
A PLURALISTIC ANALYSIS OF THE
THERAPIST/PHYSICIAN DUTY TO WARN THIRD
PARTIES

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Following *Tarasoff v. Regents of the University of California*¹ and a majority of jurisdictions,² section 41 of the *Restatement (Third) of Torts: Liability for Physical Harm* imposes a duty on mental-health professionals (“therapists”) to warn foreseeable victims of a risk posed by one of their patients.³ The *Restatement (Third)* “takes no position,” however, as to whether a non-mental-health physician owes a similar duty to warn foreseeable third parties of a risk, for example, of communicating disease, posed by one of the physician’s patients.⁴ 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 *Restatement (Third)* ought to recognize a physician’s duty to warn foreseeable third parties, (2) as a normative matter, the question is more nuanced perhaps even than the courts and the *Restatement (Third)* recognize, and (3) the courts’ and the *Restatement (Third)*’s analysis of the issue is best captured by a pluralistic understanding of tort law.

I. EVALUATING THE DESCRIPTIVE ACCURACY OF SECTION 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

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1. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 342 (Cal. 1976).

2. See RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 reporters’ note cmt. g (Proposed Final Draft No. 1, 2005); see also 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”).

3. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41(b)(4) (Proposed Final Draft No. 1, 2005).

4. *Id.* § 41 cmt. h.

reasonable care to protect foreseeable victims, including the duty to warn them directly.⁵ As the *Restatement (Third)* correctly notes, since *Tarasoff*, a majority of jurisdictions have adopted some version of its holding,⁶ 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.⁷

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 duty of reasonable care to warn the girlfriend? The *Restatement (Third)* essentially punts on this question, explaining in section 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.⁸

In my view, as a “re-statement” of the law, the *Restatement (Third)* gets this wrong.

It is true that cases involving a physician’s duty to third parties arise in a whole host of fact patterns. For example, they involve different risks (such as hepatitis,⁹ tuberculosis,¹⁰ genetic

5. *Tarasoff*, 551 P.2d at 340.

6. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. g (Proposed Final Draft No. 1, 2005). Four jurisdictions have rejected a *Tarasoff*-like duty. See *Boynton v. Burglass*, 590 So. 2d 446, 447 (Fla. Dist. Ct. App. 1991) (en banc) (declining to recognize a duty to warn when a psychiatrist “knows, or should know” that a patient of his presents a serious threat of violence to a third party”); *Thapar v. Zedulka*, 994 S.W.2d 635, 638 (Tex. 1999) (declining to adopt a duty to warn because it would conflict with a state confidentiality statute); *Nasser v. Parker*, 455 S.E.2d 502, 506 (Va. 1995) (holding that no special relationship giving rise to a duty to warn can exist unless a defendant has “tak[en] charge of the patient”); see also *Gregory v. Kilbride*, 150 N.C. App. 601, 610, 565 S.E.2d 685, 692 (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)).

7. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. g (Proposed Final Draft No. 1, 2005); see also *Leonard v. Latrobe Area Hosp.*, 625 A.2d 1228, 1231–32 (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 foreseeably “within the zone of danger, that is, subject to probable risk of the patient’s violent conduct”).

8. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM §41 cmt. h (Proposed Final Draft No. 1, 2005).

9. See, e.g., *Candelario v. Teperman*, 789 N.Y.S.2d 133, 135 (App. Div. 2005) (denying a duty to warn patient’s daughter of the risks of transmission of hepatitis C).

10. See, e.g., *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App.

conditions,¹¹ even Rocky Mountain Spotted Fever)¹² and a variety of wrongdoings (for example, failure to diagnose or properly treat the patient,¹³ failure to warn the patient of the risk of transmission of disease,¹⁴ or failure to warn third parties of the risk of transmission).¹⁵ The *Restatement (Third)* 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.¹⁶ Despite the differences among cases, however, the case law reveals much more consensus than the *Restatement (Third)* 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.¹⁷ And an even

1970) (imposing a duty on a physician to warn family members of a minor child living with a tuberculosis patient of the risks of catching that disease).

11. See, e.g., *Safer v. Estate of Pack*, 677 A.2d 1188, 1192 (N.J. Super. Ct. App. Div. 1996) (imposing a duty on physicians "to warn those known to be at risk of avoidable harm from a genetically transmissible condition").

12. See, e.g., *Bradshaw v. Daniel*, 854 S.W.2d 865, 872 (Tenn. 1993) (holding that a physician had duty to warn the family of a Rocky Mountain Spotted Fever patient "against foreseeable risks emanating from [the] patient's illness").

13. See, e.g., *Britton v. Soltes*, 563 N.E.2d 910, 913 (Ill. App. Ct. 1990) (refusing to hold a physician liable to family members not living with the patient for failure to diagnose the patient's disease).

14. See, e.g., *Pate v. Threlkel*, 661 So. 2d 278, 282 (Fla. 1995) ("[W]e emphasize that in any circumstances in which the physician has a duty to warn of a genetically transferable disease, that duty will be satisfied by warning the patient.").

15. See, e.g., *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300, 1302 (N.Y. 1997) (finding that a physician had a duty to warn the parents of his infant patient of the risk of contracting polio "despite the absence of a direct doctor/patient treatment relationship between them").

16. Compare *Jones v. Stanko*, 160 N.E. 456, 456 (Ohio 1928) (recognizing a physician's duty to warn foreseeable persons of the communicability of smallpox), with *D'Amico v. Delliquadri*, 683 N.E.2d 814, 815-16 (Ohio Ct. App. 1996) (implicitly distinguishing *Jones* as a case involving a fatal infectious disease and dismissing a suit by a patient's girlfriend against physician for failing to warn the patient of the risks of transmission of genital warts).

17. See *Reisner v. Regents of the Univ. of Cal.*, 37 Cal. Rptr. 2d 518, 523 (Ct. App. 1995) (allowing a suit by a third party for failure to warn the patient of the communicability of her disease); *Myers v. Quesenberry*, 193 Cal. Rptr. 733, 736 (Ct. App. 1983) (allowing a suit by a third party for a physician's failure to warn the patient against driving in an uncontrolled diabetic condition complicated by a missed abortion); *Pate*, 661 So. 2d at 282 (holding that a physician may owe a duty of care to the child of a patient to warn the patient of a genetic condition that could affect the child); *Lemon v. Stewart*, 682 A.2d 1177, 1184 (Md. Ct. Spec. App. 1996) (denying a fear-of-infection claim by relatives of an HIV patient because there was no foreseeable risk to them, but stating that "[h]ad any of the appellants been a sexual 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");

greater majority has imposed on physicians a *Tarasoff*-like duty of reasonable care to warn those foreseeably at risk of infection by the patient.¹⁸

C.W. v. Cooper Health Sys., 906 A.2d 440, 450–51 (N.J. Super. Ct. App. Div. 2006) (imposing a duty on physicians to warn patients of the risk of transmitting HIV and extending the duty to patients' sexual partner(s)); DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422, 423–25 (Pa. 1990) (holding that a physician's duty to warn patients of the risks of communicating hepatitis B runs to patients' sexual partner(s)). *But see D'Amico*, 683 N.E.2d at 816–17 (dismissing a suit by a patient's girlfriend against a physician for failing to warn the patient of the risks of transmitting genital warts because the state's physician-patient privilege statute would bar the physician from testifying in his own defense); Praesel v. Johnson, 967 S.W.2d 391, 398 (Tex. 1998) (declining to impose on physicians a duty to third parties to warn epileptic patients not to drive).

18. *See Gammill v. United States*, 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"); *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"); *Gill v. Hartford Accident & Indem. Co.*, 337 So. 2d 420, 421 (Fla. Dist. Ct. App. 1976) (allowing a plaintiff, who was the hospital roommate of defendant's patient, to allege that the physician had a duty to warn the plaintiff of patient's highly contagious infection); *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (holding that a physician has a duty to warn the patient's family about the risks of the patient's tuberculosis); *Shepard v. Redford Cmty. Hosp.*, 390 N.W.2d 239, 240–41 (Mich. Ct. App. 1986) (stating that a physician has a duty to warn the patient's family members of the possibility of infection of spinal meningitis); *Safer v. Estate of Pack*, 677 A.2d 1188, 1192 (N.J. Super. Ct. App. Div. 1996) (imposing a duty on a physician to warn a patient's daughter of the risk of genetic predisposition to cancer and defining the duty as "requir[ing] 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 Am.*, 183 N.Y.S.2d 351, 358–59 (Sup. Ct. 1959) (imposing a duty to warn a patient of the communicability of tuberculosis and affirming, *in dicta*, the duty to warn the patient's wife); *Jones*, 160 N.E. at 456 ("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 such contagious disease to other persons who are known by the physician to be in dangerous proximity to such patient . . ."); *Troxel v. A.I. DuPont Inst.*, 675 A.2d 314, 322–23 (Pa. Super. Ct. 1996) (holding that a physician owed a duty to a friend of a patient-child's family, who was infected by the patient-child's cytomegalovirus, to warn the family of the risks of communicability); *Bradshaw v. Daniel*, 854 S.W.2d 865, 872 (Tenn. 1993) (holding that a physician had a duty to warn family members of patient who contracted Rocky Mountain Spotted Fever "against foreseeable risks emanating from [the] patient's illness"); *see also Heigert v. Riedel*, 565 N.E.2d 60, 63–65 (Ill. App. Ct. 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 nurses of an infectious patient because there existed neither a physician-patient relationship nor a patient-plaintiff relationship). *See generally Gregory G. Sarno, Physician's Failure to Protect Third Party from Harm by Nonpsychiatric Patient*, 43 *Am. Jur. 2d Proof of Facts* § 657 (2009)

In the face of relatively clear majority rules, why might the *Restatement (Third)* recognize a duty on the part of therapists, yet refuse to take a position on an analogous physician duty? First, the *Restatement (Third)*'s description of the current state of the law is not entirely without merit. As with *Tarasoff*, there does exist some variety among jurisdictions in physician cases,¹⁹ and (somewhat confoundingly) many jurisdictions have yet to address the question directly. Furthermore, even among courts that generally favor the imposition of a third-party duty 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 the patient has some special relationship.²⁰ The increasing enactment of statutes involving physician-patient confidentiality only muddles the picture further.²¹ Nonetheless, a consensus in favor of imposing a duty to warn third

(“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.”); Tracy A. Bateman, Annotation, 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 . . .”).

19. See *Pate*, 661 So. 2d at 282 (recognizing that a physician may owe a duty of care to the child of a patient to warn the patient of a genetic condition that could affect the child, but distinguishing inheritable disease from prior communicable-disease cases in Florida and refusing to impose a duty to warn the patient’s family); *Candelario v. Teperman*, 789 N.Y.S.2d 133, 135 (App. Div. 2005) (holding, in the context of a suit by a patient’s daughter, who contracted hepatitis C while caring for the 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”); see also *Reisner*, 37 Cal. Rptr. 2d at 523 (allowing a suit by a third party for failure to warn the patient of the communicability of the disease, but stating that “[o]nce 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”).

20. Compare *Heigert*, 565 N.E.2d at 65 (declining to impose a duty on physicians to warn a nurse of an infectious patient because there existed neither a physician-patient relationship nor a patient-plaintiff relationship), with *Gammill*, 727 F.2d at 954 (“A physician may be found liable for failing to warn . . . persons likely to be exposed to the patient . . .”).

21. 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. Dist. of Columbia*, 674 A.2d 498, 499 (D.C. 1995) (finding no duty to tell the plaintiff of the patient’s HIV because of statutory duty *not* to reveal such information without the patient’s written consent); *Santa Rosa Health Care Corp. v. Garcia*, 964 S.W.2d 940, 944 (Tex. 1998) (finding no common-law or statutory duty to notify the plaintiff that she was at risk of contracting HIV).

parties seems to have been accepted by the courts, and possibly even by the medical community, for decades.²² At the very least, the case law is in no more disarray than other areas of negligence—therapists’ duties included—on which the *Restatement (Third)* takes a firm position.

With all of this in mind, the *Restatement (Third)*’s strongest rationale lies in its statement that the policies underlying physician-third-party duty questions are “sufficiently balanced” such that no position warrants the American Law Institute’s endorsement.²³ 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 an affirmative duty to warn, protect, or rescue another person from a risk of harm that the defendant did not create.²⁴ 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,²⁵ 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?).²⁶

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. Under either reasoning, because the caregiver has chosen to have a relationship with another person under circumstances in 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.²⁷

In the context of a therapist’s duty to third parties, the *Tarasoff*

22. For over fifty years, the American Medical Association has endorsed breaches of physician-patient confidentiality when “it becomes necessary in order to protect the welfare of the individual or of the community.” AM. MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS § 9 (1957), available at http://www.ama-assn.org/ama/upload/mm/369/1957_principles.pdf.

23. See RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM §41 cmt. h (Proposed Final Draft No. 1, 2005).

24. DAN B. DOBBS, THE LAW OF TORTS § 314, at 853 (2000).

25. Richard A. Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151, 198 (1973).

26. WILLIAM L. PROSSER, THE LAW OF TORTS § 56, at 341 (4th ed. 1971).

27. W. PAGE KEETON ET AL., THE LAW OF TORTS § 56, at 374 (5th ed. 1984).

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.²⁸ This was a dramatic expansion of the 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 doctor-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 doctor knows to be threatened by the patient."²⁹ Apart from this rather conclusory statement, the court's reasoning was entirely instrumental. The court weighed the external 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 third-party injuries, finding ultimately that "[t]he protective privilege ends where the public peril begins."³⁰ Subsequent decisions in other jurisdictions have been based on similar instrumental analyses.³¹

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 therapists do. In addition, physicians have a particular ability to foresee risks posed by their patients and a similar obligation of confidentiality. They 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

28. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976).

29. *Id.* at 344 (quoting John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma* 62 CAL. L. REV. 1025, 1030–31 (1974)). The court also cited section 315 of the *Restatement (Second) of Torts*, 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 to protection." *Tarasoff*, 551 P.2d at 343 (quoting RESTATEMENT (SECOND) OF TORTS § 315 (1965)). The comments to section 315, however, specifically limit the types of relationships that give rise to a duty to those listed in sections 316–319, which impose duties arising from parent-child, master-servant, and owner-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." RESTATEMENT (SECOND) OF TORTS §§ 315 cmt. c (1965), 316–319 (1965). 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).

30. *Tarasoff*, 551 P.2d at 347.

31. See generally RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. g (Proposed Final Draft No. 1, 2005).

physicians or, if they decline to impose a duty, to distinguish the case. In fact, courts do not usually view *Tarasoff* as controlling precedent in physician cases, although courts sometimes cite the case in support of imposing a duty.³² 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 improper dosage of medication or failed to warn the patient of a medication's side effects,³³ or cases in which the physician failed to diagnose or treat the patient's condition appropriately.³⁴ As the *Restatement (Third)* properly explains, these cases are not within the purview of section 41 because they are not affirmative-duty cases.³⁵ Rather, they fall within the section 7 default duty not to create an unreasonable risk of harm to others.³⁶ Cases in which the plaintiff claims that the physician failed to fulfill 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 section 41 (and are included in the discussion below). The most analogous cases are those in which the plaintiff claims that the physician's failure was in not warning 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

32. See, e.g., *Bradshaw v. Daniel*, 854 S.W.2d 865, 871–72 (Tenn. 1993) (citing *Tarasoff* as analogous precedent in holding that a physician had a duty to warn family members of a patient who contracted Rocky Mountain Spotted Fever).

33. See, e.g., *Shortnacy v. N. Atlanta Internal Med., P.C.*, 556 S.E.2d 209, 213–15 (Ga. Ct. App. 2001) (denying a suit by third parties injured by a physician's patient, whose driving was influenced by prescription drugs prescribed by the physician); *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 399 (Ill. 1987) (same).

34. See, e.g., *Fosgate v. Corona*, 330 A.2d 355, 359 (N.J. 1974) (upholding a malpractice suit by a family infected by the patient's tuberculosis as a result of the defendant-physician's failure to diagnose disease).

35. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. h (Proposed Final Draft No. 1, 2005).

36. Despite this explanation, however, the Reporters' Note to section 41 is not altogether careful to cite only cases on point. For example, the notes cite a number of cases that involve, for example, issues with a physician's prescription. See *id.* §§ 7, 41 reporters' note cmts. g–h (Proposed Final Draft No. 1, 2005).

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.³⁷ The analysis typically begins with a rather cursory citation to the physician-patient special relationship—as in *Tarasoff*, without an explanation of why the relationship should give rise to a duty to third parties.³⁸ Courts sometimes also explain that a legal duty to foreseeable third parties tracks community norms and norms within the medical profession.³⁹ Often, the discussion then moves to broader policy considerations, many of which resemble those contemplated in *Tarasoff*. Common policy considerations include the desire to prevent the spread of disease, concerns about breaching physician-patient confidentiality (which is vital to the success of treatment), concern for the “medical malpractice and insurance crisis,” the possibility that physicians will be held to too high a standard, and the possibility that courts will fail to sort out

37. See, e.g., *Hoover's Dairy, Inc. v. Mid-Am. Dairymen, Inc.*, 700 S.W.2d 426, 432 (Mo. 1985) (considering “the social consensus that the interest is worthy of protection; the foreseeability of harm and the degree of certainty that the protected person suffered injury; moral blame society attaches to the conduct; the prevention of future harm; consideration of cost and ability to spread the risk of loss; [and] the economic burden upon the actor and the community—the others”); *Safer v. Estate of Pack*, 677 A.2d 1188, 1192–93 (N.J. Super. Ct. App. Div. 1996) (noting that the 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”); *McNulty v. City of N.Y.*, 792 N.E.2d 162, 166 (N.Y. 2003) (declining to impose a duty to nonpatients after analyzing “common concepts of morality, logic and consideration of the social consequences of imposing the “duty” (quoting *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300, 1302 (N.Y. 1997)); *Troxel v. A.I. DuPont Inst.*, 675 A.2d 314, 319–20 (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.’” (quoting *Gardner ex rel. Gardner v. Consol. Rail Corp.*, 573 A.2d 1016, 1020 (Pa. 1990))); *Bradshaw*, 854 S.W.2d at 869–70 (stating that the existence of a duty depends on the 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”). For a more extensive discussion of these fundamental duty considerations, see W. Jonathan Cardi, *Purging Foreseeability*, 58 VAND. L. REV. 739 (2005).

38. E.g., *Shepard v. Redford Cmty. Hosp.*, 390 N.W.2d 239, 241 (Mich. Ct. App. 1986).

39. *Id.*

issues of factual causation adequately.⁴⁰ Finally, if courts decide to impose a duty, they are careful to limit the physician's duty to those persons foreseeably infected by the physician's patient.⁴¹

Courts declining to impose a duty on physicians often consider many of these same factors, only to reach the opposite conclusion. Some courts refuse to impose a duty on physicians without the existence of a special relationship between the physician and the plaintiff or the patient and the plaintiff.⁴² 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.⁴³ 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.⁴⁴ Still others express concern for the possibility of sweeping liability.⁴⁵ Finally, in some jurisdictions, courts are compelled to defer to state statutes that prohibit violations of physician-patient confidentiality.⁴⁶

40. *See, e.g., id.* at 241 (considering, among other factors, "concerns about confidentiality in the physician-patient relationship and the present medical malpractice crisis"); RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. h (Proposed Final Draft No. 1, 2005) ("[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 . . .").

41. *See, e.g., Gammill v. United States*, 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 *Restatement (Third)*, of course, purges foreseeability from the duty calculus. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 7 cmt. j (Proposed Final Draft No. 1, 2005).

42. *See supra* note 20 and accompanying text. This is really the same thing as saying that the court refuses to extend the special-relationship doctrine in the same fashion as *Tarasoff*—it does not offer, in itself, an explanation as to why this is so.

43. *E.g., Candelario v. Teperman*, 789 N.Y.S.2d 133, 135 (App. Div. 2005). Such analysis begs the question—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.

44. *See, e.g., Pate v. Threlkel*, 661 So. 2d 278, 282 (Fla. 1995) (refusing to impose a duty to warn the patient's family because it would violate Florida's confidentiality rules and put too great a burden on the physician).

45. *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300, 1303 (N.Y. 1997) (limiting the duty to warn to patient's immediate family).

46. *See, e.g., N.O.L. v. District of Columbia*, 674 A.2d 498, 499 (D.C. 1995) (recognizing a statutory duty not to reveal the patient's diagnosis as HIV-positive); *Santa Rosa Health Care Corp. v. Garcia*, 964 S.W.2d 940, 944 (Tex. 1998) (same). Most confidentiality statutes, however—including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")—provide an exception where a breach of confidentiality is required by common-law rule. *See* HIPAA Privacy Rule, 45 C.F.R. § 164.512(a)–(b), (j) (2008).

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 (although one similarly lacking in empirical data) of physician and therapist scenarios in an attempt to evaluate the *Restatement (Third)*'s distinction between them. In addition, at the risk of attempting too much in so brief an exposition, I will frame this discussion in the context of its possible jurisprudential undercurrents.

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, corrective-justice theory 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 exclusively 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.⁴⁷ On the other hand, instrumentalist theories view tort law as 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.⁴⁸ Both corrective justice and instrumentalism offer 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.⁴⁹

47. 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) ("Tort law, on this view, aims both to specify the primary duties actors owe to one another and to provide a vehicle by which the secondary duty to repair is enforced."); Stephen R. Perry, *Tort Law*, in *A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 57, 72 (Dennis Patterson ed., 1999) ("The basic idea is that tort law should attempt to do justice strictly between the parties, without taking account of larger distributive issues in the community as a whole. Corrective justice purports to impose an obligation to pay compensation on persons who have caused harm in certain ways to others; those who suffer the harm are viewed as having a correlative right, held against their particular injurers and no one else, to recover for their losses.")

48. For the classic efficiency account of tort law, see WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* 1–28 (1987).

49. There are a variety of possibilities about what qualifies as a "unified

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. 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.⁵⁰

On the face of it, cases involving therapist and physician duties to warn third parties evidence a mix of corrective justice and instrumentalist reasoning. Courts focus on the relationship between the parties and draw upon community notions of obligation—both pillars of corrective justice reasoning.⁵¹ 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.⁵² Despite courts'

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 deviates from the path. This Article does not rely on any particular definition of unified, but rather rests on the admittedly indeterminate line between a tort system that encompasses multiple goals or means of reasoning and one that is, to some extent, limited to one.

50. See, e.g., Guido Calabresi, *Toward a Unified Theory of Torts*, J. TORT L., Oct. 2007, at 1, <http://www.bepress.com/jtl/vol1/iss3/art1>; Bruce Chapman, *Pluralism in Tort and Accident Law: Toward a Reasonable Accommodation*, in PHILOSOPHY AND THE LAW OF TORTS 276–321 (Gerald J. Postema ed., 2001); Izhak Englard, *The Idea of Complementarity as a Philosophical Basis for Pluralism in Tort Law*, in PHILOSOPHICAL FOUNDATIONS OF TORT LAW 183–95 (David G. Owen ed., 1997); Mark Geistfeld, *Economics, Moral Philosophy, and the Positive Analysis of Tort Law*, in PHILOSOPHY AND THE LAW OF TORTS, *supra*, at 250–75; 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); Eyal Zamir & Barak Medina, *Law, Morality, and Economics: Integrating Moral Constraints with Economic Analysis of Law*, 96 CAL. L. REV. 323 (2008).

51. See, e.g., *Santana v. Rainbow Cleaners*, 969 A.2d 653, 658 (R.I. 2009) (taking into account “the relationship between the parties [and] the scope and burden of the obligation to be imposed upon the defendant” in determining whether a mental-health facility had a duty to prevent a violent assault by a patient).

52. See, e.g., *Lee v. Corregedore*, 925 P.2d 324, 338 (Haw. 1996) (“Requiring counselors to breach counselor-client confidentiality would force counselors to incur a greater risk of civil liability . . . [W]e are not familiar with the value and availability of insurance for counselors’ liability arising out of a duty to prevent the suicides of noncustodial clients . . .”).

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 *Restatement (Third)*'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 *Restatement (Third)*—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?

A. *Instrumentalist Reasoning*

A typical therapist third-party duty case seems to involve (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 commonly 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 often 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.⁵³ 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

53. 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, Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 181 n.83 (1978). On the other hand, a significant minority of responding therapists felt reluctant to probe deeply into their patients' lives because they might discover and be forced to report violence, and 54.0% of therapists believed *Tarasoff* "increased [their] anxiety as an issue relating to dangerousness is broached in the clinical setting." *Id.* at 181–82 nn.86–87. And more directly to the point, 24.5% 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 commentators have suggested that the prospect of increased legal liability will make therapists more discerning in their patient selection, leaving many 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).

therapist, the warning can actually facilitate treatment and therapist-patient trust.⁵⁴ Finally, it is important to note that therapists have the legal option of initiating civil-commitment proceedings against a patient deemed dangerous to self or others.⁵⁵

Physician cases, on the other hand, seem to regularly 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 therapist and patient. Indeed, the physician-patient relationship is often fungible—the relationship itself is less important to continuation and success of treatment, second opinions are common, and patients often change providers. 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.⁵⁶

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,⁵⁷ the

54. 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); Lawson R. 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) (suggesting that warning in the presence of the patient or having the patient issue the warning himself enhances trust).

55. *Schuster v. Alternberg*, 424 N.W.2d 159, 164 (Wis. 1988) (“[W]e analyze failure to commit alongside the allegations of failure to warn third parties, since commitment is paramountly justified as a measure to protect the public.”).

56. Edward P. Richards et al., *Quarantine Laws and Public Health Realities*, 33 J.L. MED. & ETHICS (SPECIAL SUPPLEMENT) 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. See Public Health Service Act § 361, 42 U.S.C. § 264 (2006).

57. 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).

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).⁵⁸ 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 generally 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 often 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 a patient's life and relationships. Paired with the option to civilly commit dangerous patients, therapists' ability to defend third parties is particularly valuable. In physician cases, the patient himself usually is able to take steps to reduce the risk of harm to others (as 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 does not have the same power to civilly commit patients that pose a risk to others.⁵⁹ For these reasons, the benefit of imposing a duty on physicians is perhaps less than the benefit of imposing 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

58. I do not 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.

59. 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 him. 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, 980–81 (2005). I have also argued that, despite this fact, using foreseeability in this manner is normatively undesirable. *Id.* at 981–83.

expanding physicians' tort liability have not been quantified in any reliable way,⁶⁰ and there appear to be viable arguments on both sides of the issue. It is possible, however, that for the reasons sketched above, the risks posed by breaching patient confidentiality are 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”⁶¹—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 empirical support for this intuition). Thus, an instrumental good might be achieved by imposing a duty 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 more likely to be accurate than those of therapists and therefore more efficient at preventing harm to third parties. Moreover, one by-product of therapists' relatively weak ability to assess risk is the increased likelihood of false positives (especially post-*Tarasoff*).⁶² Each false alarm not only undermines patient trust, but no doubt causes pain and embarrassment to the patient in the public eye.⁶³

60. As mentioned previously, empirical studies 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. See RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 reporters' note cmt. g (Proposed Final Draft No. 1, 2005) (offering an excellent discussion of existing empirical evidence).

61. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 347 (Cal. 1976).

62. Even before *Tarasoff*, therapists had a tendency to overpredict violence in their patients. Fleming & Maximov, *supra* note 29, at 1045 (1974); D.L. Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250, 258 (1973). One post-*Tarasoff* study found that forty-five percent of therapists who have issued *Tarasoff* warnings felt 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).

63. 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

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.⁶⁴ 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.⁶⁵

Apart from the practical limitations faced by a purely instrumental understanding of these cases, even if courts had access to all of 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 Part, taking courts’ words at face value, the answer must be no. Courts commonly ground their analyses of therapist and physician duties by citation to the special caregiver-patient relationship and in other corrective-justice-based reasoning.⁶⁶

B. *Corrective-Justice Reasoning*

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 patients willingly do so. Therapists voluntarily take responsibility for helping to resolve their patients’ psychological issues and for improving patients’ happiness generally. And patients’ issues usually involve third parties—psychological conditions often manifest in, revolve around, or are triggered or aggravated by patients’ relationships. Thus, in some sense, therapists voluntarily become involved in their patients’ relationships and interactions with others.

Understanding the therapist-patient relationship in this way

those made by the courts in these cases. The *Restatement (Third)* seems to agree. See RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. h (Proposed Final Draft No. 1, 2005) (“[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.”).

64. It is outside the scope of this Article to consider the possibility that neither duty would be efficient, although such a conclusion is possible.

65. 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 courts do not even ask the proper questions.

66. See, e.g., *Santana v. Rainbow Cleaners*, 969 A.2d 653 (R.I. 2009).

might shed light on a moral basis for the duty imposed by the court in *Tarasoff*. Unlike members of the general public—whose liberty interests, in the typical affirmative-duty case, 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 usually rise to the level of legal third-party beneficiaries.⁶⁷ 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 doctor-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 doctor knows to be threatened by the patient."⁶⁸

In contrast, a physician's relationship with a patient is often less extensive and usually 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 is hired to treat. Thus, the physician's moral duty arguably does not encompass protecting the patient from the emotional fallout 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

67. 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.

68. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 344 (Cal. 1976) (quoting Fleming & Maximov, *supra* note 29, at 1030).

power.⁶⁹ 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.⁷⁰ 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 does not rise to the level of "taking charge" of a patient, it arguably indicates some greater responsibility for the patient's actions.⁷¹

Finally, corrective-justice theorists often look to non-instrumentalist community norms as a proper source for the existence of a legal duty.⁷² In this regard, it is worth noting that a norm in favor of warning identifiable victims already existed in the psychological community pre-*Tarasoff*.⁷³ There is also evidence that a similar norm has existed among physicians for several decades,⁷⁴ although it is difficult to ascertain the depth and strength of this norm. Indeed, from conversations with physicians, my impression is 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 militate against the distinction. For example, to the extent

69. See *supra* note 56 and accompanying text.

70. See RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 reporters' note cmt. h (Proposed Final Draft No. 1, 2005) ("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.").

71. 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.

72. 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).

73. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 41 cmt. g (Proposed Final Draft No. 1, 2005) ("Before *Tarasoff*, mental-health professionals believed that professional ethical obligations required them to breach confidentiality and issue warnings in certain circumstances, including when a patient posed a risk to the community.").

74. See *supra* note 22 and accompanying text.

that a therapist's particular ability to foresee risk to third parties plays a part in the moral justification for the therapist duty,⁷⁵ a physician's ability to foresee third-party risk is only more refined.⁷⁶ Furthermore, neither the therapist's nor the physician's relationship with his or her patient is for the benefit of third parties, as is sometimes required for a tort duty to exist.⁷⁷ And it is arguable that neither physicians nor therapists exercise such a degree of control over their outpatients that the caregiver possesses sufficient agency to be "responsible" for the patient's actions toward others.⁷⁸ Thus, from a corrective-justice vantage, perhaps neither duty ought to exist at all. 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.⁷⁹ 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.⁸⁰ If the therapist-patient

75. See John C.P. Goldberg & Benjamin C. Zipursky, *The Moral of MacPherson*, 146 U. PA. L. REV. 1733, 1839 (1998) (explaining the holding in *Tarasoff* in such terms).

76. See *supra* notes 62–63 and accompanying text.

77. See, e.g., RESTATEMENT (SECOND) OF TORTS § 552(2) (1977) (limiting professional liability to third parties to "loss suffered . . . 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.

78. See generally Stephen R. Perry, *Responsibility for Outcomes, Risk, and the Law of Torts*, in PHILOSOPHY AND THE LAW OF TORTS, *supra* note 50, at 96–97 (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, 399 (Ill. 1987) (refusing to find a physician duty, although in the context of misfeasance); *Nasser v. Parker*, 455 S.E.2d 502, 506 (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, his or her 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.

79. See, e.g., Gary T. Schwartz, *Feminist Approaches to Tort Law*, 2 THEORETICAL INQUIRIES IN L. 6, 31–32 (2001), <http://www.bepress.com/til/default/vol2/iss1/art6> ("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?").

80. See, e.g., *Santana v. Rainbow Cleaners*, 969 A.2d 653, 660 (R.I. 2009)

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.⁸¹

CONCLUSION

Although I disagree with the *Restatement (Third)*'s neutral approach to physician duties as a descriptive statement (and perhaps even 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 such 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 courts' 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 *Restatement (Third)*) 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. The reality is that most courts do impose third-party duties on both therapists and physicians, and theory must account for this fact, not the reverse.

If one takes courts' reasoning as it is offered, the cases discussed in this Article are best understood from a pluralistic approach to 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.

("When the duty is to control, and not to warn a specific person, courts generally require the existence of a special relationship, where the defendant: (1) knew or should have known that the patient posed a serious risk of violence to others; and (2) had the legal right and ability to control the patient.").

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