

# Protective Privilege Versus Public Peril: How Illinois Has Failed to Balance Patient Confidentiality with the Mental Health Professional's Duty to Protect the Public

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## I. INTRODUCTION

Mental health professionals face an ethical predicament when the duty to maintain patient confidentiality conflicts with the duty to promote the welfare of others. There would be no conflict if a clinician's duty extended

only to his patients, but the obligation has been broadened to include a protective duty toward third parties in certain circumstances.<sup>1</sup> When a psychiatric patient during the course of treatment expresses a serious and credible intention to harm an identifiable third party, the clinician to whom the threat was voiced is placed on the horns of a dilemma: the therapist must decide how to best protect the intended victim while remaining mindful of the obligation to maintain confidentiality.<sup>2</sup> The decision is fraught with possible adverse consequences, both as a result of a breach of confidentiality<sup>3</sup> and as a result of failing to take adequate measures to protect the intended victim from the patient's violent impulses.<sup>4</sup> The clinician must decide "whether more harm is done by occasionally breaching confidentiality or by always respecting it regardless of the consequences."<sup>5</sup> In many cases, the laws governing confidentiality and protection of the public, as currently interpreted, understood, and enforced, place clinicians in a position where they are legally required to violate the confidence that they believe to be their overriding professional obligation in favor of a protective duty toward potential victims.<sup>6</sup>

Breaches of confidentiality can erode the therapeutic relationship or lead to an increase in violence when patients terminate treatment after a breach of confidence or withhold information that is necessary for effective treatment due to fears of compromised confidentiality.<sup>7</sup> Equally serious, however, is the confusion among mental health professionals about what measures can and should be taken in fulfilling their duty to protect third parties and the potential for unnecessary breaches of confidentiality in response to this confusion.<sup>8</sup>

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1. Fillmore Buckner & Marvin Firestone, "Where the Public Peril Begins": 25 Years After Tarasoff, 21 J. LEGAL MED. 187, 213 (2000); see also Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345-46 (Cal. 1976).

2. Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976) (noting social policy as the basis for resolving the tension between the conflicting duties to the patient and the public).

3. *Id.* at 347 (acknowledging that disclosures of confidential information have the potential to disrupt the therapeutic relationship).

4. *Id.* ("The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved.")

5. Michael H. Kottow, *Medical Confidentiality: An Intransigent and Absolute Obligation*, 12 J. MED. ETHICS 117, 117 (1986).

6. *Id.* at 118.

7. Buckner & Firestone, *supra* note 1, at 214 (discussing a commentary on the Tarasoff decision in which it was postulated that fear of breaches of confidentiality might chill the therapeutic dialogue) (citing Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 378 n.52 (1976)).

8. *Id.* ("The ill-defined nature of the duty to protect has led to great confusion about clinicians' obligations [with] therapists . . . overreacting to Tarasoff and its progeny in an effort to protect threatened victims.") (citing Paul S. Appelbaum, Howard Zonana, Rich-

This article begins, in part II, with general background on the duties of mental health professionals to their patients and to the public and on the landmark case of *Tarasoff v. Regents of University of California*,<sup>9</sup> which raised public awareness of the tension between these duties.<sup>10</sup> Part III contains a more thorough analysis of the duty of patient confidentiality and the limits to that duty in the form of protecting third parties. Part IV represents an examination of the legislative, psychiatric, and judicial responses to the confidentiality/public protection dilemma. Finally, part V focuses on the laws in Illinois. Specifically, the Illinois statutes may cause unnecessary confusion regarding a clinician's duty, regarding the events that trigger the duty, and regarding the acceptable methods of fulfilling the duty.<sup>11</sup> Furthermore, Illinois laws have been judicially interpreted and applied in ways that may exacerbate the problems by leaving classes of potential victims unprotected or by causing unnecessary breaches of confidentiality.<sup>12</sup> However, these difficulties are not insurmountable.<sup>13</sup> There are possible improvements, both in wording and in application, of the Illinois statutes that may bring Illinois closer to achieving the requisite balance between patient privilege and public protection.<sup>14</sup>

## II. BACKGROUND

### A. OVERVIEW

The American Medical Association recognizes the dual duties of mental health professionals—to protect the rights of their patients, as well as to protect members of the public from the violent impulses of their patients—and also recognizes the necessity for exceptions to patient confidentiality created by these conflicting duties.<sup>15</sup> The 1976 California Supreme Court

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and Bonnie & Loren H. Roth, *Statutory Approaches to Limiting Psychiatrists' Liability for Their Patients' Violent Acts*, 146 AM. J. PSYCHIATRY 821 (1989)).

9. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878 (Cal. App. 1973), *vacated*, 529 P.2d 553 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976).

10. *Id.* at 880.

11. See discussion *infra* Part IV (discussing the inconsistencies between the wording of the two Illinois statutes, as well as the lack of uniformity and predictability of judicial interpretation of the statutes).

12. See discussion *infra* Part IV (discussing the specific problems related to judicial interpretation and application of the Illinois statutes).

13. See discussion *infra* Part IV.C.

14. See discussion *infra* Part IV.C.

15. Dudley Stewart, *In Defense of Exceptions to Confidentiality*, 5 VIRTUAL MENTOR AM. MED. ASS'N J. ETHICS, Oct. 2003, <http://virtualmentor.ama-assn.org/2003/10/hlaw1-0310.html> (explaining that the duty of confidentiality in the psychotherapeutic relationship is subject to exceptions when the safety of third parties is jeopardized by a violent patient).

decision in *Tarasoff*<sup>16</sup> has fundamentally influenced currently accepted principles relating to the ethics of patient confidentiality within the psychiatric setting.<sup>17</sup> More than thirty years after the decision, the case remains relevant not just in California but in the many jurisdictions that have since followed it, with numerous courts citing *Tarasoff* as an important case and relying on its reasoning as a basis for their decisions.<sup>18</sup> Even the Supreme Court of the United States, in explaining that there are instances in which publication of otherwise privileged material is allowable, used *Tarasoff* as its example of the exception to psychiatric confidentiality when public safety is at issue.<sup>19</sup> Therefore, a thorough analysis of the laws relating to patient confidentiality and their limits and exceptions in cases of danger to the public must begin with a review of *Tarasoff*, the “first case to find that a mental health professional may have a duty to protect others from possible harm by their patients.”<sup>20</sup>

B. *TARASOFF V. REGENTS OF UNIVERSITY OF CALIFORNIA*: FACTUAL AND PROCEDURAL HISTORY

Prosenjit Poddar met Tatiana Tarasoff in 1968 at the University of California at Berkeley, where they were both graduate students.<sup>21</sup> Poddar was romantically interested in Tarasoff but became depressed and despondent when the feelings were not mutual.<sup>22</sup> Poddar sought outpatient counseling with Dr. Lawrence Moore, a psychologist at Cowell Memorial Hospital, located at the university.<sup>23</sup> During a therapy session on August 18,

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

17. See Kenneth Kipnis, *In Defense of Absolute Confidentiality*, 5 VIRTUAL MENTOR AM. MED. ASS'N J. ETHICS, Oct. 2003, <http://virtualmentor.ama-assn.org/2003/10/hlaw2-0310.html> (“The conventional wisdom on the ethics of medical confidentiality has been largely shaped by the *Tarasoff* case.”); see also Paul S. Appelbaum & Alan Rosenbaum, *Tarasoff and the Researcher: Does the Duty to Protect Apply in the Research Setting?*, AM. PSYCHOLOGIST, June 1989, at 885 (explaining that the legal duty of mental health providers to protect third parties began with the *Tarasoff* case).

18. See, e.g., *Currie v. United States*, 644 F. Supp. 1074, 1077 (M.D.N.C. 1986) (“[*Tarasoff* is] the seminal case in this area, and the case from which all courts examining a duty to commit have begun their examination.”); *Brady v. Hopper*, 570 F. Supp. 1333, 1336 (D. Colo. 1983) (“[*Tarasoff* is] the leading case on a therapist’s liability for the violent actions of a patient . . . .”); *Charleston v. Larson*, 696 N.E.2d 793, 798 (Ill. App. Ct. 1998) (“[*Tarasoff* is a] leading case encompassing the issue of special relationships.”); *Emerich v. Phila. Ctr. for Human Dev.*, 720 A.2d 1032, 1036 (Pa. 1998) (“Our analysis must begin with the California Supreme Court’s landmark decision in *Tarasoff* . . . .”).

19. *Bartnicki v. Vopper*, 532 U.S. 514, 539 (2001).

20. *Emerich*, 720 A.2d at 1036.

21. *People v. Poddar*, 518 P.2d 342, 344 (Cal. 1974).

22. *Id.*

23. *Tarasoff v. Regents of Univ. of Cal.*, 108 Cal. Rptr. 878, 880 (Cal. Ct. App. 1973), *vacated*, 529 P.2d 553 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976).

1969, Poddar confided in Dr. Moore that he wanted to kill “an unnamed girl, readily identifiable as Tatiana Tarasoff, when she returned home to Berkeley from Brazil.”<sup>24</sup> Moore notified campus police that he believed Poddar was capable of harming himself or someone else and asked police to transport Poddar to a nearby hospital for seventy-two-hour emergency detention and evaluation.<sup>25</sup> Campus police detained Poddar and questioned him, but they released him after they found him to be rational and willing to stay away from Tarasoff.<sup>26</sup> On October 27, 1969, Poddar went to Tarasoff’s home armed with a pellet gun and a kitchen knife.<sup>27</sup> He shot Tarasoff with the pellet gun and when she ran from the house, he pursued her, repeatedly and fatally stabbing her.<sup>28</sup>

Poddar was convicted of second degree murder, but his conviction was overturned on appeal because of a prejudicial error in the jury instructions.<sup>29</sup> Although the case was remanded, Poddar was never actually retried, possibly because of the length of time that had elapsed since the murder and the resultant difficulty in recalling witnesses and reconstructing evidence; instead, Poddar was released on the condition that he return to India.<sup>30</sup>

Tatiana’s parents, Vitaly and Lydia Tarasoff, filed a wrongful death action against the university regents, the psychologist, the supervising psychiatrists, and the police.<sup>31</sup> The causes of action for “failure to detain a dangerous patient” and for “breach of primary duty to [the] patient and the public” were barred by governmental immunity.<sup>32</sup> The cause for “failure to warn on a dangerous patient”<sup>33</sup> found no protection in governmental immunity since the court held that only basic policy decisions were included in the category of discretionary functions protected from liability in tort.<sup>34</sup> Over the strenuous objections of amici representing the American Psychiatric Association, the court found that “the therapist owes a legal duty not only to his patient, but also to his patient’s would-be victim.”<sup>35</sup>

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24. *Id.*

25. *Id.*

26. *Id.*

27. *People v. Poddar*, 518 P.2d 342, 345 (Cal. 1974).

28. *Id.*

29. *Id.* at 350. The defense requested several jury instructions related to the insanity defense. *Id.* The court refused one requested instruction, the absence of which reasonably could have caused the jury to find malice without properly considering evidence of the effect of diminished mental capacity on the “awareness of duty” and “acting despite the awareness” prongs of the implied malice test. *Id.*

30. CHARLES PATRICK EWING & JOSEPH T. McCANN, *MINDS ON TRIAL: GREAT CASES IN LAW AND PSYCHOLOGY* 60 (2006).

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

32. *Id.* at 341.

33. *Id.*

34. *Id.* at 349.

35. *Id.* at 345-46.

The court elaborated on the principle that the duty to third parties is necessarily limited to situations in which harm to the third party is foreseeable.<sup>36</sup> However, the court added the vital caveat that when foreseeable harm may be avoided only by controlling the conduct of the would-be aggressor, the common law traditionally had imposed liability only when the defendant was in a position of a “special relationship” to the dangerous person or to the intended victim.<sup>37</sup> The “special relationship” requirement represents an exception to the principle that there is no general duty to come to the aid of another person.<sup>38</sup> That is, a special relationship to the aggressor or to the intended victim creates a duty to control the actions of the aggressor or creates a right to protection in the would-be victim.<sup>39</sup> Examples of common relationships cited in the *Restatement (Second) of Torts* as imposing a duty to control the actions of another person include parent-child and master-servant, among others.<sup>40</sup>

Although the doctor-patient relationship was not specifically mentioned in the *Restatement*, the court pointed out that a doctor necessarily is required to “exercise reasonable care to protect others against dangers emanating from the patient’s illness” in cases of contagious disease<sup>41</sup> and that other courts had imposed liability for harm to third parties based solely on the therapist-patient relationship in the absence of any special relationship with the victim.<sup>42</sup> This reasoning led to the court’s presumption that the doctor-patient relationship falls under the category of “special relationships” that require the doctor to take 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.”<sup>43</sup> Having extended “special relationship” status to the therapist-patient relationship, the court concluded that a patient’s right to confidentiality is necessarily limited to the degree necessary to protect the public from danger, asserting that “[t]he protective privilege ends where the public peril begins.”<sup>44</sup>

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36. *Id.* at 342.

37. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 342-43 (Cal. 1976).

38. RESTATEMENT (SECOND) OF TORTS § 314 (1965).

39. *Id.* § 315.

40. *Id.* §§ 316-17.

41. *Tarasoff*, 551 P.2d at 344.

42. *Id.* (referring to the holding in *Merch. Nat’l Bank & Tr. Co. of Fargo v. United States*, 272 F. Supp. 409 (D.N.D. 1967)).

43. *Id.* (quoting John G. Fleming & Bruce Maximov, Note, *The Patient or His Victim: The Therapist’s Dilemma*, 62 CAL. L. REV. 1025, 1030 (1974)).

44. *Id.* at 347.

### III. ANALYSIS OF THE CONFLICTING DUTIES

#### A. PATIENT CONFIDENTIALITY

The principal of confidentiality is the basis on which therapeutic trust is built within the setting of medical treatment in general and mental health treatment in particular.<sup>45</sup> The promise of confidentiality allows patients to feel safe in giving true, complete, and uncensored versions of the information that they share with their physicians, whereas the possibility of breaches of this trust may seriously impair effective treatment.<sup>46</sup>

##### 1. *Particular Importance of Confidentiality in the Mental Health Treatment Setting*

Despite the biological basis of many psychiatric disorders, mental illnesses are not as easily detected and measured via physical examination or diagnostic tests as are other types of physical illnesses, making complete disclosure by the patient especially vital to accurate diagnosis and treatment.<sup>47</sup> Within the setting of psychotherapy, effective treatment is

based on a collaboration between the therapist and the non-pathologic (or “healthy”) aspects of the patient’s personality. To attain this collaborative stance, the therapist attempts to see the world through the patient’s eyes, striving for a state of empathic rapport. At the same time, . . . the therapist must inevitably work in opposition to the pathologic (or “sick”) aspects of the patient’s psyche . . . , in effect acting as an advocate for the healthy side of the patient.

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45. *Id.* at 354 (Clark, J., dissenting) (“Until today’s majority opinion, both legal and medical authorities have agreed that confidentiality is essential to effectively treat the mentally ill . . .”).

46. *Id.* at 359 (“[A]ssurance that the confidential relationship will not be breached is necessary to maintain his trust in his psychiatrist—the very means by which treatment is effected.”).

47. *See generally* Boadie W. Dunlop & Anne L. Dunlop, *Counseling via Analogy: Improving Patient Adherence in Major Depressive Disorder*, 7 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 300, 301-02 (2005) (discussing the need to encourage patient discussion of mental health symptoms with primary care physicians by analogizing depression to other biologically-based illnesses, such as diabetes and hypertension).

The foregoing requires from the patient an openness in self-disclosure and comfort with candor, in respect to which the clinician owes the protection of confidentiality.<sup>48</sup>

Unfortunately, psychiatric care still carries with it a great deal of social stigma,<sup>49</sup> causing many patients to feel ambivalent about seeking treatment for emotional problems.<sup>50</sup> In addition to the sense of shame associated with having a psychiatric disorder, the issues about which individuals consult psychiatrists and psychologists have the potential to cause embarrassment or disgrace if not kept in strict confidence.<sup>51</sup> Consequently, “the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.”<sup>52</sup> Worse, the reticence about discussing psychiatric symptoms may lead to avoidance of treatment altogether if patients fear that their disclosures may become public.<sup>53</sup> Courts have acknowledged the particularly sensitive nature of psychiatric records and have protected the contents of those records when the patient’s interest in maintaining confidentiality outweighs any evidentiary benefit that might be gained from compelling disclosure.<sup>54</sup> It is significant to note that even in states in which there is no privilege for communications between general physicians and patients, such a privilege is statutorily extended to communications between mental health professionals and their patients.<sup>55</sup> As one court noted,

Among physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent upon their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communica-

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48. THOMAS G. GUTHEIL & PAUL S. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 16 (4th ed. 2006).

49. *Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting).

50. GUTHEIL & APPELBAUM, *supra* note 48, at 18.

51. *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

52. *Id.*

53. GUTHEIL & APPELBAUM, *supra* note 48, at 18.

54. *See Jaffee v. Redmond*, 518 U.S. 1 (1996) (refusing to compel disclosure of a therapist’s records for defendant police officer, who underwent therapy to cope with the effects of trauma after the officer shot and killed a man, in an action brought by the administrator of the estate of the victim because ample eyewitness testimony could provide sufficient evidence); *Wiles v. Wiles*, 448 S.E.2d 681 (Ga. 1994) (upholding the lower court’s decision to grant a motion to quash a subpoena for psychiatric records when both the patient and the doctor asserted privilege).

55. *Wiles*, 448 S.E.2d at 682.

tion. . . . A threat to secrecy blocks successful treatment.<sup>56</sup>

Although a breach of doctor-patient confidentiality is serious and possibly damaging in any medical context, disclosure of the sensitive, private, and potentially embarrassing information that is the source of many psychiatric problems can have even more deleterious effects.

## 2. *Potential Adverse Consequences of Breaches of Confidentiality*

It is posited that breaches of confidentiality will “undermine the patient’s trust of the therapist, deter the patient from taking advantage of treatment, and deprive the patient and society of the beneficial effects of psychiatric interventions.”<sup>57</sup> Furthermore, there exists a potential adverse impact on the patient’s illness if trust in the confidential nature of the therapeutic environment is lacking.<sup>58</sup> For example, in the absence of an assurance of confidentiality, individuals who need psychiatric treatment may be deterred altogether from seeking necessary care.<sup>59</sup> If a patient begins treatment but becomes fearful that his confidence will be breached, he may distort or fabricate information or may fail to fully disclose all the information necessary to make an accurate diagnosis, any of which would inhibit effective treatment.<sup>60</sup> Furthermore, “even if full disclosure is accomplished, assurance that the confidential relationship will not be breached is necessary to maintain the patient’s trust of his psychiatrist.”<sup>61</sup>

Openness in the therapeutic environment is especially important when a patient is struggling with aggressive urges. It is argued that any decreased likelihood that a patient will reveal information about violent feelings, in turn, increases the likelihood that the patient will act on the violent impulses in the absence of the clinician’s opportunity to treat the underlying psychiatric disorder.<sup>62</sup> For example, there are some who argue that the *Ta-*

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56. *Id.* at 683 (quoting KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE § 98, at 370 (John William Strong ed., 4th ed. 1992)).

57. Jerome S. Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCI. & L. 273, 277 (1984).

58. *Id.* (“[A]ny evidence of breach of confidentiality will . . . deprive the patient and society of the beneficial effects of psychiatric interventions.”); *see also* *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553, 566 (Cal. 1974) (Clark, J., dissenting) (noting the importance of psychiatric treatment and the necessity for assurances of confidentiality in successful therapeutic interventions), *vacated*, 551 P.2d 334 (Cal. 1976).

59. Beigler, *supra* note 57, at 277-78.

60. Kottow, *supra* note 5, at 118 (noting that any impairments in physician-patient communication may “render the patient’s medical care less than optimal”).

61. *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553, 567 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976).

62. Kipnis, *supra* note 17.

*rasoff* case may have had a less-tragic outcome for Tatiana if Dr. Moore had not breached confidentiality by alerting campus police to Poddar's threats of violence.<sup>63</sup> That is, if Poddar had not been picked up by the police at Dr. Moore's request, it is posited that he might have continued his treatment, dealt with his angry and violent impulses in the therapeutic setting, and never acted on such impulses.<sup>64</sup> Although this alternative ending to *Tarasoff* can never be predicted with any degree of accuracy, the mere possibility of a different result in the absence of the breach should be enough to underscore the importance of trust in the therapeutic setting and the potentially devastating consequences when patients withhold information because of the fear of disclosure.

The duty to protect society from violent patients has purportedly complicated mental health treatment at the very least and possibly even impaired its effectiveness due to the therapist's fear of legal repercussions that could result from both a failure to take protective measures against a credible threat and from an overreactive warning based on a noncredible threat.<sup>65</sup> Confusion over the protective duty can impair a therapist's ability to effectively treat a patient when the focus shifts from the patient's problems to the therapist's duty and potential liability.<sup>66</sup> When this interference with the therapeutic process is sufficiently disruptive, it may lead to termination of therapy.<sup>67</sup> The shift in focus from therapeutic to legal intervention has at times extended to other areas of mental health treatment with potentially devastating consequences to patients who need help. For example, during the first several years after the *Tarasoff* decision, staff members of a California suicide prevention hotline were advised that any calls involving serious potential threats to others "would be responded to first by trying to learn the identity of the threatened party and then by telling the caller of their duty to warn. Fifty percent of the callers terminated contact."<sup>68</sup> Whether any callers harmed themselves or others after prematurely terminating their calls to the suicide hotline can only be speculated; however, this possibility represents another example of the potential deleterious effect of a lack of trust within the therapeutic setting that can result from the possibility of breaches of confidentiality and the care that must be taken in balancing psychiatric confidentiality with protection of third parties.

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63. Max Siegel, *Privacy, Ethics and Confidentiality*, PROF. PSYCHOL., Apr. 1979, at 249, 253.

64. *Id.*

65. Beigler, *supra* note 57, at 278 (describing the lack of spontaneity in therapy due to discussions about confidentiality, therapists' anxiety about their responsibilities in assessing violence, and the resultant tendency to overpredict violence).

66. *Id.*

67. *Id.*

68. *Id.*

B. PROTECTION OF THE PUBLIC FROM DANGEROUS PATIENTS: LIMITS ON THE RIGHT TO CONFIDENTIALITY

Despite the importance of confidentiality in the mental health treatment setting, a patient's right to privacy is not absolute but is "subject to certain exceptions, which are ethically and legally justified because of overriding social considerations."<sup>69</sup> Specifically, the right to confidentiality must be balanced against the right of the public at large to protection from harm at the hands of violent patients. The American Medical Association (AMA) endorses the principle that

[w]here a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.<sup>70</sup>

This principle is congruent with the standard established in *Tarasoff* that when a therapist reasonably determines "that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."<sup>71</sup> Of note is the fact that neither the AMA principles nor the *Tarasoff* rule specifically establish a duty to *warn* intended victims or to otherwise breach confidentiality. Instead, they establish a duty to *protect* such victims, with warnings being only one protective method available. Health care providers generally agree that confidentiality may properly be breached in some circumstances,<sup>72</sup> and, in fact, breaches are mandated in certain situations involving protection of the public, such as the reporting of infectious diseases and child abuse, among others.<sup>73</sup>

One psychiatrist's decision to issue a protective warning was put to the test when his patient sued him for medical malpractice and invasion of privacy after the doctor warned police and the patient's intended victim of the patient's homicidal impulses.<sup>74</sup> The patient, Mr. Viviano, was referred to the psychiatrist, Dr. Stewart, for medication to treat depression.<sup>75</sup> Viviano had been injured in the course of his employment and had won a jury ver-

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69. Stewart, *supra* note 15 (quoting AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 5.05, at 60-61 (2002-2003 ed. 2002)).

70. *Id.*

71. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345 (Cal. 1976).

72. Beigler, *supra* note 57, at 278.

73. *Id.* at 277.

74. *Viviano v. Moan*, 93-1368 (La. App. 4 Cir. 11/17/94); 645 So. 2d 1301.

75. *Id.* at 2, 645 So. 2d at 1303.

dict of over \$1 million, but the judge in his case had overturned the verdict and ordered a retrial.<sup>76</sup> During the course of treatment with Dr. Stewart, while the retrial of the injury case was pending, Viviano made gradually escalating threats against the trial judge, his attorney, and one of the attorneys for the defendants.<sup>77</sup> Dr. Stewart was concerned that the patient's threats were credible and likely to be carried out, especially after Viviano reported "that he had watched the judge, could see into her home, and knew where she parked; he chronicled her morning 'routine,' including her 'jog.'"<sup>78</sup> The psychiatrist was not successful in dealing with Viviano's violent impulses therapeutically, since the patient had begun abusing drugs, had become noncompliant with his prescribed psychiatric medication, and had begun missing his scheduled appointments.<sup>79</sup> In addition, involuntary hospitalization was not an option; although Viviano had a mental illness in the form of depression, his "repeated threats to murder Judge Wicker grew not out of his depression but out of pure rage and anger, the result of her vacating the \$1.225 million judgment that had been rendered in his favor."<sup>80</sup> Dr. Stewart consulted with colleagues and with attorneys, and all agreed that the judge should be notified of the patient's homicidal intentions toward her.<sup>81</sup> The judge was warned and Viviano was arrested.<sup>82</sup> Of note is the fact that Viviano was armed when police detained him.<sup>83</sup> Viviano was tried for attempted murder, pled guilty to obstructing justice, was fined, and was sentenced to a private psychiatric hospital, after which he sued both the psychologist and the psychiatrist for malpractice.<sup>84</sup> The doctors prevailed at trial and on appeal.<sup>85</sup>

It would be easy to rationalize that the favorable outcome for the judge in the *Viviano* case in and of itself justified any breach of confidentiality necessary to achieve that outcome. However, it must be noted that the court's analysis in finding in favor of the clinicians went further than simple

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76. Stewart, *supra* note 15 (recounting the author's experience as the defendant in the *Viviano* malpractice action in an article advocating for exceptions to the principle of patient confidentiality).

77. *Viviano*, 93-1368, p. 2; 645 So. 2d at 1303.

78. Stewart, *supra* note 15.

79. *Id.*

80. *Viviano*, 93-1368, p. 8; 645 So. 2d at 1304 (explaining that state law governing involuntary psychiatric hospitalization provides that the person being committed is dangerous *as a result of* a mental illness).

81. Stewart, *supra* note 15.

82. *Viviano*, 93-1368, pp. 2-3; 645 So. 2d at 1303.

83. Stewart, *supra* note 15.

84. *Viviano*, 93-1368, p. 3, 645 So. 2d 1303.

85. *Id.* at 21, 645 So. 2d at 1308.

utilitarian reasoning that a life saved justifies a breach of confidentiality.<sup>86</sup> Plaintiffs argued that other protective measures should have been taken that would have accomplished the same positive outcome for the judge while the patient's confidentiality would have been maintained.<sup>87</sup> Defendants were able to prevail only after showing that they had exhausted other means of protecting the judge before breaching confidentiality.<sup>88</sup> Specifically, they demonstrated that medication and supportive therapy had failed due to Viviano's increasing noncompliance<sup>89</sup> and that hospitalization was impossible because Viviano did not meet the statutory criteria for involuntary commitment to a psychiatric hospital.<sup>90</sup> Furthermore, the clinicians were able to demonstrate the reasonableness of their belief in the credibility of Viviano's threats against the judge as justification of the breach of confidentiality.<sup>91</sup>

The *Viviano* case demonstrates the ideal application of the *Tarasoff* duty to protect as merely an exception to the doctrine of patient confidentiality, applicable in only a narrow set of circumstances. First, the doctor-patient relationship between the clinicians and Viviano met the "special relationship" criterion that is the basis of the duty.<sup>92</sup> Second, the increasingly frequent threats were evaluated within the treatment setting and were deemed serious and credible enough to trigger the protective duty.<sup>93</sup> Finally, confidentiality was breached only after other measures, such as psychotherapy and medication, had failed to thwart the patient's violent impulses<sup>94</sup> and after it became clear that involuntary hospitalization was impossible.<sup>95</sup>

In many situations, however, this ideal outcome is blocked by confusion about the clinician's protective duty and its application. While the statutes in some states are clearer and subject to less problematic judicial inter-

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86. *Id.* at 19-20, 645 So. 2d at 1307 (explaining that the decision was based on the totality of the evidence, including a balancing of the disclosure by the doctors against the patient's right to privacy as well as expert testimony on the standard of care in all treatment attempts prior to the disclosure).

87. *Id.* at 7, 645 So. 2d at 1304.

88. *See Viviano*, 93-1368; 645 So. 2d 1301 (finding Dr. Stewart's disclosure of confidential information to be reasonable when balanced against Viviano's right to privacy only after a thorough discussion of the reasons why other measures were impossible or ineffective).

89. Stewart, *supra* note 15.

90. *See Viviano*, 93-1368, p. 8; 645 So. 2d at 1304.

91. *Id.* at 17, 645 So. 2d at 1307.

92. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 344 (Cal. 1976).

93. *Viviano*, 93-1368, p. 17; 645 So. 2d at 1307 (referring to expert testimony that "Judge Wicker was in imminent danger").

94. Stewart, *supra* note 15.

95. *Viviano*, 93-1368, p. 8; 645 So. 2d at 1304.

pretation than those in other states, a complete analysis and comparison of all such statutes is beyond the scope of this article.<sup>96</sup>

#### IV. AFTERMATH OF *TARASOFF*

In the thirty years since the *Tarasoff* decision, most states have enacted statutes addressing the circumstances under which a mental health professional has a duty to protect third parties from potentially violent patients.<sup>97</sup> However, despite the attempt by the *Tarasoff* court to clearly define a therapist's obligation to the public as a "duty to protect,"<sup>98</sup> to specify the circumstances and events that would trigger the duty,<sup>99</sup> and to describe how the duty could be fulfilled,<sup>100</sup> problems remained. Specifically, this attempt apparently did not assist other states in writing clear and understandable statutes, did not elucidate the duty in a way that was understandable and useful to mental health professionals, and did not assist courts in interpreting the statutes in a way that accomplished the balance between confidentiality and public safety.<sup>101</sup>

##### A. LEGISLATION

There is wide variation among states in the descriptions of the duty, with the statutes falling into four general categories: those that explicitly establish a duty, those that prohibit liability except under particular circumstances, those that seem to permit but not require disclosure, and those that take other approaches.<sup>102</sup> In states whose statutes clearly establish an affirmative duty with unambiguous wording, such as "a mental health professional has a duty,"<sup>103</sup> there is little doubt about the existence of the duty. Conversely, statutes in other states simply remove liability for failing to

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96. For this type of comparison, see Claudia Kachigian & Alan R. Felthous, *Court Responses to Tarasoff Statutes*, 32 J. AM. ACAD. PSYCHIATRY L. 263 (2004).

97. *Id.* at 265.

98. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 346 (Cal. 1976).

99. *Id.* at 345 ("[The duty is triggered] once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others.").

100. *Id.* at 340 (explaining that the duty may be discharged by undertaking to "warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances").

101. Kachigian & Felthous, *supra* note 96, at 266-68 & tbl.1 (presenting, in Table 1, a compilation of cases, by state, with judicial decisions categorized based on reference to applicable "duty to protect" statutes and use of the statutes in the analysis; notably, many courts did not reference applicable statutes or did not apply the statutes to their decisions).

102. *Id.* at 265.

103. IDAHO CODE ANN. § 6-1902 (2004); MICH. COMP. LAWS § 330.1946 (West 1999).

protect third parties under some circumstances, stating, for instance, “[n]o cause of action shall lie against a mental health services provider . . . unless . . .”<sup>104</sup> and “[a] mental health professional . . . shall not be liable . . . except where . . .”<sup>105</sup> Other statutes seem to passively permit disclosure but do not establish a clear affirmative duty, with wording such as “[t]he psychiatrist may disclose patient communications”<sup>106</sup> and “[t]he treating physician . . . may communicate the threat.”<sup>107</sup> Still other statutes have wording that is not easily categorized as either requiring or permitting disclosure and places the existence of any duty in doubt, with language such as “[a] mental health professional . . . may be held liable . . . only if . . .”<sup>108</sup>

There is further disparity among states in the description of protected parties as well as in the acceptable methods for discharging the duty. Most states that impose an affirmative duty to protect third parties apply the duty to any identified or reasonably identifiable subjects of a patient’s threats,<sup>109</sup> but others require that the potential victim be specified or clearly identified before the protective duty is triggered.<sup>110</sup> Requirements for fulfillment of the duty vary from state to state, with some statutes mentioning only warnings and/or disclosures<sup>111</sup> and others referring to additional protective measures that might fulfill a clinician’s duty either in addition to or independent of a warning.<sup>112</sup>

#### B. REACTIONS WITHIN THE MEDICAL COMMUNITY

Reactions to the *Tarasoff* decision from those in the medical community showed confusion, with many psychiatrists throughout the United States erroneously believing that the California court’s decision applied nationally.<sup>113</sup> This uncertainty in the medical community was further illus-

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104. DEL. CODE ANN. tit. 16, § 5402 (2003).

105. COLO. REV. STAT. ANN. § 13-21-117 (West 2005 & Supp. 2008).

106. FLA. STAT. ANN. § 456.059 (West 2007).

107. MISS. CODE ANN. § 41-21-97 (2005 & Supp. 2008).

108. OHIO REV. CODE ANN. § 2305.51 (LexisNexis 2005).

109. CAL. CIV. CODE § 43.92 (West 2007); *see also* FLA. STAT. ANN. § 456.059 (West 2007); MICH. COMP. LAWS § 330.1946 (West 1999); N.H. REV. STAT. ANN. § 330-A:35 (LexisNexis 2003); N.J. STAT. ANN. § 2A:62A-16 (West 2000); TENN. CODE ANN. § 24-1-207 (2000); UTAH CODE ANN. § 78-14a-102 (2002); VA. CODE ANN. § 54.1-2400.1 (2005).

110. COLO. REV. STAT. ANN. § 13-21-117 (West 2005 & Supp. 2008); LA. REV. STAT. ANN. § 9:2800:2 (2009).

111. FLA. STAT. ANN. § 456.059 (West 2007); UTAH CODE ANN. § 78-14a-102 (2002).

112. COLO. REV. STAT. ANN. § 13-21-117 (West 2005 & Supp. 2005); MICH. COMP. LAWS ANN. § 330.1946 (West 1999); N.H. REV. STAT. ANN. § 330-A:35 (LexisNexis 2003); VA. CODE ANN. § 54.1-2400.1 (2005).

113. David T. Armitage, *Legal Duties Involving Physicians, Patient and Third Parties: Part Two*, ARMED FORCES INST. PATHOLOGY, May 1, 1995, at 3,

trated by the fact that as late as 1984, more than seventy-five percent of psychiatrists in one survey incorrectly believed that their duty to third parties was specifically to warn them, whereas only about thirty percent of psychiatrists believed that they had a duty to use reasonable care to protect third parties in a way other than warning them.<sup>114</sup> This misinformation persisted with eighty-five percent of therapists acknowledging awareness of the *Tarasoff* decision but admitting to confusion about what the law required of them.<sup>115</sup>

### C. JUDICIAL INTERPRETATION

Court decisions in many states also show a disquieting lack of predictability and uniformity in judicial application and interpretation of “duty to protect” statutes. It is disturbing that even in states whose statutes and/or case law delineate protective measures other than warnings, courts have interpreted the statutes as imposing only a duty to warn.<sup>116</sup> In one multistate analysis of cases involving potential protective disclosure issues, over twenty-five percent of cases examined “did not mention the [applicable] statute even with factual circumstances that would seemingly implicate it,”<sup>117</sup> and over fifteen percent mentioned the applicable statute but failed to use it in their analysis.<sup>118</sup> It is clear that despite the intention of the California Supreme Court in the *Tarasoff* decision to balance a therapist’s conflicting duties to his patient and to the public,<sup>119</sup> when other states attempted to codify and interpret these same principles and when mental health professionals attempted to implement them, the letter of the law created so much confusion that it obscured the spirit of the law.

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114. Daniel J. Givelber, William J. Bowers & Carolyn L. Blicht, *Tarasoff: Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 465-66 (1984).

115. Buckner & Firestone, *supra* note 1, at 219.

116. *See, e.g.*, *Gammill v. United States*, 727 F.2d 950, 954 (10th Cir. 1984); *Thompson v. County of Alameda*, 614 P.2d 728, 733 (Cal. 1980) (misquoting *Tarasoff* as imposing a “duty to warn”); *Latimer v. Havenwyck Hosp.*, No. 255277, 2006 WL 445957, at \*1 (Mich. Ct. App. Feb. 23, 2006); *Powell v. Catholic Med. Ctr.*, 749 A.2d 301, 305 (N.H. 2000).

117. Kachigian & Felthous, *supra* note 96, at 268.

118. *Id.* at 269.

119. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 346 (Cal. 1976) (“We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy . . . . Against this interest, . . . we must weigh the public interest in safety from violent assault.”).

## V. ANALYSIS OF ILLINOIS LAWS

Illinois is among the states whose statutes fall into the aforementioned fourth category, “other approaches,” with regard to its establishment of protective duties.<sup>120</sup> Illinois has codified a mental health professional’s duties to patients and to the public in two statutes: The Mental Health and Developmental Disabilities Confidentiality Act (Confidentiality Act)<sup>121</sup> and the Miscellaneous Provisions chapter of the Mental Health and Developmental Disabilities Code (Mental Health Code).<sup>122</sup> These Illinois statutes have proved especially problematic to judicial interpretation and application. For example, in their analyses of “duty to protect” situations, some Illinois courts have referred only to case law and to the *Restatement*, failing to mention either statute.<sup>123</sup> Other courts have based their decisions only on the Confidentiality Act, ignoring the Mental Health Code.<sup>124</sup> A closer analysis leads to the conclusion that there are possible solutions to the problems inherent in the existing Illinois statutes.

### A. CONFIDENTIALITY ACT

The Mental Health and Developmental Disabilities Confidentiality Act (Confidentiality Act) protects a patient’s right to privacy with respect to mental health records.<sup>125</sup> The Act describes a set of circumstances in which records may be disclosed, including situations involving abused or neglected children,<sup>126</sup> initiation or continuation of inpatient psychiatric commitment hearings,<sup>127</sup> provision of emergency medical care to patients unable to consent to disclosure of information relevant to their care,<sup>128</sup> collection of payments from third parties for mental health care,<sup>129</sup> procurement of internment sites for deceased patients,<sup>130</sup> representation in judicial proceedings under the Mental Health Code,<sup>131</sup> and compliance with requirements of the Census Bureau,<sup>132</sup> among others. When faced with potential

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120. Kachigian & Felthous, *supra* note 96, at 265.

121. 740 ILL. COMP. STAT. 110/1 to 110/17 (2002 & Supp. 2008).

122. 405 ILL. COMP. STAT. 5/6-100 to 5/6-107 (2005).

123. *E.g.*, *Charleston v. Larson*, 696 N.E.2d 793, 797-98 (Ill. App. Ct. 1998).

124. *E.g.*, *Chapa v. Adams*, No. 94 C 2048, 1997 WL 414107, at \*6 (N.D. Ill. July 17, 1997).

125. 740 ILL. COMP. STAT. 110/11 (2002 & Supp. 2008).

126. 740 ILL. COMP. STAT. 110/11(i) (Supp. 2008).

127. 740 ILL. COMP. STAT. 110/11(ii) (2002 & Supp. 2008).

128. *Id.* at 110/11(iii).

129. *Id.* at 110/11(iv).

130. *Id.* at 110/11(v).

131. *Id.* at 110/11(vi).

132. *Id.* at 110/11(vii).

“duty to protect” situations, Illinois courts consistently look to subsection viii of the Confidentiality Act, which provides that disclosures are allowed “when, and to the extent, in the therapist’s sole discretion, disclosure is necessary to warn or protect a specific individual against whom a recipient has made a specific threat of violence where there exists a therapist-recipient relationship or a special recipient-individual relationship.”<sup>133</sup>

As discussed more fully below, a review of judicial interpretation and application of the Confidentiality Act has highlighted three distinct problems. First, the Confidentiality Act does not create an affirmative requirement to disclose threatening communications but simply *allows* disclosure, stating, “Records and communications *may be* disclosed.”<sup>134</sup> That fact notwithstanding, courts refer specifically to an affirmative duty to third parties.<sup>135</sup> Second, the Confidentiality Act allows disclosure to protect threatened individuals when a “therapist-recipient relationship or a special recipient-individual relationship” exists,<sup>136</sup> but courts interpret this as narrowing the class of protected third parties,<sup>137</sup> leaving many potential victims unnecessarily vulnerable. Third, although the Act allows disclosure when necessary to warn *or protect* an individual, courts repeatedly refer only to the “duty to warn,”<sup>138</sup> failing to mention any alternative protective measures that would safeguard not just the welfare of the threatened party but also the rights of the patient to confidentiality.

### 1. *Is There an Affirmative Duty?*

The Confidentiality Act, which governs the circumstances under which mental health records may be disclosed, does not establish an affirmative duty to disclose otherwise privileged communications but merely excuses a clinician from liability if disclosure is made in a narrow range of

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133. 740 ILL. COMP. STAT. 110/11(viii) (using the word “recipient” to refer to a patient receiving mental health services).

134. 740 ILL. COMP. STAT. 110/11 (2002 & Supp. 2008) (emphasis added).

135. *E.g.*, *Tedrick v. Cmty. Res. Ctr., Inc.*, 869 N.E.2d 421, 426 (Ill. App. Ct. 2007) (“The present action is predicated on the duties of the physicians . . .”); *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1345 (Ill. App. Ct. 1989) (“The plaintiff has failed to . . . establish the element of the duty . . .”).

136. 740 ILL. COMP. STAT. 110/11(viii).

137. *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 399 (Ill. 1997) (“[A] plaintiff cannot maintain a[n] . . . action absent a direct physician-patient relationship between [the] doctor and the plaintiff or a special relationship . . . between the patient and the plaintiff.”); *see also Tedrick*, 869 N.E.2d at 430; *Doe ex rel. Tanya S. v. N. Cent. Behavioral Health Sys., Inc.*, 816 N.E.2d 4, 10 (Ill. App. Ct. 2004) (Holdridge, J., concurring); *Eckhardt*, 534 N.E.2d. at 1344.

138. *Tedrick*, 869 N.E.2d at 426; *Tanya S.*, 816 N.E.2d at 9; *Eckhardt*, 534 N.E.2d at 1345.

circumstances specified in the statute.<sup>139</sup> Notwithstanding the passively permissive wording of the Confidentiality Act,<sup>140</sup> Illinois courts have imposed an affirmative duty to disclose. For example, in a case involving disclosure of psychiatric records pursuant to a civil commitment hearing, the court correctly cited the Confidentiality Act as providing that “[r]ecords and communications may be disclosed”<sup>141</sup> but went on to note that “[u]nder this provision, [the mental health professional] had a *duty to report* [his patient’s] activities.”<sup>142</sup> The Confidentiality Act is not intended to create a duty in mental health professionals to disclose otherwise protected information; its goal is to maintain the “level of privacy necessary to encourage other people to seek mental health treatment.”<sup>143</sup> Therefore, reliance on the Confidentiality Act as the basis for establishing any affirmative disclosure duty is misplaced.

## 2. *Who Are the Protected Parties?*

The Confidentiality Act allows disclosure of psychiatric records or communications if necessary to protect “a specific individual against whom a recipient has made a specific threat of violence,”<sup>144</sup> but only where either of two types of special relationships exist: “a therapist-recipient relationship or a special recipient-individual relationship.”<sup>145</sup> This implies a three-tiered analysis: first, that the threat must be specific; second, that it must be directed toward an identified individual; and third, if those requirements are met, that one of the two types of special relationship exists.<sup>146</sup> Historically, “[t]he fact that the actor realizes or should realize that action on his part is necessary for another’s aid or protection does not of itself impose upon him a duty to take such action.”<sup>147</sup> The existence of a special relationship between the actor and the third party represents an exception to the principle that there is no duty to come to the aid of others.<sup>148</sup> The wording of the Confidentiality Act is logically problematic, however, because it seems to allow disclosure in order to safeguard the welfare of *any person* threatened by a patient under a clinician’s care; but the mention of the two varieties of

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139. 740 ILL. COMP. STAT. 110/11(i)-(xii) (2002 & Supp. 2008).

140. 740 ILL. COMP. STAT. 110/11 (2002 & Supp. 2008) (“Records and communications may be disclosed . . .”).

141. *Magnus v. Dep’t of Prof’l Regulation*, 835 N.E.2d 77, 86 (Ill. App. Ct. 2005) (citing 740 ILCS 110/11 (West 2002)).

142. *Id.* (emphasis added).

143. *Doe v. Ill. Dep’t of Prof’l Regulation*, 793 N.E.2d 119, 126 (Ill. App. Ct. 2003).

144. 740 ILL. COMP. STAT. 110/11(viii).

145. *Id.*

146. *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1344 (Ill. App. Ct. 1989).

147. RESTATEMENT (SECOND) OF TORTS § 314 (1965).

148. *Id.* § 314A.

special relationships has been interpreted by Illinois courts as imposing limitations on the class of protected parties rather than as triggering an exception to the “no duty to aid” rule.

Regarding the “special recipient-individual relationship,”<sup>149</sup> Illinois courts have held that a clinician’s duty is triggered if it is necessary to protect an individual with whom the patient himself has a special relationship.<sup>150</sup> A special relationship has been defined as one in which the parties are intimately related.<sup>151</sup> For example, a protective duty existed between a physician and the unborn child of his patient for harm resulting from a blood transfusion<sup>152</sup> and between a physician and a patient’s wife when the patient carried out the threat to kill his wife.<sup>153</sup> The other category of relationship noted in the Confidentiality Act, the “therapist-recipient relationship,” seems to refer simply to the relationship between the clinician and the patient. However, Illinois courts interpret this phrase as permitting disclosure only if there is a physician-patient relationship *between the doctor and the target of the threat*.<sup>154</sup>

This interpretation was established in a case involving injury to an automobile passenger, James Kirk, when the driver lost control of his car, allegedly due to the effects of prescription medication; the passenger’s claims against the prescribing doctor failed because there was no relationship between the doctor and the passenger and, therefore, no protective duty owed to the passenger.<sup>155</sup> Another court applied this principle in an action brought by the administrator of the estate of a man killed by his wife against the wife’s psychiatrist.<sup>156</sup> The court noted that by “[a]pplying the duty analysis set forth in *Kirk* to the facts of this case, it is clear that plaintiff’s decedent had no direct physician-patient relationship with defendant.”<sup>157</sup> Although it is true that neither the automobile passenger nor the murdered husband had a physician-patient relationship with the respective doctors, there was no need to analyze the facts of either case based on the presence or absence of a doctor-patient relationship. That is, since neither case involved a specific threat by the patient against an identified individ-

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149. 740 ILL. COMP. STAT. 110/11(viii).

150. *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 399 (Ill. 1997); *Eckhardt*, 534 N.E.2d at 1339.

151. *Renslow v. Mennonite Hosp.*, 367 N.E.2d 1250, 1255 (Ill. 1977).

152. *Id.*

153. *Tedrick v. Cmty. Res. Ctr., Inc.*, 869 N.E.2d 421, 430-31 (Ill. App. Ct. 2007).

154. *Kirk*, 513 N.E.2d at 399 (emphasis added); *Eckhardt*, 534 N.E.2d at 1344.

155. *Kirk*, 513 N.E.2d at 399.

156. *Eckhardt*, 534 N.E.2d 1339.

157. *Id.* at 1346 (Reinhard, J., concurring).

ual, the analysis should have stopped when these threshold requirements were not met.<sup>158</sup>

Although the distinctions may seem benign as applied in these cases, using either the “special recipient-individual relationship” or the “therapist-recipient relationship” as determinative of the existence of a protective duty to threatened parties may lead to unintended negative outcomes in other situations. Specifically, under the Illinois standard, no protective duty exists if a patient admits an intent to harm a readily identifiable third party who has no relationship with the therapist or with the patient himself.<sup>159</sup> Instead, the duty exists only if the patient threatens to harm another person who also has a physician-patient relationship with that same clinician or who is intimately related to the patient.<sup>160</sup> Concerned about this limitation on the class of protected parties in Illinois, one judge pointed out the belief by the third district that Illinois would adopt *Tarasoff*'s reasoning and extend the protective duty to any foreseeable third parties.<sup>161</sup> Specifically, Justice Holdridge stated, “I agree with the standard articulated in *Tarasoff* . . . ; however, the Illinois Supreme Court has declined to adopt it.”<sup>162</sup> The failure by Illinois courts to adopt the *Tarasoff* standard leaves unprotected all potential victims of violent psychiatric patients who are not themselves patients of the therapist who heard the threat or who are not intimately related to the patient making the threat. This is a direct contradiction of the protection established by the *Tarasoff* court. That is, the court specifically noted that it was an unnecessary restriction to limit the duty to situations in which there existed “a special relationship both to the victim and to the person whose conduct created the danger.”<sup>163</sup> Instead, the court noted that “the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient’s illness.”<sup>164</sup> Therefore, if *Tarasoff* had been judged based on the Illinois special relationship criteria, the court would have found no duty for the physicians to protect Tatiana Tarasoff since she lacked both the requisite intimate relationship with Poddar and the “direct physician-patient relationship between the doctor and [the] plaintiff.”<sup>165</sup> Furthermore, the Illinois

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158. Although the decision in *Eckhardt* was ultimately based on the lack of a clear threat against an identified party, much discussion was devoted to the “special relationship” aspect of the test. See *Eckhardt*, 534 N.E.2d 1339.

159. See *Kirk*, 513 N.E.2d at 399; *Id.* at 1344.

160. See *Eckhardt*, 534 N.E.2d at 1346 (Reinhard, J., concurring).

161. *Doe ex rel. Tanya S. v. N. Cent. Behavioral Health Sys., Inc.*, 816 N.E.2d 4, 10 (Ill. App. Ct. 2004) (Holdridge, J., concurring) (referring to the court’s belief as expressed in *Novak v. Rathnam*, 505 N.E.2d 773, 775 (Ill. App. Ct. 1987)).

162. *Id.* at 10.

163. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 344 (Cal. 1976).

164. *Id.*

165. *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 399 (Ill. 1997).

analysis would have forced the *Viviano*<sup>166</sup> court to find Dr. Stewart liable for breach of confidentiality based on his disclosure to Judge Wicker because the judge had neither an intimate relationship with the violent patient nor a doctor-patient relationship with Dr. Stewart.

More disturbing than hypothetical negative outcomes is the result in a recent case in which parents of sexually abused children brought a negligence action against the mental health clinic that treated the perpetrator, a minor who lived in the same apartment complex as the victims.<sup>167</sup> The clinic did not alert parents of neighboring children about the perpetrator's violent tendencies, despite his admission that he had previously been abusing other children in the apartment building.<sup>168</sup> In affirming the lower court's dismissal of the claim against the clinic, the court noted, "[A]lthough David made specific threats of violence, and the violence was directed against a readily identifiable set of victims, there was no direct physician-patient relationship between the Clinic and the victims, nor was there a special relationship between David and the victims."<sup>169</sup> If Illinois had adopted the *Tarasoff* standard extending protection to any readily identifiable third parties, this standard would have "warrant[ed] a reversal in the instant case."<sup>170</sup> Unfortunately, the lack of this wider standard of protection left the abused children without legal recourse.

### 3. *What Protective Measures Fulfill the Duty?*

Even more serious than the confusion about the existence of an affirmative duty and the lack of clarity about which parties are protected is the frequent mischaracterization of the duty as a "duty to warn."<sup>171</sup> The Confidentiality Act allows disclosure of confidential information by a therapist when "disclosure is necessary to warn *or protect*."<sup>172</sup> The importance of distinguishing between warning and protection is related to the particularly crucial nature of patient confidentiality within the mental health treatment setting and the especially deleterious consequences of unnecessarily revealing a patient's psychiatric problems.<sup>173</sup> It must be noted that issuing a warning to the intended victim of a violent patient is only one way to protect the threatened party; numerous alternative measures exist that would still safeguard the threatened party but would also allow patient con-

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166. *Viviano v. Moan*, 93-1368 (La. App. 4 Cir. 11/17/94); 645 So. 2d 1301.

167. *Tanya S.*, 816 N.E.2d 4.

168. *Id.* at 6.

169. *Id.* at 9.

170. *Id.* at 10 (Holdridge, J., concurring).

171. *E.g.*, *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1345 (Ill. App. Ct. 1989).

172. 740 ILL. COMP. STAT. 110/11(viii) (2002 & Supp. 2008) (emphasis added).

173. *See* discussion *supra* Part III.A.

fidentiality to be maintained.<sup>174</sup> Therefore, any duty owed by mental health professionals to the public is better characterized as a “duty to protect,” with warnings being viewed as only one among many methods of fulfilling the protective duty.

Despite the distinction between warnings and other protective measures and the separate references to warning and protection contained in the Confidentiality Act, Illinois courts repeatedly mischaracterize the clinician’s duty as a “duty to warn,” ignoring the fact that issuing a warning is not the only way that protection of the public may be achieved. For example, many Illinois courts specifically cite *Tarasoff* and discuss the importance of the case in establishing a psychotherapist’s duty toward third parties but then erroneously quote *Tarasoff* as establishing a “duty to warn.”<sup>175</sup> The *Tarasoff* court was careful to describe the duty not as a duty to warn but as “a duty to exercise reasonable care to protect the foreseeable victim.”<sup>176</sup> Also of note is the fact that the *Tarasoff* court does not hold that warning the would-be victim is the only way to fulfill the duty but instead explicitly asserts that “discharge of this duty of due care will necessarily vary with the facts of each case . . . [and] must be measured against . . . reasonable care under the circumstances.”<sup>177</sup> Although this distinction was made too late to save Tarasoff from a violent death at the hands of Poddar, the importance of the difference between warning and protection is illustrated by the court’s observation that after confidentiality was breached and police were called, “Poddar broke off all contact with the hospital staff and discontinued psychotherapy. From those facts, one could reasonably infer that defendants’ actions led Poddar to halt treatment which, if carried through, might have led him to abandon his plan to kill [Tarasoff].”<sup>178</sup>

The likelihood that breaches of confidentiality will cause patients to discontinue treatment that might otherwise help them to control their violent impulses underscores the importance of using alternative therapeutic modes of dealing with patient violence—breaching confidentiality by warn-

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174. For a complete discussion of alternative protective measures, see *infra* Part V.C.3.

175. See *Tanya S.*, 816 N.E.2d at 10 (Holdridge, J., concurring) (quoting the belief by the *Novak* court that Illinois should adopt *Tarasoff*’s “duty on therapists to warn foreseeable third parties”); *Eckhardt*, 534 N.E.2d at 1342 (“*Tarasoff* dealt with the duty to warn.”); *Novak v. Rathnam*, 505 N.E.2d 773, 775 (Ill. App. Ct. 1987) (“We note that *Tarasoff* dealt with the duty to warn . . . [and] we believe Illinois would adopt *Tarasoff*’s affirmative duty . . . to warn.”).

176. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345 (Cal. 1976) (emphasis added).

177. *Id.*

178. *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553, 559 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976).

ing police or potential victims is only a last resort.<sup>179</sup> It is apparent that Illinois courts do not draw this important distinction. That is, the Illinois Supreme Court has noted its adoption of the *Restatement of Torts*'s analysis of the duty to protect the public from criminal attacks.<sup>180</sup> The *Restatement* imposes liability on any party who "render[s] services to another . . . necessary for the protection of a third person . . . [and who fails to] exercise reasonable care to protect his undertaking."<sup>181</sup>

In applying the *Restatement*'s language to a case in which a psychiatric patient carried out his threat to kill his wife,<sup>182</sup> the court interchanged the ideas of protection and warning, failing to note the different outcomes that might have been achieved under both alternatives. Specifically, after discharge from inpatient psychiatric hospitalization, a patient presented at an outpatient follow-up appointment claiming that he was going to kill his wife and asking to be re-admitted to inpatient treatment.<sup>183</sup> When the patient suddenly changed his mind about hospitalization and asked to be allowed to return home to his wife, clinic personnel allowed him to leave and simply referred the patient to his family physician, who advised the patient to seek psychiatric care.<sup>184</sup> Three days later, the patient strangled his wife to death and attempted suicide by overdose.<sup>185</sup> Although the patient survived the suicide attempt, he required amputation of both legs below the knee "because of the way his body was positioned during the period following his ingestion of the medication."<sup>186</sup> In its analysis of any duty owed by clinic personnel to the deceased wife, the court used the language of the *Restatement*, noting that the wife was harmed by "the defendants' failure to exercise reasonable care in the performance of their undertakings,"<sup>187</sup> but it mischaracterized this duty of care as imposing "a duty to warn [the wife] about the violent propensities of her husband."<sup>188</sup> Although the court found the outpatient clinic negligent, providing damages to the estate of the deceased wife and her children, it is important to note the difference in potential outcomes in the absence of negligence depending on whether the duty was for the clinic to warn the wife or to protect her. The court specifically characterized the duty in this case as a duty to warn the wife about her husband's

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179. GUTHEIL & APPELBAUM, *supra* note 48, at 12 ("Other measures can be taken without breaching confidentiality and should ordinarily be considered first.")

180. Pippin v. Chi. Hous. Auth., 399 N.E.2d 596, 600 (Ill. 1979).

181. RESTATEMENT (SECOND) OF TORTS § 324A (1965).

182. Tedrick v. Cmty. Res. Ctr., Inc., 869 N.E.2d 421 (Ill. App. Ct. 2007).

183. *Id.* at 424.

184. *Id.* at 425.

185. *Id.*

186. *Id.*

187. *Id.* at 429.

188. *Tedrick*, 869 N.E.2d at 429.

violent impulses.<sup>189</sup> Since the wife was already aware of her husband's threats against her and had, in fact, expressed her concern to clinic staff over her husband's moods and behavior,<sup>190</sup> there is no indication that warning her of violent impulses about which she was already aware would have saved her life. However, if the duty was applied consistent with the *Restatement's* wording as a duty to "exercise reasonable care to protect,"<sup>191</sup> measures other than warnings would have been considered, especially where a warning would be ineffective in light of the would-be victim's prior awareness of the threats against her life. One protective measure that might have fulfilled a duty to protect is involuntarily hospitalization. This option is possible when a patient's violent threats are the direct result of a mental illness<sup>192</sup> and it is expected that treatment of the underlying mental illness will alleviate the patient's violent impulses. If the patient had been hospitalized and his suicidal and homicidal impulses subsided as his psychiatric disorder was effectively treated, the outcome would certainly have been better for his wife, since she would not have been killed. Furthermore, it would have been better for the patient as well, since the protective environment of the hospital would likely have prevented his suicide attempt, thus saving the patient from below-the-knee amputations. In addition, hospitalization also would have prevented the murder of his wife and the resulting legal charges and penal or psychiatric incarceration, as well as prevented the possible emotional repercussions of his actions.

Extending this reasoning to its logical conclusion, if Illinois courts correctly characterize the duty as a "duty to protect," congruent with the language of the Confidentiality Act, the *Tarasoff* decision, and the *Restatement*—all sources cited by Illinois courts in their analyses—protective measures other than warnings would also fulfill the protective duty and would provide the possibility of positive outcomes impossible with warnings alone.

#### B. MENTAL HEALTH CODE

The Mental Health and Developmental Disabilities Code (Mental Health Code) releases physicians, clinical psychologists, and qualified examiners from liability for "failure to warn of and protect from a recipient's threatened or actual violent behavior except where the recipient has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victims."<sup>193</sup> The practitioner is exempt from

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189. *Id.*

190. *Id.* at 425.

191. RESTATEMENT (SECOND) OF TORTS § 324A (1965).

192. *Estate of Johnson v. Condell Mem'l Hosp.*, 520 N.E.2d 37, 40 (Ill. 1988).

193. 405 ILL. COMP. STAT. 5/6-103(b) (2005).

liability after making a good-faith attempt to fulfill the duty via “a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the recipient.”<sup>194</sup>

The wording of the Mental Health Code is less problematic than that of the Confidentiality Act in regard to the creation of an affirmative duty, the classification of the protected parties, and the fulfillment of the protective duty. First, although neither the Confidentiality Act nor the Mental Health Code specifically and clearly establish an affirmative duty to protect the public from violent psychiatric patients, the language of the Mental Health Code stating that “there shall be no liability . . . [for] failure to [warn of and] protect . . . except where . . .”<sup>195</sup> seems more affirmative than the passive language of the Confidentiality Act, which reads, “[r]ecords . . . may be disclosed.”<sup>196</sup> That is, “no liability . . . except where . . .” creates the inference that there *is* liability if the specified conditions are met. Therefore, the Mental Health Code would have provided a logical basis upon which Illinois courts could have relied in their imposition of an affirmative protective duty.<sup>197</sup>

With regard to defining the protected parties, the Mental Health Code protects any “reasonably identifiable victim or victims . . . [against whom a patient has made] a serious threat of physical violence.”<sup>198</sup> This language is consistent with the language of *Tarasoff*, which is frequently cited by Illinois courts<sup>199</sup> and which requires protection by the clinician “not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient.”<sup>200</sup> If the court in the *Tanya S.* case<sup>201</sup> had relied on the expansive protection provided by the Mental Health Code rather than on the restricted protection offered by the Confidentiality Act,<sup>202</sup> the sexually abused children, who were readily identifiable and specifically threatened,<sup>203</sup> would have been provided the legal recourse denied to them under the Confidentiality Act.

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194. *Id.* at 5/6-103(c).

195. *Id.* at 5/6-103(b).

196. 740 ILL. COMP. STAT. 110/11 (2002 & Supp. 2008).

197. *E.g.*, *Magnus v. Dep’t of Prof’l Regulation*, 835 N.E.2d 77 (Ill. App. Ct. 2005).

198. 740 ILL. COMP. STAT. 110/11(viii).

199. *See, e.g.*, *Doe ex rel. Tanya S. v. N. Cent. Behavioral Health Sys., Inc.*, 816 N.E.2d 4, 10 (Ill. App. Ct. 2004) (Holdridge, J., concurring) (referring to the duty owed to “foreseeable third parties”); *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1342 (Ill. App. Ct. 1989) (referring to the duty owed to “foreseeable third parties”); *Novak v. Rathnam*, 505 N.E.2d 773, 775 (Ill. App. Ct. 1987) (noting the duty owed to “a readily identifiable victim”).

200. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 344 (Cal. 1976).

201. *Tanya S.*, 816 N.E.2d 4.

202. *See* discussion *supra* Part V.A.2.

203. *Tanya S.*, 816 N.E.2d at 9.

Regarding the specific methods for fulfilling the protective duty, the Mental Health Code is preferable to the Confidentiality Act in this regard as well. That is, although the Confidentiality Act permits disclosures when necessary to “warn or protect,” it gives no examples of what protective measures, other than warning, might fulfill the duty.<sup>204</sup> The Mental Health Code, on the other hand, permits disclosures when necessary to “warn of and protect”<sup>205</sup> and elaborates on methods of discharging the duty, including “making a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the recipient.”<sup>206</sup> Although there are more protective measures available to clinicians besides warning the intended victim and hospitalizing a violent patient,<sup>207</sup> the Mental Health Code introduces some guidance as to alternatives to breaches of confidentiality.<sup>208</sup> It is important to note that if the Mental Health Code had been consistently cited by Illinois courts in their descriptions of a mental health professional’s duty, the *Tedrick*<sup>209</sup> case may have had a more favorable outcome for all parties involved. Specifically, as previously discussed, involuntary hospitalization of the patient in *Tedrick* would likely have provided the protective environment necessary to prevent the patient from acting on his violent compulsions and murdering his wife, as well as to prevent him from the suicide attempt that ultimately caused the amputation of his legs.<sup>210</sup>

It is disturbing to note that despite the more favorable results that could be achieved by application of the Mental Health Code, Illinois courts, inexplicably, have neither cited nor applied this statute in their analyses of situations involving a clinician’s duty to protect the public.<sup>211</sup> In fact, the

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204. 740 ILL. COMP. STAT. 110/11(viii) (2002 & Supp. 2008).

205. 405 ILL. COMP. STAT. 5/6-103(b) (2005).

206. *Id.* at 5/6-103(c).

207. For a complete discussion of the possible hierarchy of protective measures, see *infra* Part V.C.3.

208. 405 ILL. COMP. STAT. 5/6-103(c) (2005) (noting that a reasonable effort to hospitalize the patient is one method of fulfilling the clinician’s duty).

209. *Tedrick v. Cmty. Res. Ctr., Inc.*, 869 N.E.2d 421 (Ill. App. Ct. 2007).

210. See discussion *supra* Part V.A.3.

211. See *Magnus v. Dep’t of Prof’l Regulation*, 835 N.E.2d 77, 86 (Ill. App. Ct. 2005) (citing the Confidentiality Act and not the Mental Health Code in situations involving protective duties); *Doe v. Ill. Dep’t of Prof’l Regulation*, 793 N.E.2d 119, 126 (Ill. App. Ct. 2003) (citing the Confidentiality Act and not the Mental Health Code in situations involving protective duties). For cases citing only *Tarasoff*, other case law, or the *Restatement of Torts* in situations involving protective duties, also see *Renslow v. Mennonite Hospital*, 367 N.E.2d 1250 (Ill. 1977); *Tedrick v. Community Resource Center, Inc.*, 869 N.E.2d 421 (Ill. App. Ct. 2007); *Doe ex rel. Tanya S. v. North Central Behavioral Health Systems, Inc.*, 816 N.E.2d 4 (Ill. App. Ct. 2004); *Charleston v. Larson*, 696 N.E.2d 793 (Ill. App. Ct. 1998); *Eckhardt v. Kirts*, 534 N.E.2d 1339 (Ill. App. Ct. 1989); and *Novak v. Rathnam*, 505 N.E.2d 773 (Ill. App. Ct. 1987).

only case that cites this section of the Mental Health Code at all cites subsection (a), which releases a clinician from liability for statements made on a certificate for involuntary admission if such statements were made in good faith.<sup>212</sup> However, this court's reference to the Mental Health Code was not made for the purpose of clarifying the heretofore convoluted protective duty in the setting of threats to third parties but was made only for the purpose of denying a party's request to raise the Code as part of his argument on appeal, since he had not raised it in his argument at trial.<sup>213</sup>

### C. SUGGESTED IMPROVEMENTS TO ILLINOIS LAW

Illinois courts could eliminate the three major problems created by their interpretation of "duty to protect" cases simply by basing their analyses on the wording of the Mental Health Code rather than on the Confidentiality Act with only slight amendments to the language of the Mental Health Code. With these changes in place, Illinois could more effectively strike a balance between a mental health professional's duty to maintain patient confidentiality and the conflicting duty to protect third parties from a patient's violent impulses.

#### 1. Clarification of the Duty

Although the language of the Mental Health Code, "[t]here shall be no liability on the part of . . . [a] physician, clinical psychologist, or qualified examiner . . . except where . . .,"<sup>214</sup> is more indicative of an affirmative duty than is the wording of the Confidentiality Act, "[r]ecords . . . may be disclosed,"<sup>215</sup> the Mental Health Code could be clarified further and strengthened with only a slight modification. That is, changing the law to read, "A physician, clinical psychologist or qualified examiner shall protect reasonably identifiable victims from recipients where there has been a serious and credible threat of physical violence," leaves little doubt as to the existence of an affirmative duty to act in the specified circumstances. This change to more affirmative wording is consistent with the American Medical Association's *Code of Medical Ethics*, which states, "'A physician shall respect the rights of patients . . . ' [But] [w]here a patient threatens to inflict serious bodily harm to another . . . , the physician *should* take reasonable precautions for the protection of the intended victim."<sup>216</sup>

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212. Arthur v. Lutheran Gen. Hosp., 692 N.E.2d 1238, 1241 (Ill. App. Ct. 1998).

213. *Id.*

214. 405 ILL. COMP. STAT. 5/6-103(b) (2005).

215. 740 ILL. COMP. STAT. 110/11 (2002 & Supp. 2008).

216. Stewart, *supra* note 15 (emphasis added) (quoting AM. MED. ASS'N, CODE OF MEDICAL ETHICS pmbl at xii, § 5.05, at 60-61 (2002-2003 ed. 2002)).

Furthermore, it is crucial to make clear that the duty owed by mental health providers to threatened members of the public is to protect them, not necessarily to warn them.<sup>217</sup> Although a warning might be appropriate in some circumstances, as was the case in *Viviano*<sup>218</sup> where the physician had already exhausted all other protective measures, warning is only one way of fulfilling the protective duty. However, warning should never be the first protective measure considered because breaches of confidentiality carry with them the potential for damage to the therapeutic trust that is especially vital within the mental health treatment setting.<sup>219</sup> Therefore, the current Mental Health Code language, “to warn of and protect from,”<sup>220</sup> should be amended to remove references to warning and to state only, “to protect from.”

## 2. *Expansion of Protected Parties*

The language of the Confidentiality Act, “where there exists a therapist-recipient relationship or a special recipient-individual relationship,”<sup>221</sup> has been interpreted by Illinois courts as narrowing the class of protected parties, resulting in a complete lack of protection or legal recourse for any threatened parties who do not fall into one of the two narrow categories.<sup>222</sup> This represents one important reason for restricting use of the Confidentiality Act to its intended area, protection of patient psychiatric records,<sup>223</sup> and not using it as the basis for analyzing cases involving protection of the public from violent patients. Instead, protection should be extended to any reasonably identifiable member of the public who is seriously threatened. This can be accomplished by analyzing protective duty cases with reference to the language of the Mental Health Code, which bases the protective duty on the existence of “a serious threat of physical violence against a reasonably identifiable victim or victims.”<sup>224</sup>

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217. For a discussion of the distinction between protection and warning, and the different outcomes that may be achieved under each option, see *supra* Part V.A.3.

218. *Viviano v. Moan*, 93-1368 (La. App. 4 Cir. 11/17/94); 645 So. 2d 1301.

219. See discussion *supra* Part III.A.1-2.

220. 405 ILL. COMP. STAT. 5/6-103(b) (2005).

221. 740 ILL. COMP. STAT. 110/11(viii) (2002 & Supp. 2008).

222. *Doe ex rel. Tanya S. v. N. Cent. Behavioral Health Sys., Inc.*, 816 N.E.2d 4, 9 (Ill. App. Ct. 2004) (holding that the defendant was not liable for failing to protect sexually abused children despite a specific threat of violence against a readily identifiable set of victims when there was “no direct physician-patient relationship . . . nor was there a special relationship between [the abuser] and the victims”).

223. *Doe ex rel. Tanya S. v. Ill. Dep’t of Prof’l Regulation*, 793 N.E.2d 119, 126 (Ill. App. Ct. 2003) (explaining that the goal of the Confidentiality Act is to insure the level of privacy that will encourage patients to seek mental health treatment).

224. 405 ILL. COMP. STAT. 5/6-103(b).

Judicial interpretation based on the Mental Health Code language, which extends protection to any reasonably identifiable third party, is consistent with the protection extended by *Tarasoff*,<sup>225</sup> which is frequently cited by Illinois courts as the basis for a clinician's protective duty.<sup>226</sup> Furthermore, the Mental Health Code language is similar to the language of statutes in other states,<sup>227</sup> whose courts interpret such statutes as protecting reasonably identifiable parties.<sup>228</sup> Use of the Mental Health Code for judicial interpretation of protective duty cases would eliminate the unnecessarily restricted class of protected parties imposed by Illinois courts based on their reference to the Confidentiality Act.

### 3. *Hierarchy of Protective Measures*

Because of the particular importance of maintaining patient confidentiality within the psychiatric treatment setting and the potential for adverse consequences when confidentiality is breached,<sup>229</sup> it is crucial that mental health providers understand that their protective duty to the public can be fulfilled in various ways without breaching confidentiality. Although there are circumstances in which it is appropriate to warn a potential victim of a patient's threat, "the duty to protect is not synonymous with a duty to warn. Other measures can be taken without breaching confidentiality and should ordinarily be considered first . . . ."<sup>230</sup> The Mental Health Code already contains language indicative of the fact that protective measures other than warnings will satisfy a clinician's duty to protect the public.<sup>231</sup> This language could be expanded by including additional alternative measures in a hierarchical format with issuance of a warning being seen as a last resort.

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

226. *See, e.g., Tanya S.*, 816 N.E.2d at 10 (Holdridge, J., concurring); *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1342 (Ill. App. Ct. 1989); *Novak v. Rathnam*, 505 N.E.2d 773, 775 (Ill. App. Ct. 1987). All of the foregoing cases cite *Tarasoff* as the basis for extending protection to reasonably identifiable parties.

227. *See, e.g., CAL. CIV. CODE* § 43.92 (West 2007); *FLA. STAT. ANN.* § 456.059 (West 2007); *KY. REV. STAT. ANN.* § 202A.400 (LexisNexis 2007); *MICH. COMP. LAWS ANN.* § 330.1946 (West 1999); *OHIO REV. CODE ANN.* § 2305.51 (LexisNexis 2005). All of the foregoing statutes protect clearly or reasonably identifiable parties.

228. *See, e.g., Mavroudis v. Super. Ct.*, 162 Cal. Rptr. 724, 730 (Cal. Ct. App. 1980); *Boynton v. Burglass*, 590 So. 2d 446, 450 (Fla. Dist. Ct. App. 1991); *Evans v. Morehead Clinic*, 749 S.W.2d 696, 699 (Ky. Ct. App. 1988); *Paul v. Plymouth Gen. Hosp.*, 408 N.W.2d 492, 495 (Mich. Ct. App. 1987); *Estates of Morgan v. Fairfield Family Counseling Ctr.*, 673 N.E.2d 1311, 1330 (Ohio 1997).

229. *See discussion supra* Part III.A.

230. *GUTHEIL & APPELBAUM, supra* note 48, at 12.

231. 405 ILL. COMP. STAT. 5/6-103(c) (2005) ("Any duty . . . shall be discharged by . . . making a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the recipient.").

The first protective step on the proposed hierarchy involves measures that may be taken as part of the patient's current treatment, such as "changing the nature of therapy to focus on the feared violence, adding or changing medications, [or] expanding therapy to include a threatened intimate of the patient's."<sup>232</sup> These initial protective steps will allow the clinician to exercise reasonable professional judgment in assessing the seriousness of the patient's violent impulses and determining the effectiveness of continued outpatient therapy in addressing the patient's feelings.<sup>233</sup>

The second suggested step involves use of the therapeutic alliance to form an agreement between therapists and patients under which patients agree to comply "in order to protect themselves rather than those at risk."<sup>234</sup> That is, patients can be reminded of the legal consequences of acting on violent impulses and of the advantages in refraining from doing so; within the setting of trust in the therapist, patients may agree to allow the therapist to implement specific protective measures, such as supervision by a trusted person or more frequent contact with the therapist.<sup>235</sup>

The third recommended step involves the use of crisis counseling or assertive community treatment programs available through some outpatient treatment clinics<sup>236</sup> or a short term observational detention, such as the seventy-two-hour program initially sought for the potentially violent patient in *Tarasoff*.<sup>237</sup> Since the records pertaining to these services are subject to the same confidentiality requirements as all other psychiatric records, the patient's confidentiality would be safeguarded while providing the closer monitoring necessary to prevent the patient from acting on any violent impulses.

The fourth step involves voluntary hospitalization of the patient.<sup>238</sup> This measure is possible when the patient consents to the clinician's recommendation for inpatient treatment, so it is a natural result of the establishment of therapeutic trust necessary for successful psychiatric treatment.<sup>239</sup> The protective environment of the inpatient setting safeguards the would-be victim while at the same time protecting the patient from the consequences of his violent impulses.

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232. GUTHEIL & APPELBAUM, *supra* note 48, at 13.

233. See *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345 (Cal. 1976) ("[T]he therapist is free to exercise his or her own best judgment without liability . . .").

234. Kipnis, *supra* note 17.

235. *Id.* (referring to various monitoring interventions and protective measures patients might agree to accept within the therapeutic setting).

236. See Janet Wattles Center: Treating Mental Illness in Rockford, <http://www.janetwattles.org/adult.asp> (last visited Apr. 19, 2009), for an example of one provider's services.

237. *Tarasoff*, 551 P.2d at 341.

238. See GUTHEIL & APPELBAUM, *supra* note 48, at 13.

239. See discussion *supra* Part III.A.

The fifth suggestion is to involuntarily hospitalize the patient.<sup>240</sup> Although this represents a restriction of the patient's liberty since it must be done against the patient's wishes, there are safeguards in place to prevent unnecessary hospitalization. For example, when a patient is taken to a hospital emergency department for evaluation for possible psychiatric hospitalization, a petition is completed setting forth detailed reasons why hospitalization is being sought. The petition must be accompanied by a certificate completed by the emergency department physician or qualified mental health professional validating the necessity of involuntary hospitalization.<sup>241</sup> Furthermore, the patient must be "suffering from a mental illness . . . that . . . may . . . cause him to inflict serious physical harm upon himself or another."<sup>242</sup> If these criteria are met, the patient may be transferred from the emergency department to a psychiatric hospital. Upon admission, a second validating certificate must be completed by a licensed psychiatrist within twenty-four hours, or the patient must be released.<sup>243</sup> Hospitalizing a potentially violent patient can be viewed as restricting the patient's freedom to the extent necessary to protect the intended victim from the patient's violent urges and to protect the patient from the results of his impulsive actions.

Finally, if other protective measures have been tried and exhausted or if hospitalization is impossible, as was the case in *Viviano* where the patient's violent threats toward the judge were not the result of a mental illness but were simply the result of his uncontrolled anger at her,<sup>244</sup> the victim should be warned and/or law enforcement personnel should be notified.

## VI. CONCLUSION

Although patient confidentiality is the cornerstone of physician-patient trust in all branches of medicine, it is particularly crucial in psychiatry because of the stigma associated with mental illnesses, the sensitive and potentially embarrassing nature of the topics discussed in the mental health treatment setting, and the possible adverse consequences of unnecessary breaches of confidentiality. The duty of physicians and other mental health professionals to maintain confidentiality is not absolute, however, and there are times when this duty conflicts with the equally compelling duty to protect members of the public from potential harm by patients. The rights of patients to confidentiality must be weighed against the rights of the public to be free from serious injury or endangerment. Since the 1976 landmark

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240. GUTHEIL & APPELBAUM, *supra* note 48, at 13.

241. Estate of Johnson v. Condell Mem'l Hosp., 520 N.E.2d 37, 40 (Ill. 1988).

242. *Id.*

243. *Id.*

244. Viviano v. Moan, 93-1368, p. 8 (La. App. 4 Cir. 11/17/94); 645 So. 2d 1301, 1304.

*Tarasoff* case, in which the California Supreme Court held that mental health professionals have a duty to protect readily identifiable victims from credible threats at the hands of their patients,<sup>245</sup> many states have codified a similar duty and have cited *Tarasoff* as the basis for judicial interpretation of similar cases. Interpretation of the Illinois Mental Health and Developmental Disabilities Confidentiality Act has resulted in confusion about the existence of an affirmative duty, an overly restricted definition of the class of protected parties, and the potential for unnecessary breaches of confidentiality based on lack of specificity about how the protective duty may be fulfilled. These problems could be minimized or alleviated if courts interpreted “duty to protect” cases via the Illinois Mental Health Code instead of via the Confidentiality Act, with only minor modification to the Mental Health Code being necessary. If Illinois makes the changes necessary to clarify the mental health professional’s protective duty and to reinforce the principle that the duty to protect is not limited to the duty to warn, these steps may bring Illinois courts closer to achievement of the delicate balance between patient confidentiality and public protection. It is this scenario that will produce the best possible outcome for patients, mental health providers, and the public.

MARY I. WOOD\*

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

\* J.D. Candidate, May 2009, Northern Illinois University College of Law; B.A., Psychology, summa cum laude, Northern Illinois University, 2006. I would like to thank my husband, Bill, for being my most steadfast and enthusiastic fan (whether I merited such admiration or not), and my daughter, Sarah, and son, Ben, whose pride in me has sustained me through the many moments when I doubted my own ability to continue—seeing the young adults that you both have become remains my proudest accomplishment. I also want to express my gratitude to the *Northern Illinois University Law Review* editors and staff who patiently and diligently caught and corrected my Bluebook errors. Finally, I must thank my Notes and Comments Editor, Jeff Powell, whose persistence in asking me the “hard questions” throughout the entire production process helped me to shape this comment into something that was ultimately interesting and relevant enough to warrant reading.