s underlying theory. But first, I begin with a discussion of the relevant doctrine.

## II. Therapist/Physician Duties: Doctrine and Stated Rationale

As a general rule, the law does not impose a duty to affirmatively warn, protect, or rescue another person from a risk of harm that the defendant did not create.<sup>23</sup> The most common justifications for this default rule are that (1) it would be too great an imposition on one’s liberty to force one to act charitably,<sup>24</sup> and (2) to impose a blanket affirmative duty to protect others would present courts with intractable line-drawing difficulties (e.g., if we have a legal duty to rescue a baby that we find on the railroad tracks, why should we not also have a duty to give our spare change to the homeless?).<sup>25</sup>

It is also accepted doctrine that both the physician and the therapist owe a duty to their patients to use due care in treating them—either due to a special relationship with the patient or because the caregiver has voluntarily undertaken a duty of care.<sup>26</sup> Under either reasoning, because the caregiver has chosen to have a relationship with another under circumstances in

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<sup>19</sup> Compare Heigert, 565 N.E.2d at 60 (declining to impose duty on physicians to warn nurse of infectious patient because there existed neither a physician-patient relationship nor a patient-plaintiff relationship) with Gammill, 727 F.2d at 954 (holding that “A physician may be found liable for failing to warn . . . persons likely to be exposed to the patient . . .”).

<sup>20</sup> Many jurisdictions, for example, have dealt with the privacy of HIV diagnoses by statute. A few of these statutes have proscribed courts’ imposition of a legal duty to warn third parties of a patient’s HIV-positive status. See N.O.L. v. District of Columbia, 674 A.2d 498 (D.C. 1995) (holding no duty to tell plaintiff of patient’s HIV because statutory duty not to reveal such information); Santa Rosa Health Care Corp. v. Garcia, 964 S.W.2d 940 (Tex. 1998) (same).

<sup>21</sup> The American Medical Association has for over fifty years endorsed breaches of physician-patient confidentiality when “it becomes necessary in order to protect the welfare of the individual or of the community.” Principles of Medical Ethics of the American Medical Association, § 9 (1957).

<sup>22</sup> See *supra* note 9.

<sup>23</sup> DAN B. DOBBS, THE LAW OF TORTS § 314, at 853 (2000).

<sup>24</sup> Richard Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151, 197-98 (1973).

<sup>25</sup> Prosser, Torts (4th ed. 1971) § 56, p. 341.

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which the caregiver has a special power to protect the other from harm and the other is less than fully able to self-protect, the concerns for liberty and arbitrary line-drawing are mitigated.<sup>27</sup>

In the context of therapists' duties to third parties, the *Tarasoff* court ostensibly based its holding on the existence of a special relationship—not between the defendant therapist and the third party, however, but between the therapist and the patient.<sup>28</sup> This was a dramatic expansion of special relationship doctrine, and one would expect the court to have explained why the therapist-patient relational nexus justifies the imposition of a duty to warn a third party. Unfortunately, the court's reasoning in this regard was less than illuminating. The court offered only that “by entering into a physician-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the physician knows to be threatened by the patient.”<sup>29</sup> Apart from this rather conclusory statement, the court's reasoning was entirely instrumental. The court weighed the risks of imposing a duty—the risk of undermining therapist-patient confidentiality, the risk of false-positive danger assessments, the risk of holding therapists to implausible standards—against the benefit of preventing injury, finding ultimately that “[t]he protective privilege ends where the public peril begins.”<sup>30</sup> Subsequent decisions in other jurisdictions have been based on similar instrumental analyses.<sup>31</sup>

In light of the holdings of *Tarasoff* and its progeny, there would seem to be a strong case in favor of imposing a parallel duty on physicians. Physicians have relationships of care with their patients just as do therapists. Physicians have a particular ability to foresee risks posed by their patients and a similar obligation of confidentiality. Physicians are also often a last line of defense against the spread of disease, just as therapists may be the last line of defense against a dangerous patient. The scenarios are so similar, in fact, that one might expect courts that have adopted *Tarasoff* to feel bound to impose an analogous duty on physicians or, if they decline to impose a duty, to distinguish the case. In fact, courts do not typically view *Tarasoff* as controlling precedent in physician cases, although courts sometimes cite the case in support of imposing a duty.<sup>32</sup> I have found no case that distinguishes *Tarasoff* in the context of refusing to impose a parallel physician duty.

Before discussing what courts actually do say in physician cases, it is important to narrow the range of cases relevant to a comparison with *Tarasoff*. As in the therapist context, some cases brought by third parties against physicians involve claims that the physician's conduct in some way enhanced the risk to the plaintiff—for example, claims that the physician prescribed an

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<sup>27</sup> W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAWS OF TORTS § 56, at 374 (5th ed. 1984).

<sup>28</sup> *Tarasoff*, 551 P.2d at 340.

<sup>29</sup> *Id.* at 344 (quoting Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma* 62 CAL. L. REV. 1025, 1030 (1974)). The court also cited § 315 of the Second Restatement, which provides that a duty of care may arise from “(a) a special relation . . . between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or (b) a special relation . . . between the actor and the other which gives to the other a right of protection.” The comments to § 315, however, specifically limit the types of relationships that give rise to a duty to those listed in §§ 316-19, which impose duties arising from parent-child, master-servant, and owners-bailee relationships, and on “[o]ne who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled . . . .” None of these sections endorses a duty by therapists to warn foreseeable victims of the therapist's outpatients (although the last likely applies to an inpatient scenario).

<sup>30</sup> *Id.* at 347.

<sup>31</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, Reporters' Notes to § 41, cmt. g at --.

<sup>32</sup> *See, e.g.,* Bradshaw v. Daniel, 854 S.W.2d 865, 871 (Tenn. 1993) (citing *Tarasoff* as analogous precedent in holding that physician had duty to warn family members of patient who contracted Rocky Mountain spotted fever).

improper dosage of medication or failed to warn the patient of a medication's side-effects,<sup>33</sup> or cases in which the physician failed properly to diagnose or treat the patient's condition.<sup>34</sup> As the R3 properly explains, these cases are not within the purview of § 41 because they are not affirmative duty cases.<sup>35</sup> Rather, they fall within the § 7 default duty not unreasonably to create a risk of harm to others.<sup>36</sup> Cases in which the plaintiff claims that the physician failed an obligation to warn the *patient* of the risk of transmitting a disease also are not completely analogous to *Tarasoff*, in which the claim was failure to warn the *plaintiff*. Such claims more clearly involve affirmative duties, however, and would therefore be covered by § 41 (and are therefore included in the discussion below). The most analogous cases are those in which the plaintiff claims that the physician's failure was to warn him or her about the risks posed by the physician's patient.

Where courts have imposed on physicians a duty to warn third parties, they have analyzed the question using concepts similar to other duty cases. Specifically, they consider some combination of the following factors: community notions of obligation, a broad view of social policy, concern for the rule of law, administrative capability and convenience, and foreseeability of the plaintiff or the plaintiff's injury.<sup>37</sup> The analysis typically begins with a rather cursory citation to the physician-patient special relationship—like *Tarasoff*, without explanation of why the relationship should give rise to a duty to third parties.<sup>38</sup> Courts sometimes also explain that a legal duty to foreseeable third parties tracks community norms and norms within the medical profession.<sup>39</sup> Often, the discussion then moves to a discussion of broader policy considerations,

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<sup>33</sup> See, e.g., *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387 (Ill. 1987) (denying suit by third party injured by physician's patient, whose driving was influenced by physician's prescription drugs); *Shortnacy v. N. Atlanta Internal Med., P.C.*, 556 S.E.2d 209 (Ga. 2001) (same).

<sup>34</sup> See, e.g., *Fosgate v. Corona*, 330 A.2d 355 (N.J. 1974) (upholding suit by family infected by patient's tuberculosis as a result of defendant physician's failure to diagnose disease).

<sup>35</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. *h*.

<sup>36</sup> Despite this explanation, however, the Reporters' Notes to § 41 are not altogether careful to cite only cases on point. For example, the Notes cite a number of cases that involve physician prescriptions and misdiagnoses.

<sup>37</sup> See, e.g., *Bradshaw v. Daniel*, 854 S.W.2d 865, 869-72 (Tenn. 1993) (stating that the existence of duty depends on foreseeability of injury to the third party, "reflects society's contemporary policies and social requirements concerning the right of individuals and the general public to be protected from another's act or conduct," and is the "sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection"); *Safer v. Pack*, 677 A.2d 1188 (N.J. 1996) (holding that third-party physician duty turns on consideration of "serious and conflicting medical, social and legal policies," foreseeability of injury to the plaintiff, and the fact that "substantial future harm may be averted or minimized"); *Hoover's Dairy, Inc. v. Mid-America Dairymem, Inc.*, 700 S.W.2d 426, 432 (Mo. 1985) (considering, "(1) the social consensus that the interest is worthy of protection; (2) the foreseeability of harm and degree of certainty that the protected person suffered injury; (3) moral blame attached to the conduct by society; (4) the extent to which the conduct could prevent future harm; (5) the potential cost and the ability to spread the risk of loss; and (6) the economic burden placed on the actor and the community that may be affected." ); *McNulty v. City of New York*, 792 N.E.2d 162 (N.Y. 2003) (declining to impose a duty to nonpatients after analysis of "common concepts of morality, logic and consideration of the social consequences of imposing the duty"); *Troxel v. A.I. DuPont Inst.*, 675 A.2d 314, 320 (Pa. Super. Ct. 1996) ("In the decision whether or not there is a duty, many factors interplay: The hand of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall. In the end the court will decide whether there is a duty on the basis of the mores of the community, "always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind.""). For a more extensive discussion of these fundamental duty considerations, see W. Jonathan Cardi, *Purging Foreseeability*, 58 VAND. L. REV. 739, -- (2005).

<sup>38</sup> E.g. *Shepard v. Redford Community Hosp.*, 390 N.W.2d 239, 245-46 (Mich. 1986).

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many of which resemble those discussed in *Tarasoff*. Common policy considerations include (1) the desire to prevent the spread of disease; (2) concerns about breaching physician-patient confidentiality, which is vital to the success of treatment; (3) concern for the “medical malpractice and insurance crisis,” as some refer to it; (4) the possibility that physicians will be held to too high a standard; and (5) the possibility that courts will fail adequately to sort out issues of factual causation.<sup>40</sup> Finally, if the court decides to impose a duty, courts are careful to limit the physician’s duty to those persons foreseeably infected by the physician’s patient.<sup>41</sup>

Courts declining to impose a duty on physicians consider many of these same factors, only reaching the opposite conclusion. Some courts refuse to impose a duty on physicians without the existence of a special relationship between the physician and plaintiff or the patient and plaintiff.<sup>42</sup> The New York courts refuse to extend the physician’s duty to third parties unless it was the physician’s malpractice toward the patient that led to the third party’s injury.<sup>43</sup> Other courts reason that the burden on physicians of warning third parties would be too great and the need for confidentiality too important to impose a duty.<sup>44</sup> Still others express concern for the possibility of sweeping liability.<sup>45</sup> Finally, in some jurisdictions, courts are compelled to defer to state statutes that prohibit violations of physician-patient confidentiality.<sup>46</sup>

Both courts that impose and those that reject physician duties are similar in one respect—their duty rationale is almost always superficial. The typical opinion lists, or at best sketches, the relevant considerations and then simply announces a conclusion. Certainly, no case articulates a hierarchy according to which the various considerations are to be weighed. And very few cases cite empirical data in support of their relevant policy evaluations. In the following pages, I will offer what I hope is a more nuanced comparison of physician and therapist scenarios (although with not much more empirical data than is offered by the courts) in an attempt to evaluate the R3’s distinction between them. In addition, at the risk of attempting too much in so brief an exposition, I will frame this discussion in context of its possible jurisprudential undercurrents.

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<sup>40</sup> See, e.g., *Shepard v. Redford Community Hosp.*, 390 N.W.2d 239, 241 (Mich. 1986) (considering, among other factors, “concerns about confidentiality in the physician-patient relationship and the present medical malpractice crisis”); add more cites; PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. h. (“[S]ome courts are concerned that any precaution a physician might take would have little or no effect in reducing the risk, especially for warnings to patients about risks of which they were already aware. These courts might lack confidence in their ability accurately to address factual causation.”).

<sup>41</sup> See, e.g., *Gammill v. U.S.*, 727 F.2d 950, 954 (10th Cir. 1984) (stating that “A physician may be found liable for failing to warn a patient’s family, treating attendants, or other persons likely to be exposed to the patient,” but denying the plaintiff recovery as unforeseeable). Courts do not, however, explain why foreseeability is relevant to duty analysis rather than solely breach or proximate cause. The R3 of course purges foreseeability from the duty calculus. PROPOSED FINAL DRAFT NO. 1, *supra* note --, §7, cmt. j.

<sup>42</sup> See *supra* note – and accompanying text. This is really the same thing as saying that the court refuses to extend special relationship doctrine in the same fashion as *Tarasoff*—it does not really offer, in itself, an explanation as to why not.

<sup>43</sup> E.g., *Candelario v. Teperman*, 789 N.Y.S.2d 133, 134 (N.Y. App. Div. 2005). Such analysis begs the question—in other words, it is simply a conclusion that the court refuses to impose an affirmative duty on physicians, but will only extend recovery to third parties as a result of the physician’s misfeasance.

<sup>44</sup> See, e.g., *Pate v. Threlkel*, 661 So. 2d 278 (Fla. 1995) (refusing to impose duty to warn patient’s family because it would violate Florida confidentiality policies and put too great a burden on physician).

<sup>45</sup> *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300 (N.Y. 1997) (duty to warn limited to patient’s family).

<sup>46</sup> See, e.g., *N.O.L. v. District of Columbia*, 674 A.2d 498 (D.C. 1995) (recognizing statutory duty not to reveal patient’s diagnosis as HIV-positive); *Santa Rosa Health Care Corp. v. Garcia*, 964 S.W.2d 940 (Tex. 1998) (same). Most confidentiality statutes, however,—HIPPA included—provide an exception where a breach of confidentiality is required by common-law rule. Cite Mark Hall’s textbook.

### III. An Evaluation of the Issue's Underlying Policy and Jurisprudence

For decades, there has been a consistent tension between two positive theories of tort law. On the one hand, the corrective justice view proposes that tort law is a means of enforcing an individual's moral obligation to repair a loss inflicted on another. Corrective justice generally posits that the tort system is only about establishing justice through examining the relationship between the parties to the action, balancing their respective rights and obligations under the circumstances, and resolving their individualized dispute justly.<sup>47</sup> On the other hand, the instrumentalist view is that tort is the state's means of achieving certain goals external to the dispute between the parties—the dominant theory being economic instrumentalism with the goal of reducing injuries to their most efficient level.<sup>48</sup> Each of these theories offers a monist, or unified theory of what tens of thousands of judges have done and continue to do in deciding tort cases through the decades.<sup>49</sup>

It is my instinct that most scholars of tort law—as well as most judges and practitioners—find monist theories to be rigid and ultimately incomplete. In recent years, a number of scholars have proposed instead that tort law must be considered a pluralistic enterprise—that is, that any positive theory of tort law must accommodate a plurality of aims or methods, or even embrace multiple fully-developed strains of tort theory simultaneously in some integrated way.<sup>50</sup> Among others, Gary Schwartz, Mark Geistfeld, Bruce Chapman, Chris Robinette, and recently even Guido Calabresi—for years, a stalwart instrumentalist—have all urged some pluralistic conception of tort law.<sup>51</sup>

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<sup>47</sup> See ERNEST J. WEINRIB, *THE IDEA OF PRIVATE LAW* 56–83 (1995) (describing Aristotle's original notions of "corrective justice"); John C.P. Goldberg, *Twentieth-Century Tort Theory*, 91 *GEO. L.J.* 513, 570 (2003); Stephen R. Perry, *Tort Law*, in *A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 72 (Dennis Patterson ed., 1999).

<sup>48</sup> For the classic efficiency account of tort law, see WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* (1987).

<sup>49</sup> There are a variety of possibilities about what qualifies as a "unified theory," a term borrowed from theoretical physics. Must all judges apply such a theory, whether consciously or unconsciously, in every case? Judge Posner seems to posit as much for economic theory. Others propose that a theory is robust and unified if it describes some largely consistent structure that governs tort law, even if a significant, though limited body of cases deviate from the path. This article does not rely on any particular definition of unified, but rather rests on the admittedly contingent line between a tort system that encompasses multiple goals or means of reasoning and one which is to some extent limited to one.

There are also other unified tort theories. Greg Keating and others have offered what might generally be described as a distributive justice theory. **Cite** John Goldberg and Ben Zipursky have written a barrage of articles urging what they call a civil recourse theory. See, e.g., Benjamin C. Zipursky, *Civil Recourse, Not Corrective Justice*, 91 *GEO. L.J.* 695 (2003) (describing the limits of corrective justice theory and exploring a positive theory of tort based on the idea of "rights, wrongs, and recourse"). And there are others. For an excellent summary of extant theories, see Goldberg, *supra* note --. For purposes of this article, I focus on the two theories most developed in the courts and commentary.

<sup>50</sup> A pluralistic theory of tort law might also propose that no one theory can describe all of tort law, but instead that multiple theories are required to describe different areas of doctrine. Because this article focuses on only one area of the tort law, I will not further discuss this version of pluralism.

<sup>51</sup> For expositions on the possibility of a pluralistic view of tort law, see generally Mark Geistfeld, *Economics, Moral Philosophy, and the Positive Analysis of Tort Law*, in *PHILOSOPHY AND THE LAW OF TORTS* 250-75 (Gerald J. Postema ed., 2001); Bruce Chapman, *Pluralism in Tort and Accident Law*, in *PHILOSOPHY AND THE LAW OF TORTS*, *supra* at 276-321; Izhak Englard, *The Idea of Complementarity as a Philosophical Basis for Pluralism in Tort Law*, in *PHILOSOPHICAL FOUNDATIONS OF TORT LAW*, 183 (David G. Owen ed., 1997); Eyal Aamir & Barack Medina, *Law, Morality, and Economics: Integrating Moral Constraints into Economic Analysis of Law*, 96 *Cal. L. Rev.* 323

On the face of it, cases involving therapist and physician duties to warn third parties evidence a mix of corrective justice and instrumental reasoning. Courts focus on the relationship between the parties and draw upon community notions of obligation—both pillars of corrective justice reasoning. They also evaluate instrumentalist factors such as the net reduction in risk, the effect of violations of confidentiality on patient care, and the result of tort liability on malpractice insurance. Despite courts’ recitation of these factors, however, courts’ analyses of third-party duties leave much to simple intuition. A more thorough comparison of therapist and physician cases reveals the complexity of the issue, provides a means for evaluating the R3’s distinction between the cases, and, in my view, evidences the necessity of a pluralistic understanding of duty. The following discussion may be summarized as an inquiry into two questions: Is it possible to justify the position held by a minority of courts and kept alive by the R3—the imposition of a third-party duty on therapists, but not on physicians? And would either an instrumentalist or corrective justice account of such a distinction *alone* capture all that is necessary to resolve the issue?

The typical therapist third-party duty case involves: (1) an affirmative act, (2) of non-ordinary, (3) violence, (4) by one who has some degree of decreased capacity of self-control. Furthermore, the relationship between therapist and patient is typically quite involved, with a high degree of emotional reliance by the patient and frequent meetings, often over a relatively long period of time. The therapist-patient relationship is not generally fungible—that is, the dynamics of the relationship are typically critical to the continuation and success of treatment. The risk of breaking confidentiality is perhaps great because trust in the relationship is so important—not only for successful treatment of the patient, but also for the success of psychology as a treatment option generally.<sup>52</sup> On the other hand, some recent studies suggest that the risk is perhaps not as great as one might think. One study has found that if a warning is conveyed to a third party with the patient’s knowledge, or if the patient is counseled to deliver the warning personally in the presence of the therapist, the warning can actually facilitate treatment and therapist-patient trust.<sup>53</sup> Finally, it is important to note that therapists have the

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(2008); Guido Calabresi, *Toward a Unified Theory of Torts*, 1 J. TORT LAW 1 (2007), <http://www.bepress.com/jtl/vol1/iss3/art1>; Christopher J. Robinette, *Torts Rationales, Pluralism, and Isaiah Berlin*, 14 GEO. MASON L. REV. 329 (2007); Gary T. Schwartz, *Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice*, 75 TEX. L. REV. 1801 (1997).

<sup>52</sup> Indeed, the question of the effects of *Tarasoff* on psychological treatment is more complicated and likely under-researched. According to a study conducted not long after *Tarasoff*, 26.8% of therapists reported directing therapy more toward the subject of dangerousness than they had before *Tarasoff*. Toni Pryor Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 180-81 n.82 (1978). On the other hand, a significant minority of responding therapists felt reluctant to probe deeply into their patients' lives because of they might discover and be forced to report violence, and 54% of therapists believed *Tarasoff* “increased [their] anxiety as an issue relating to dangerousness is broached in the clinical setting.” *Id.* at 181 n.86. And more directly to the point, 25% of therapists noticed an increase in patients’ reluctance to divulge violent thoughts after being advised that therapist-patient confidentiality might be broken. *Id.* at 177 n.67. Finally, some have suggested that the prospect of increased legal liability will make therapists more discerning in their patient selection, potentially leaving troubled people without treatment. Brian Ginsberg, *Tarasoff at Thirty: Victim’s Knowledge Shrinks the Psychotherapist’s Duty to Warn and Protect*, 21 J. CONTEMP. HEALTH L. & POL’Y 1, 14 (2004).

<sup>53</sup> See Damon Muir Walcott et al., *Current Analysis of the Tarasoff Duty: An Evolution Towards the Limitation of the Duty to Protect*, 19 BEHAV. SCI. & L. 325, 340 (2001) (reporting that *Tarasoff* warnings might actually strengthen the sense of trust between therapist and patient); Wulsin et al., *Unexpected Clinical Benefits of the Tarasoff Decision: The Therapeutic Alliance and the Duty to Warn*, 140 AM. J. PSYCHIATRY 601, 602 (1983)

legal option of initiating civil commitment proceedings against a patient deemed dangerous to self or others.

Physician cases, on the other hand, typically involve: (1) a passive (rather than intentional), (2) nonviolent act, (3) leading to a common and pervasive risk (transmitting disease), (4) by a patient that can and often wishes to take steps to avoid creating risks to others. Furthermore, the relationship between physician and patient is often not as involved in modern medicine as that of the therapist and patient. Indeed, the physician-patient relationship is often fungible—the relationship itself is less important to continuation and success of treatment, and second opinions or a change in provider are common. Although the physician-patient relationship is arguably not as important to treatment as that of the therapist and patient (and therefore the concern with ruining it potentially not as great), the risk of breaching physician-patient confidentiality might in fact be greater in the physician context—the risk of ostracism might be heightened because recipients of the warning might fear for their own infection. Finally, although patients are occasionally quarantined after falling ill from an unusually-dangerous infectious disease, the standards for quarantine are generally much more stringent than for civil commitment.<sup>54</sup>

In light of these differences, one might construct a plausible instrumentalist argument in favor of a distinction between therapist and physician cases. Assuming that the *Tarasoff* court correctly weighed the costs and benefits in the therapist context,<sup>55</sup> the relevant question is whether the cost/benefit ratio in physician cases is so comparatively low that it justifies denial of recovery. On the benefit side, because the danger sought to be averted in therapist cases is that of affirmative, violent acts, the potential harm to victims and to society is great. By contrast, the danger sought to be averted in physician cases—the passive, nonviolent act of transmitting disease—although risk-producing, does not typically have the same jarring effect on society or even on its victims (with the exception, perhaps, of deadly pandemics).<sup>56</sup> At least theoretically, the relative impact of violent acts by the mentally-ill versus disease-transmission is quantifiable and might well counsel greater protection against the former than the latter.

Furthermore, because the risks of mentally-ill patients are non-ordinary and violent, it is more difficult for members of society to protect themselves against them—both because the acts are less foreseeable and because they are physically more difficult to prevent. Potential victims of disease have some ability to reduce their own risk of infection—they can remain abstinent, wash their hands frequently, avoid coughing individuals, wear a face mask, et cetera.

Similarly, because a dangerous mentally-ill person is typically less capable of self-control than the average person, the therapist is often the last line of defense against potential harm. Moreover, the therapist has an intimate knowledge of patients' lives and relationships. Paired with the option to civilly commit dangerous patients, therapists' ability to defend third parties is

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(suggesting that issuing a warning in the presence of the patient, or having the patient issue the warning himself, enhances trust).

<sup>54</sup> Edward P. Richards, Scott Burris, Richard P. McNelis, Eric Hargan, Quarantine Laws and Public Health Realities, 33 J.L. MED. & ETHICS 69, 70 (2005). As one example, the federal government has the power to quarantine immigrants and travelers from abroad, but its quarantine power is limited to particular diseases listed in an Executive Order. Section 361 of the Public Health Service Act, 42 U.S.C. § 264 ().

<sup>55</sup> Although it is not within the scope of this article to question *Tarasoff*, at least one recent commentator has argued that *Tarasoff* warnings are sometimes inefficient. See Brian D. Ginsberg, *Therapists Behaving Badly: Why the Tarasoff Duty is not Always Economically Efficient*, 43 WILLAMETTE L. REV. 31 (2007).

<sup>56</sup> I don't mean to downplay the emotional impact of becoming ill from an infectious disease. My point is that where one is injured intentionally and violently, there is an added dimension of emotional injury to the individual and anxiety in the public.

a valuable one. In physician cases, the patient himself usually is able to take steps to reduce the risk of harm to others (so long as he is armed with the information to do so), so the physician might not be the last line of defense. Furthermore, the physician typically is not privy to patients' personal lives, and the physician does not have the same power to civilly commit patients that pose a risk to others.<sup>57</sup> For these reasons, the benefit of imposing a duty on physicians is perhaps less than the benefit of a duty in the therapist context.

The cost side of the equation is more difficult to assess. The risks of breaching patient confidentiality and ultimately of expanding physicians' tort liability have not been quantified in any reliable way,<sup>58</sup> and there appear to be viable arguments on both sides of the issue. It is possible, however, that for the reasons sketched above the risk of breaching confidentiality is greater for physicians than for therapists.

In light of the foregoing points, a distinction between the duties owed by therapists and those owed by physicians seems to be supported by some instrumental considerations. There is ample ammunition on the other side, however. For example, the reason articulated most strongly by the *Tarasoff* court—the interest in protecting people from a “risk-infested society”<sup>59</sup>—arguably works in favor of imposing a *Tarasoff*-like duty on physicians. The annual harm caused by warning-preventable disease is surely greater than the harm caused by warning-preventable violence by the mentally ill (although, I admit, I do not have the statistics to support this intuition). Thus, an instrumental good might be achieved by imposing on physicians that is greater even than the good to which *Tarasoff* aspires.

This effect is likely pronounced by the relative abilities of therapists and physicians to assess the risks posed by their patients. Physicians' risk-assessments are often based on epidemiological studies coupled with knowledge of the mechanics of transmission, whereas therapists' assessments are more organic and less amenable to empirical deduction. Physicians' risk assessments are thus likely more accurate than those of therapists, and therefore more efficient at preventing harm to third parties. Moreover, one byproduct of therapists' relatively weak ability to assess risk is the increased likelihood of false-positives (especially post-

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<sup>57</sup> One might argue that the foreseeability of third parties is irrelevant to deciding whether to impose a duty—what is relevant is whether, if the third party is foreseeable, the defendant ought to have an obligation to warn them. I have explained elsewhere, however, how a particular capability to foresee injury might serve as a reason to impose a duty on a class of defendants. See W. Jonathan Cardi, *Reconstructing Foreseeability*, 46 B.C. L. REV. 921, -- & fn.-- (2005) one might argue that because a class of defendant has a particular capability of foreseeing injury courts should impose a duty on that class to do so. I have also argued, however, that using foreseeability in this manner is normatively undesirable. *Id.* at --.

<sup>58</sup> As mentioned previously, empirical study of the effects on treatment and ultimate societal risk are scant and conflicting. Moreover, I am aware of no studies measuring in comprehensive fashion the cost to caregivers and society generally of breaching confidentiality and imposing liability specifically for a failure to warn third parties. The Reporters' Notes to § 41, cmt. g offer an excellent discussion of existing empirical evidence regarding the potential costs of violating therapist-patient confidentiality.

<sup>59</sup> *Tarasoff*, 551 P.2d at 340.

*Tarasoff*).<sup>60</sup> Each false-alarm not only undermines patient trust, but no doubt causes pain and embarrassment to the patient in the public eye.<sup>61</sup>

In sum, although some instrumental reasons appear to support a distinction between duties imposed on therapists and physicians, the balance of “protective privilege” against the “public peril” might well favor imposing a duty on both.<sup>62</sup> In fact, the only conclusion one may safely draw from the foregoing discussion is that the information necessary for a complete and accurate cost-benefit analysis of the issue is currently unavailable and quite possibly always will be. Thus, unless courts are writing exceedingly sloppy opinions, recklessly guessing as to the correct result of cost-benefit calculus, courts’ evaluation of these cases cannot possibly rest entirely on an instrumental analysis.<sup>63</sup> That is, although courts clearly see instrumental factors as important considerations, instrumental reasoning alone does not explain either the majority or the minority approach with regard to the duty owed by physicians to warn third parties.

Apart from the practical limitations faced by a purely instrumental understanding of these cases—even if courts had access to all the requisite cost-benefit information, would courts feel that they had all that they needed to render a just decision? It is hard to know the answer to this question. As explained in the previous section, taking courts’ words at face value, the answer must be no. Courts commonly ground their analyses of therapist and physician duties in a discussion of the special caregiver-patient special relationship and in other corrective-justice-based reasoning—and not because of any explicit recognition of the short-falls of instrumentalism. I now turn to an examination of the role of corrective-justice reasoning in these cases.

Therapists voluntarily enter into an intimate relationship of care with their patients. They ask patients to reveal their deepest problems, and the patient willingly reveals them. Therapists voluntarily take responsibility for helping to resolve their patient’s psychological issues and for improving patients’ happiness generally. And patients’ issues typically involve third parties—psychological conditions often manifest in, revolve around, or are triggered or aggravated by relationships with others. Thus, in some sense, therapists voluntarily become involved in their patients’ relationships and interactions with others.

Understanding the therapist-patient relationship in this way might shed light on a moral basis for the duty imposed by the court in *Tarasoff*. Unlike members of the general public—whose

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<sup>60</sup> Even before *Tarasoff*, therapists had a tendency to overpredict violence in their patients. John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1045 (1974); D.L. Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250, 258 (1973). One post-*Tarasoff* study found that 45% of therapists issued *Tarasoff* warnings despite the fact that the warnings directly conflicted with the therapists’ clinical judgment. Daniel J. Givelber et al., *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 470 (1984).

<sup>61</sup> Again, I know of no statistics measuring the relative rate of false-positive assessments as between physicians and therapists. My assessment that the rate is higher among therapists is only an educated guess, not unlike those made by the courts in these cases. The R3 seems to agree. See PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. *h* (“[T]he burden on a physician may be less than that on a psychiatrist, because the costs of breaching confidentiality may be lower. Diagnostic techniques may be more reliable for physical disease and the risks that it poses than for mental disease and its risks.”).

<sup>62</sup> It is outside the scope of this article to consider the possibility that neither duty would be efficient, although such a conclusion is possible.

<sup>63</sup> Indeed, if the proper analysis is either (a) to measure whether the costs of breaching physician/patient confidentiality are outweighed by the marginal benefit of warning foreseeable victims or (b) to measure the relative cost/benefit ratios of therapist warnings to physician warnings, then I don’t see courts even asking the proper questions.

liberty interests, in the typical affirmative duty case, typically outrank the interest in securing compensation for an injured third party—a therapist has voluntarily become intertwined with the patient and, through the patient, with third parties who might be affected by the patient’s behavior. Thus, it might be argued that with respect to such third parties, the therapist has waived a portion of her or his liberty interest and assumed some responsibility for the patient’s web of relationships. Of course, the patient’s family, friends, and co-workers do not typically rise to the level of legal third-party beneficiaries.<sup>64</sup> The therapist’s connection with them might, however, constitute a pale analog to such relationships. Indeed, this reasoning might underlie the *Tarasoff* court’s statement that “by entering into a physician-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the physician knows to be threatened by the patient.”<sup>65</sup>

In contrast, a physician’s relationship with a patient is often less extensive and typically encompasses only the patient’s immediate physical health concerns. It does not often involve the patient’s relationships with others at any substantive level. Thus, physicians’ scope of care arguably reflects a narrower relinquishment of the physician’s liberty interest than does that of the therapist.

Similarly, the scope of the therapist’s care for a patient might also give rise to a moral duty to protect the patient against his or her own actions. Without intervention by the therapist, a violent patient may serve time in jail and endure feelings of guilt. The therapist’s duty to care for the patient might therefore give rise to a moral duty to warn the potential victim. Again, by contrast, the scope of a physician’s care for a patient typically does not extend beyond the particular physical harm the physician was hired to treat. Thus, the physician’s moral duty arguably does not encompass protecting the patient from the emotional fall-out of transmitting disease to another.

The relative depth of care for patients owed by therapists and physicians might also be evidenced by the difference in their ability to initiate the commitment or quarantine procedures. As mentioned before, the power of commitment is broader than the quarantine power.<sup>66</sup> In one sense, this distinction hardly seems relevant in cases where the plaintiff claims that the therapist or physician failed to warn the victim, not control the patient.<sup>67</sup> However, the fact that a therapist may initiate civil commitment proceedings in response to a patient’s danger to himself might speak to the depth of care to which the therapist is committed. Physicians have no analogous option—so long as a patient is mentally capable of making decisions, physicians may not force a patient to undergo treatment. Although a therapist’s mere ability to initiate civil commitment

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<sup>64</sup> In some circumstances, the therapist-patient relationship is, at least in part, for the benefit of a third party—for example, where the therapist is performing an evaluation of the patient for employment purposes or (more controversially) where a therapist treats a child for the purpose of protecting the parents.

<sup>65</sup> *Tarasoff*, 551 P.2d at 344.

<sup>66</sup> See *supra* note – and accompanying text.

<sup>67</sup> See PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. *h* (“Some courts have reasoned that because a physician does not have control over the patient, no special relationship exists. . . . That reasoning is . . . unpersuasive when, as in the psychotherapist-patient situation, . . . the plaintiff claims that the physician should have provided a warning to the patient.”).

does not rise to the level of “taking charge” of a patient, it arguably indicates some greater responsibility for the patient’s actions.<sup>68</sup>

Finally, corrective justice theorists often look to non-instrumentalist community norms as a proper source for the existence of a legal duty.<sup>69</sup> In this regard, it is worth noting that a norm in favor of warning identifiable victims already existed in the psychological community pre-*Tarasoff*.<sup>70</sup> There is also evidence that a similar norm has existed among physicians for several decades,<sup>71</sup> although it is difficult to ascertain the depth and strength of this norm. From conversations with physicians, I am under the impression that the culture among physicians is much more in favor of confidentiality, even in the face of risks to third parties, than is the culture among therapists.

In the foregoing respects, there exist viable corrective justice grounds to justify a distinction between therapists’ duties to third parties and those of physicians. In my view, however, just as instrumentalist reasoning does not alone justify the distinction, neither does corrective justice. Strong moral arguments also exist that mitigate against the distinction. For example, to the extent that a therapist’s particular ability to foresee risk to third parties plays a part in the moral justification for the therapist duty,<sup>72</sup> a physician’s ability to foresee third-party risk is only more refined.<sup>73</sup>

Furthermore, neither the therapist’s nor the physician’s relationship with their patient is for the benefit of third parties, as is sometimes required for a tort duty to exist.<sup>74</sup> And it is arguable that neither physicians nor therapists exercise a degree of control over their outpatients that the caregiver possesses sufficient agency to be “responsible” for the patient’s actions toward others.<sup>75</sup> Thus, from a corrective justice vantage, perhaps neither duty ought to exist at all.

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<sup>68</sup> This point should not be pushed too hard. There are other possible explanations for therapists’ ability to initiate civil commitment in response to a patient’s suicidal intentions. For example, suicide may simply be an event the public abhors more deeply than the refusal of medical treatment.

<sup>69</sup> See, e.g., John C.P. Goldberg, Note, *Community and the Common Law Judge: Restructuring Cardozo’s Theoretical Writings*, 65 N.Y.U. L. REV. 1324, 1334-35 (1990) (discussing tort law’s incorporation of social norms and expectations).

<sup>70</sup> PROPOSED FINAL DRAFT NO. 1, *supra* note --, §41, cmt. g at 716.

<sup>71</sup> See *supra* note – and accompanying text.

<sup>72</sup> See John C.P. Goldberg & Benjamin C. Zipursky, *The Moral of MacPherson*, 146 U. PA. L. REV. 1733, 1823 (1998) (explaining the holding in *Tarasoff* in such terms).

<sup>73</sup> See *supra* note – and accompanying text.

<sup>74</sup> See, e.g., RESTATEMENT (SECOND) OF TORTS § 552(2) (1977) (limiting professional liability to third parties to “losses suffered (a) by the person or one of a limited group of persons for whose benefit and guidance he intends to supply the information or knows that the recipient intends to supply it . . .”). One might also argue, however, that especially with regard to members of the patient’s family, there seems to be an implicit understanding that the physician’s work is almost as much for the benefit of the family as for the benefit of the patient.

<sup>75</sup> See generally Stephen R. Perry, *Responsibility for Outcomes, Risk, and the Law of Torts*, in PHILOSOPHY AND THE LAW OF TORTS 97-101 (Gerald Postema ed., 2001) (explaining that only an agent that is in control of her actions and, to a certain degree, of the consequences of those actions may be said to be outcome-responsible). It is interesting that a few courts that deny therapist or physician duties to third parties do so because a therapist or physician does not have the “right or ability to control” the patient’s actions. See, e.g., *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387 (Ill. 1987) (refusing physician duty, although in the context of misfeasance); *Nasser v. Parker*, 455 S.E.2d 502 (Va. 1995) (rejecting *Tarasoff* on grounds that therapists do not “take charge” of their patients). Although such courts draw the line at a different place than *Tarasoff*, they are still reasoning pursuant to a corrective justice metric. According to these courts, because the therapist or physician has not voluntarily undertaken custody of the patient, their liberty interest still outweighs the desire to protect—or, the relationship of care is not strong enough to give rise to a moral duty to others. This only supports my thesis that corrective justice notions play some role in courts’ decisions of this question.

Indeed, corrective justice scholars seem to be somewhat puzzled by the *Tarasoff* question, convinced that corrective justice reasoning is at work and yet unsure of its precise path.<sup>76</sup> And yet courts consistently recognize both physician and therapist duties on the grounds that the caregiver-patient relationship gives rise to an obligation to foreseeable victims. If the therapist-patient relationship suffices as a moral grounding for the existence of a duty to third parties, then the physician-patient relationship does not feel different enough to justify dismissal of physician cases for lack of sufficient moral agency.<sup>77</sup>

### Conclusion

Although I disagree with the R3's non-positional approach to physician duties both as a descriptive statement and on normative grounds, the analysis of the preceding pages if nothing else indicates that the question is sufficiently complex and the considerations sufficiently balanced that the R3's neutrality is justifiable.

The more important revelation, however, is that as positive conceptions of the law, neither instrumentalist reasoning nor a corrective justice account alone quite explains the imposition of a therapist or a physician duty to warn third parties. Perhaps then, the proper conclusion is that the courts (and, in the case of therapists, the R3) have gotten it wrong—they have botched the reasoning and should consider refusing to impose a duty on either physicians or therapists. The problem with this conclusion is that it puts the cart before the horse—it puts theory before the cases. If a purportedly descriptive theory does not accurately describe the case law, then the theory is either flawed or not a descriptive theory at all. With regard to many current incarnations of instrumentalist and corrective justice theories, both charges are true.

If one takes courts' reasoning as it is offered, the cases discussed in this article are best understood from a pluralistic understanding of tort law. That is, because courts view both corrective justice and instrumentalism as important foundations for their decisions, a robust descriptive theory must somehow incorporate both. I leave for a future article the work of exploring the contours of a pluralistic theory of torts.

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<sup>76</sup> See, e.g., Gary T. Schwartz, *Feminist Approaches to Tort Law*, 2 THEORETICAL INQUIRIES L. 175, 205-06 (2001) (“If one shifts from the criterion of deterrence to the criterion of corrective justice, one can appreciate that the issue in *Tarasoff* is rich but also puzzling: how does a moral therapist balance the interests of the patient (including the interest in the confidentiality of therapy) against the safety interests of a potential third-party victim?”).

<sup>77</sup> For a Kantian-based explanation of the morality underlying one version of a *Tarasoff* holding, see Douglas Mossman, M.D., *Critique of Pure Risk Assessment or, Kant Meets Tarasoff*, 75 U. CIN. L. REV. 523 (2006).