
Arkansas, Meet *Tarasoff*: The Question of Expanded Liability to Third Persons for Mental Health Professionals

J. Thomas Sullivan

Lawyers are typically asked why they are able to represent people who are guilty of committing crimes. Mental health professionals, in contrast, appear to be subjected to questioning about why they did not figure out that their patients were about to commit crimes—typically the issue arises only with violent crimes—and why they did not manage to stop them.

I. INTRODUCTION

The seemingly increasing frequency of mass shooting episodes classified as mass murder has focused media and political attention on the likely causes of random violence and its causes.¹ Typically, consideration of the causes of these

Professor of Law, University of Arkansas at Little Rock School of Law, Adjunct Professor of Law and Psychiatry, University of Arkansas for Medical Sciences. See *Psychiatric Defenses in Arkansas Criminal Trials*, 48 ARK. L. REV. 439 (1995) and *The Culpability, or Mens Rea, Defense in Arkansas*, 53 ARK. L. REV. 805 (2000). I would like to acknowledge the generous contributions made to the Law and Psychiatry course offered at the Law School by Drs. Robert Forrest and Raymond Molden, Board Certified Forensic Psychiatrists, and by other practitioners and members of the UAMS Department of Psychiatry faculty and mental health practitioners over the past two decades of my involvement with this course, including Drs. Daryl Matthews, Albert Kittrell, Alan Newman, Ben Guise, Stacy Simpson, Jeremy Hinton, Courtney Rocha, and others who have presented individual lectures in this course. I also acknowledge the generous financial assistance provided by the UALR Bowen School of Law in underwriting the research and writing of this article. This paper was the basis for my presentation at the Annual Meeting of the Arkansas Psychiatric Society on the topic “Risk Management,” held July 30, 2016, in Little Rock. Copyright 2016, by the author.

1. See *1000 Mass Shootings in 1230 Days: This Is What America’s Gun Crisis Looks Like*, THE GUARDIAN (June 14, 2016), http://www.theguardian.com/us-news/ng-interactive/2015/oct/02/mass-shootings-america-gun-violence?CMP=fb_gu [<https://perma.cc/WMC3-BXDW>]. In response to the mass shooting at a nightclub in Orlando, Florida, that occurred on June 13, 2016, The Guardian reported the following:

incidents has been directed toward evidence of mental illness or impairment of perpetrators and prior psychiatric treatment or counseling.² More recently, international terrorism has proved a significant concern, although domestic terrorism remains an important potential source of motivation for these acts.

The concern for the motivation of perpetrators will likely continue to be an important issue and subject of national debate with respect to prevention, perhaps a matter that will not abate at any point in the future. For Arkansas mental health providers, the question of a therapist's duty to take appropriate action based on disclosure of a patient's threat to commit an act of violence is now framed in terms of two significant, fairly recent legal events.³

First, in 2013, the General Assembly passed legislation extending immunity for mental health providers considering potential response to patient threats beyond the previous statutory immunity for those providers—and others—involved in initiating emergency involuntary commitment proceedings.⁴

Sunday's attack on the Pulse nightclub in Orlando, Florida was the deadliest mass shooting in American history—but there were five other mass shootings in the US during that weekend alone. "We have a pattern now of mass shootings in this country that has no parallel anywhere else in the world," Barack Obama said after the San Bernardino attack in December 2015. Data compiled by the [Gun Violence Archive] reveals a shocking human toll: there is a mass shooting—defined as four or more people shot in one incident, not including the shooter—on five out of every six days, on average.

Id.

2. Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PUB. HEALTH 240, 240 (2015).

3. See generally Rebecca Johnson, Govind Persad & Dominic Sisti, *The Tarasoff Rule: The Implication of Interstate Variation and Gaps of Professional Training*, 42 J. AM. ACAD. PSYCHOL. & L. 469 (2014) (evaluating efficacy of duties imposed on mental health professionals, after the landmark *Tarasoff v. Regents of Univ. of Cal.* rulings, to warn intended victims of potential violence by patients and noting flaws in warning protocol based on lack of national and professional uniformity in approach).

4. ARK. CODE ANN. §§ 20-45-201 to -202 (2014). The Act characterized its intent in terms of the duty to warn of threatened patient violence. House Bill 1746 was entitled: "AN ACT TO REQUIRE A MENTAL HEALTH SERVICES PROVIDER TO WARN A LAW ENFORCEMENT AGENCY OF A CREDIBLE THREAT BY A PATIENT; AND FOR OTHER PURPOSES." Act 1212, 2013 Ark. Acts 4964, 4964. Its subtitle was: "TO REQUIRE A MENTAL HEALTH SERVICES PROVIDER TO WARN A LAW ENFORCEMENT AGENCY OF A CREDIBLE THREAT BY A PATIENT." *Id.* In fact, the Act does not impose liability for failure to warn of credible threat of patient violence,

Second, in a recent decision, *Fleming v. Vest*,⁵ the Arkansas Court of Appeals recognized a cause of action under state law against mental health professionals⁶ for injuries sustained by third persons resulting from acts of violence committed by their patients.⁷ In a very real sense, these two developments are interrelated, but the second is likely the more pressing, theoretically, for practitioners.

II. LIABILITY FOR INJURY SUSTAINED BY THIRD PARTIES

The decision in *Fleming v. Vest*⁸ represents a substantial change in Arkansas medical malpractice law, or at least in its application. For decades, mental health providers were protected from liability to third parties by the doctrine of *privity* for their claimed acts of malpractice.⁹

but expands immunity for those mental health providers who notify law enforcement agencies in the county in which the intended victim or the patient resides, or notify the Arkansas State Police of the threat, or who otherwise arranges for voluntary or involuntary civil commitment of the patient. ARK. CODE ANN. § 20-45-202(b). Nor does the Act expressly create a cause of action for failure to warn, but its language, by implication, recognizes the viability of a cause of action based on a failure of a designated mental health provider to warn of the credible threat. ARK. CODE ANN. § 20-45-202.

5. 2015 Ark. App. 636, 475 S.W.3d 576.

6. ARK. CODE ANN. §§ 16-114-201 to -212 (2016 & Supp. 2015).

7. *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580. Perhaps surprisingly, the majority opinion does not directly address the issue of liability to third parties. Instead, this issue is entangled in the discussion of other issues, including the applicability of the Medical Malpractice Act and its two year statute of limitations. ARK. CODE ANN. § 16-114-203(a). Instead, Judge Harrison, in his concurring opinion actually opens the door to the fundamental question of liability for claims made by third parties:

What duty, if any, did Dr. Vest owe to Fleming under the circumstances?
That is the fighting issue in this case, and courts have split over this question since the seminal case *Tarasoff v. Regents of University of California*.

Fleming, 2015 Ark. App. 636, at 13, 475 S.W.3d at 584.

8. *See id.* at 636, 475 S.W.3d at 576.

9. John G. Crivelli, *Tort Law: Florida Takes Another Step Towards Abandoning the Professional Privity Requirement*: Pat v. Threlkel, 661 So. 2d 278 (Fla. 1995), 47 FLA. L. REV. 641, 643 (1995). The Arkansas Medical Malpractice Act, which governs actions against medical providers for negligence, includes the following definition for “medical care provider”:

“Medical care provider” means a physician, certified registered nurse anesthetist, physician’s assistant, nurse, optometrist, chiropractor, physical therapist, dentist, podiatrist, pharmacist, veterinarian, hospital, nursing home, community mental health center, psychologist, clinic, or not-for-profit home

The *privity* doctrine generally limits liability of parties based on proof of contractual relationships designed to protect those whose actions are distinguishable from other actors whose liability is obvious.¹⁰ For example, under Arkansas law, *privity* was fostered at one time by a principle in contract actions in which a party performing work on contract with another entity was not liable for defects in the work performed once it had been accepted by the contracting party.¹¹ In *Sunneson v. Holloway Constr. Co.*,¹² the Arkansas Supreme Court recognized the problem where a plaintiff sustained an injury resulting in a broken neck and total paralysis when his loaded tractor-trailer left the highway due to a contractor's negligence.

The construction performed was under contract with the Arkansas Highway and Transportation Department and this contractual relationship establishing *privity* between the Department and contractor.¹³ Once the Department accepted the work performed under the contract, the "accepted-work" rule left Sunneson without a cause of action against the contractor that negligently performed substandard work.¹⁴ But, any civil action against the Department based on the negligent performance of the construction contract would be barred by the "sovereign immunity" provision of the state constitution.¹⁵

The supreme court explained that the restriction upon recovery from the contractor was predicated on the fact that the contractor was not in *privity* with the injured party since it was contractually obligated only to the contracting party, the Department. Surveying the abandonment of the "accepted-

healthcare agency licensed by the state or otherwise lawfully providing professional medical care or services, or an officer, employee or agent thereof acting in the course and scope of employment in the providing of such medical care or medical services.

ARK. CODE ANN. §16-114-201(2).

10. David F. Tavella, *Is Privity Dead? Should It Be?*, 8 N.Y.U. J. L. & BUS. 505, 505 (2012).

11. *See Memphis Asphalt & Paving Co. v. Fleming*, 96 Ark. 442, 443-44, 132 S.W. 222, 222 (1910).

12. *See* 337 Ark. 571, 573, 579-82, 992 S.W.2d 79, 80, 83-85 (1999).

13. *Id.* at 573, 992 S.W.2d at 80.

14. *Id.* at 574, 992 S.W.2d at 80.

15. ARK. CONST. art. 5, § 20.

work” doctrine in a substantial number of jurisdictions,¹⁶ the court repudiated the bar to liability to injured third parties:

From our review of the substantial legal authority on the subject, we believe the better-reasoned view is that the accepted-work doctrine is both outmoded and often unnecessarily unfair in its application. *We believe it would be a mistake to continue to apply a doctrine based upon privity of contract when the third party’s injury is foreseeable.*¹⁷

A. Application of the Privity Doctrine to Professional Negligence Claims

In *Chatman v. Millis*,¹⁸ a 1975 decision of the Arkansas Supreme Court, the *privity* doctrine was applied to reject the argument that a psychologist’s claimed negligence demonstrated a cause of action under Arkansas law. The psychologist offered an opinion as to a father’s claimed propensity to commit acts of homosexual abuse with the minor child who was the subject of an apparently bitter visitation dispute.¹⁹ The opinion was included in a letter sent to the mother’s attorney to support her action for termination of the father’s parental rights.²⁰

The supreme court acknowledged that under state law an action for malpractice against a psychologist may exist, though it declined to rule on this point expressly:

It is not necessary, in determining this litigation, to pass on the question of whether there is a cause of action in Arkansas for malpractice available against a psychological examiner or psychologist, since we are of the view that,

16. *Sunneson*, 337 Ark. at 581, 992 S.W.2d at 84 (“[T]he accepted-work doctrine is based on a privity-of-contract theory, which is a concept that has become virtually extinct in American jurisprudence, at least to the extent privity had been recognized earlier in the product-liability context.”).

17. *Id.* at 582, 992 S.W.2d at 84 (emphasis added). This statement reflects the tradition of privity as a concept arising in contract or property law and its relationship to torts, which focuses not on identity or ownership interest, but on duty owed to third parties not in privity with those in the contractual relationship or who may share ownership interests in property, or property rights. Goodrich, Herbert F., *Privity of Contract and Tort Liability*, 21 MICH. L. REV. 200, 200-203 (1922).

18. See 257 Ark. 451, 453, 517 S.W.2d 504, 506 (1975).

19. *Id.* at 452, 517 S.W.2d at 505.

20. *Id.*

even though such a cause of action exists, the allegations of appellant's complaint do not state a cause of action.²¹

Instead, the court held that even with the existence of a cause of action for malpractice, Chatman could not state a claim for relief because the *privity* doctrine precluded recovery. This was made clear in the majority's holding:

We do not flatly state that a cause for malpractice must be predicated upon a contractual agreement between a doctor (psychologist) and patient, but we do say that *a doctor-patient relationship must exist, i.e., there must be a duty, as a doctor, owed from the practitioner to the patient*. Under the allegations before us, Millis made no examination of Chatman; in fact, he did not even know Chatman, and had never seen him. Appellant was not a patient of Millis, and the diagnosis reached was not for the benefit of Chatman. *Even if the findings of the psychologist were negligently made*, Chatman did not rely upon this diagnosis to his detriment.²²

The majority thus based its holding on the application of the *privity* of contract doctrine to preclude recovery on an action brought by a third party claiming injury as a result of the mental health professional's negligence in failing to make an accurate diagnosis, reiterating: "[Millis] owed no duty, as a doctor, to [Chatman], and this duty must be in existence before [Chatman] can recover because of negligence, constituting malpractice."²³

Justice Fogelman issued a compelling dissent, arguing "[t]he majority's result has imported a rule of *privity* into

21. *Id.* at 453, 517 S.W.2d at 506.

22. *Id.* (emphasis added).

23. *Chatman*, 257 Ark. at 454, 517 S.W.2d at 506. Chatman also alleged that Millis' diagnosis that Chatman had engaged in homosexual, incestuous conduct with his two-and-a-half-year-old son constituted defamation under Arkansas law. *Id.* at 451-52, 517 S.W.2d at 505. However, Arkansas law required that an action for defamation must be brought in the county of the defendant's residence; Chatman brought his action for malpractice and defamation in White County, rather than Jackson County, where Millis resided and the defamation count was dismissed. *Id.* at 452-53, 517 S.W.2d at 505. The specific allegations concerning Millis' diagnosis and claimed defamation were not included in the majority opinion, but in Justice Fogelman's dissenting opinion. *Id.* at 455, 517 S.W.2d at 506 (Fogelman, J., dissenting). Thus, ironically, Chatman was victimized twice by professional negligence, that of Millis, the psychologist, and his own attorney, who failed to file the defamation action in the correct court.

malpractice actions. I consider this not only undesirable but improper.”²⁴ His discussion of the history of the litigation revealed it to be confused,²⁵ stressing the need to initially resolve the question of whether a malpractice action may lie against a professional, noting that Arkansas decisions had previously recognized that professionals could be held liable for negligence in performance of the standards governing their respective professions, addressing the finding of the trial court that “there can be no cause of action against a psychological examiner or psychologist.”²⁶

Justice Fogelman then proceeded to address the question of malpractice in terms of the core doctrines of tort law, duty and foreseeability:

A malpractice action, however it may be necessary to define it in order to give recognition to factors peculiar to the practice of a profession, should be considered nothing more or less than a tort action to recover damages for either willful, ignorant or negligent misconduct of a practitioner in the practice of his profession.²⁷

24. *Id.* at 458, 517 S.W.2d at 509.

25. *See Chatman*, 257 Ark. at 455-58, 517 S.W.2d at 506-08. For example, Justice Fogelman noted that in moving to quash the complaint based on the plaintiff’s failure to file the defamation action in the county of the defendant’s residence, the trial court had treated that claim as warranting dismissal as to malpractice claim, as well. *Id.* at 455-56, 517 S.W.2d at 507. He pointed out: “[Defendant Millis] did not then allege and has never contended he could not be liable for malpractice.” *Id.*

26. Justice Fogelman first noted the following:

Malpractice has been defined as “[a]ny professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct.” Black’s Law Dictionary (4th ed.) 1111. In Arkansas, malpractice has been recognized as negligence in the practice of various professions, among which are law, medicine, and dentistry. *See Welder v. Mercer*, 247 Ark. 999, 448 S.W.2d 952; *Burton v. Tribble*, 189 Ark. 58, 70 S.W.2d 503; *Black v. Bearden*, 167 Ark. 455, 268 S.W. 27. In the last of the cited cases we held that the rules governing duties and liabilities of physicians and surgeons applied to practice of kindred branches of the healing arts. Our statutes make the practice of psychology a profession of the healing arts. Ark. Stat. Ann. §§ 72-1501-72-1518 (Repl. 1957) deal with this profession.

Id. at 456-57, 517 S.W.2d at 507.

27. *Id.* at 459, 517 S.W.2d at 509.

He then reasoned that the duty owed by a psychologist to a third person would arise in circumstances in which it was reasonably *foreseeable* that his professional negligence would cause injury to a third person.²⁸

Justice Fogelman concluded that Chatman had stated a cause of action against Millis for professional negligence—malpractice—in opining that Chatman was a homosexual:

Assuming the allegations of the complaint to be true, as we must, it would border on absurdity to say that appellee could not reasonably have foreseen that a misdiagnosis of homosexuality would harm appellant. The fact that the diagnosis was made without appellee's having known, seen or interviewed appellant or having administered any tests to him would seem, in and of itself, to be malpractice, but whether it is or not is a matter of evidence when the case is tried on its merits.²⁹

For Judge Fogelman, the diagnosis of the plaintiff without a personal examination or evaluation by Millis likely amounted to professional negligence, although he recognized this was still an issue for jury determination at trial.³⁰

In Justice Fogelman's view, the majority's focus on the absence of the doctor/patient relationship as defeating the cause of action³¹ reflected a discredited limitation on the basic principle in tort law that the foreseeability of injury to a third person would serve to establish the duty of the tortfeasor toward that third person not to engage in the act likely to cause the injury, prompting him to quip, "The 'privity requirement' was gasping its last breath in Arkansas prior to today's decision."³²

28. *Id.* at 460, 517 S.W.2d at 510. Justice Fogelman wrote the following:

Chief Judge [J. Smith] Henley had demonstrated that Arkansas cases hold that a duty to use care arises when it is reasonably foreseeable that injury will probably result to another if care is not used and that it depends upon the foreseeability of injury or damage, not upon privity of contract. *Rhoads v. Service Machinery Company*, 329 F. Supp. 367 (D.C.Ark.1971).

Id.

29. *Id.* at 465-66, 517 S.W.2d at 512.

30. *Chatman*, 257 Ark. at 465-66, 517 S.W.2d at 512.

31. *Id.* at 466, 517 S.W.2d at 512-13.

32. *Id.* at 463, 517 S.W.2d at 511. Interestingly, the privity requirement is retained by statute for actions commenced against accountants and attorneys in Arkansas. See ARK.

Chatman v. Millis has not been expressly overruled to date and was cited with approval by the Arkansas Court of Appeals in *Thompson v. Sparks Reg'l Med. Ctr.* in 2009: "The broad holding of *Chatman* is that a medical provider owed no duty to a person who was not its patient."³³ *Chatman* was cited by Judge Harrison in his concurring opinion in *Fleming v. Vest*,³⁴ but neither he nor the majority judges³⁵ even suggested their respective approaches in *Fleming* required that *Chatman* be re-examined. Instead, Judge Harrison would have relied on *Chatman*'s requirement for privity in order to exclude this action from coverage under the Arkansas Medical Malpractice Act.³⁶

B. Tarasoff: Patient Threats and the Duty to Warn

The California Supreme Court's decision in *Tarasoff v. Regents of the Univ. of Cal.*³⁷ has achieved iconic status in the law of torts.³⁸ The court concluded that mental health

CODE ANN. § 16-114-302 (2006), Accountant Liability; ARK. CODE ANN. § 16-114-303 (2006), Attorney Liability. Both statutes expressly provide that liability for negligence can only be maintained by clients in privity of contract with their accountants or attorneys. *Id.* However, that the respective professional's duty of care may be extended to third persons when "[the] primary intent of the client was for the professional services to benefit or influence the particular person bringing the action." *See id.* Under these statutes, a third person not in privity of contract with the accountant or attorney whose negligence damages the interests of the third person for whom the performance of professional services was expressly intended may recover against the accountant or attorney or their firms for malpractice. *See id.*; *see also* *Kowalski v. Rose Drugs of Dardanelle, Inc.*, 2011 Ark. 44, at 18-19, 378 S.W.3d 109, 120-21 (holding pharmacy not liable to third person for filling prescriptions ordered by patient's physician leading to patient's death from overdose rejecting claim that pharmacies owe a duty to monitor physician prescription decisions).

33. 2009 Ark. App. 190, at 5, 355 S.W.3d 35, 38.

34. 2015 Ark. App. 636, at 10, 12-13, 475 S.W.3d, 582-84 (Harrison, J., concurring).

35. *Id.* at 1, 10, 475 S.W.3d at 578, 582 (Brown, J., joined by Abrahamson, J.).

36. *Id.* at 12-14, 475 S.W.3d at 583-85.

37. 551 P.2d 334 (Cal. 1976) [hereinafter *Tarasoff II*] (en banc). The en banc decision followed an initial decision, *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553 (Cal. 1974) [hereinafter *Tarasoff I*] (en banc), in which a six-judge panel had also concluded that the treating psychologist had a duty to warn a third person of a patient's threat to commit an act of violence specifically identifying that person as the intended target of the threat. *But see id.* at 565 (Clark, J., dissenting) (arguing that the duty of confidentiality owed to the patient should not be compromised by a duty to report a threat to an intended victim whose identity has been disclosed by the patient).

38. *See, e.g.*, PAUL BATEMAN, TEN INSTRUCTIONS FOR BRIEFING CASES 12 (2003), <http://www.swlaw.edu/pdfs/briefingcases.pdf> [<https://perma.cc/GAB3-MJUY>] (Professor Bateman noted that "even in Torts, some cases do take on 'name brand' status as with

professionals at the health center at the UC Berkeley campus could be held liable for failing to warn the intended victim of a patient's threats of violence.³⁹ The victim, Tatiana Tarasoff, was the ex-girlfriend of the patient, Poddar, who had threatened to kill her once she returned from her summer vacation in Brazil for the new school year.⁴⁰ The psychologist to whom Poddar's threat was communicated apparently concluded that the threat was credible because he notified campus police, who stopped Poddar, but did not take him into custody after talking with him.⁴¹ Thereafter, the treating psychologist was directed by his supervisor at the mental health clinic action not to take any further action⁴² and the *Tarasoff* court tersely observed, "No one warned Tatiana of her peril."⁴³

Tatiana's parents sued the treating psychologist, supervising psychiatrists and other psychiatrists employed by the University who concurred in the decision not to pursue involuntary commitment of Poddar, and the University police who released Poddar after briefly detaining him.⁴⁴ The civil suit was based on two basic theories, the failure of the mental health professionals to warn Tatiana of the danger believed to be posed by Poddar and their failure to take appropriate steps to initiate emergency proceedings for the civil commitment of Poddar.⁴⁵ The court succinctly addressed the scope of its decision:

We shall explain that defendant therapists, merely because Tatiana herself was not their patient, cannot escape liability for failing to exercise due care to warn the endangered

Tarasoff, the California decision that provides an exception to doctor-patient confidentiality.").

39. *Tarasoff II*, 551 P.2d at 353.

40. On direct appeal from Poddar's conviction for murder, the intermediate appellate court noted in its opinion that "three psychiatrists and one clinical psychologist agreed that appellant suffered from chronic schizoid paranoia." *People v. Poddar*, 103 Cal. Rptr. 84, 86, 93 (Cal. Ct. App. 1972). The state supreme court subsequently reversed Poddar's conviction and the appellate court's decision in finding that the trial court committed prejudicial error in instructing the jury on implied malice, remanding the case for new trial. *People v. Poddar*, 518 P.2d 342, 344 (Cal. 1974).

41. *Tarasoff I*, 529 P.2d at 554-55.

42. *Id.*

43. *Id.* at 555.

44. *Id.* at n.2.

45. *Id.*

Tatiana or those who reasonably could have been expected to notify her of her peril. When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning.⁴⁶

Thus, the California Supreme Court initially rejected reliance on the concept of *privity of contract* to limit liability of mental health professionals to third persons that the *Chatman* court applied to deny liability under Arkansas law. The court then expressly recognized the mental health professional's affirmative duty to warn third persons of credible threat under state law.⁴⁷

The court also noted an interesting aspect of the negligence claim bearing directly on policy decisions that flow from recognition of a duty to warn. The failed attempt to detain Poddar for evaluation, which the court described as “bungled” might have led Poddar to avoid further therapy and served to aggravate his feelings toward Tatiana, placing her in even greater danger.⁴⁸ This circumstance supported the recognition of the obligation of the defendants’ “obligation to give the warning.”⁴⁹

While the University mental health clinic professionals would have been immune from liability in undertaking the emergency commitment⁵⁰ of Poddar for evaluation and

46. *Tarasoff I*, 529 P.2d at 555.

47. *See id.* at 561.

48. *Id.* at 555, 559. In fact, the court speculated that the failed effort at emergency hospitalization could have led Poddar to discontinue treatment that might have had the effect of successfully addressing his anger toward Tatiana and “led him to abandon his plan to kill Tatiana, and thus that defendants, having contributed to the danger, bear a duty to give warning.” *Id.* at 559 (relying on the record in the criminal appeal, *People v. Poddar*, 518 P.2d 342 (Cal. 1974)).

49. *Id.* at 559.

50. *Id.* at 563-64. The court relied on the state government code, which immunizes decisions made by mental health professionals with respect to involuntary commitment, in holding that the plaintiffs could not frame a cause of action based upon the subsequent determination not to engage in further action to detain Poddar for evaluation. *Id.*; CAL. GOV'T CODE § 856 (West 2016). An Arkansas provision similarly provides for immunity for mental health professionals or, in fact, any individual seeking emergency civil commitment for mental evaluation: “No officer, physician, or other person shall be held

treatment, if necessary, their very actions in initiating the involuntary commitment process could well have jeopardized their relationship with their patient. Poddar, recognizing that his own disclosures resulted in his confinement for purposes of evaluation, and likely treatment, could have easily concluded that he could not trust those therapists or, in fact, any others and rejected further therapy. This unfortunate consequence of emergency restraint for purposes of involuntary commitment likely compromises patient trust toward treating therapists who disclose threats they have assessed as credible, of course. As *Tarasoff* makes clear, however, this is a necessary cost of protecting an intended victim from injury or violence: “Against this interest, however, we must weigh the public interest in safety from violent assault.”⁵¹

The duty imposed on mental health professionals giving rise to liability in *Tarasoff* rests on two interrelated considerations, the “foreseeability” factor underlying tort liability generally and the existence of a “special relationship” existing between the therapist and patient that also gives rise to the duty of confidentiality that the patient can expect in the context of the therapeutic relationship.⁵²

The “foreseeability” test, as Justice Fogelman explained in *Chatman* and the majority upheld in *Tarasoff*, is predicated on the reasonableness of a conclusion that an individual should recognize and appreciate the risk that an action done will result in an injury to another.⁵³ But liability is not based exclusively on foreseeability, because the law imposes no special duty to act

civily liable for his or her actions pursuant to this subchapter in the absence of proof of bad faith, malice, or gross negligence.” ARK. CODE ANN. § 20-47-227 (2014).

51. *Tarasoff I*, 529 P.2d at 560.

52. *Tarasoff II*, 551 P.2d at 342-43. Even when the existence of a special relationship is apparent, liability is only imposed if the injury-producing act is foreseeable. For instance, in *Wiener v. Southcoast Childcare Ctrs., Inc.*, the court held that a childcare provider was not liable for the criminal acts against a child in the care of the center where there was no showing that prior criminal acts were known to have been committed against children while in its care, or on the property owned by the co-defendant lessor of the property because the intentional criminal act of the third person was not foreseeable in this circumstance. 88 P.3d 517, 519 (Cal. 2004).

53. See *Chatman v. Millis*, 257 Ark. 451, at 459, 517 S.W.2d 504, 509-10.

in defense of another, generally.⁵⁴ For instance, no one simply observing a dangerous situation is required to act at their own risk to prevent injury to another, or even to undertake to prevent injury even if there is no risk to them personally.

Foreseeability becomes the critical element for liability once the additional factor of a special relationship is demonstrated.⁵⁵ The special relationship, creating a duty of care within the relationship, enhances the degree of responsibility for the actions of the other party in the relationship,⁵⁶ typically the less experienced, powerful, or competent of the parties. The relationship may be established by law, such as the legal duty of care a parent may owe to a child, or the relationship between an employer and employee, giving rise to the concept of *respondeat superior* that provides that an employer may be responsible for injuries to third persons caused by employee's in the performance of the duties of their employment.⁵⁷

Alternatively, enhanced or increased duty may be found when an individual deliberately assumes responsibility for the actions of another, as in the case of the good Samaritan who voluntarily comes to the aid of another. Or, as the *Tarasoff* court observed, it may arise almost negligently, such as when a driver leaves an vehicle operational in the presence of other persons who could be expected to take possession and operate the vehicle negligently.⁵⁸

The court explained that the key to the test for liability ultimately rests on the reasonable "foreseeability" of injury to the third person for an action done by the tortfeasor personally, or by a third person with whom the tortfeasor shares the special relationship that will serve to expand liability because injury done by the other in the relationship proves "foreseeable."⁵⁹ Further, the court explained that the instances of this expanded

54. *Tarasoff II*, 551 P.2d at 343 ("[U]nder the common law, as a general rule, one person owed no duty to control the conduct of another.").

55. *Id.* at 342-43.

56. *Id.* at 344-45.

57. Michael D. Morrison & Gregory N. Woods, *An Examination of the Duty Concept: Has it Evolved in Otis Engineering v. Clark?*, 36 BAYLOR L. REV. 375, 392-93, 396 (1984).

58. *Tarasoff II*, 551 P.2d at 343 n.7.

59. *Id.* at 342-43.

concept supporting liability are increasing, grounded in recognition of more circumstances in which a *special relationship* may be inferred.⁶⁰

In *Tarasoff*, Tatiana's estate did not plead the existence of a special relationship between her and Poddar's treating therapists. But the estate did plead the existence of the special relationship existing between Poddar and those mental health professionals and the court found that this relationship created the duty of care toward Tatiana upon which liability for their failure to warn her of the danger posed by Poddar could be demonstrated.⁶¹ The court concluded, "Such a relationship may support affirmative duties for the benefit of third persons."⁶²

Tarasoff, issued by the California court only a year later than rejection of liability for mental health professionals not directly in *privity* with third persons injured by their negligent actions in *Chatman v. Millis*, became the focal point for development of law recognizing the expanded liability for those professionals for their acts foreseeably injuring third persons. Moreover, the *Tarasoff* court expressly noted that prior decisions did not limit recovery to situations in which the acts of physicians directly caused the injury supporting the claim of negligence.⁶³ Instead, the court relied on decisions in which the actual source of injury was, as in *Tarasoff*, the patient, but the foreseeable nature of the patient's act or injury was either apparent to the physician, or could reasonably have been inferred.⁶⁴

One post-*Tarasoff* decision of particular political importance involved an action originating in the unsuccessful assassination attempt upon President Ronald Reagan by mental

60. *Id.* at 343 n.5.

61. *Id.* at 343.

62. *Id.*

63. See *Tarasoff II*, 551 P.2d at 344.

64. The court explained its decision:

Decisions of other jurisdictions hold 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. The courts hold that a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease, or, having diagnosed the illness, fails to warn members of the patient's family.

Id. at 559 (internal citations omitted).

patient John Hinckley, Jr., in 1981.⁶⁵ Following Hinckley's acquittal by reason of insanity,⁶⁶ the Estate of Presidential Press Secretary James Brady, who was fatally shot in the assassination attempt, sued Hinckley's treating psychiatrist for negligence⁶⁷ based on a number of theories, including a failure to warn "Hinckley's parents of their son's extremely dangerous condition, and that he should have warned law enforcement officials of Hinckley's potential for political assassination."⁶⁸

The trial court considered the plaintiffs' allegations in the light most favorable to their complaint in the summary judgment action,⁶⁹ rejecting the claimed failure to warn based on lack of credible evidence of Dr. Hopper's knowledge of Hinckley's dangerousness. The court, summarized the argument advanced by the plaintiffs to support their claim of liability based on their characterization of *Tarasoff*:

According to plaintiffs, a duty on the part of the therapist arises whenever violence by the patient is foreseeable. In other words, depending on the nature of the patient's

65. *Brady v. Hopper*, 570 F. Supp. 1333, 1334 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984).

66. Hinckley was ordered released from further confinement in a mental hospital resulting from his acquittal on July 27, 2016, in an order by the District Court based on the court's finding that he no longer posed a danger. *See* *United States v. Hinckley*, No. 81-0306 (PLF), 2016 WL 4036414, at *1, *50 (D.D.C. July 27, 2016); *see also* Gardiner Harris, *John Hinckley, Who Tried to Kill Reagan, Will Be Released*, N.Y. TIMES (July 27, 2016), <http://www.nytimes.com/2016/07/28/us/hinckley-who-tried-to-kill-reagan-to-be-released.html> [https://perma.cc/5NBV-3XE3].

67. *Brady*, 570 F. Supp. at 1334.

68. *Id.* at 1335.

69. *Id.* at 1338. The plaintiffs, Brady's Estate and others injured in the shooting, had alleged, in addition to the failure to warn, Dr. Hopper failed to perform in compliance with the governing standard of care and that his failure resulted in Hinckley's attempt to assassinate President Reagan. *Id.* The District Judge explained the issues:

The gravamen of plaintiffs' complaint is that if Dr. Hopper had properly performed his professional duties, he would have controlled Hinckley's behavior; therefore, Hinckley would not have made the presidential assassination attempt. Specifically, plaintiffs assert that the prescription of valium and biofeedback therapy, coupled with the advice that Hinckley's parents "cut him off", aggravated Hinckley's condition and actually contributed to his dangerous propensity. Further, plaintiffs assert that Dr. Hopper should have consulted with another psychiatrist regarding his form of treatment, and that Dr. Hopper should have taken steps to have Hinckley confined.

Id. at 1335.

behavior, the therapist's duty is multifaceted: it may be to warn the potential victim or law enforcement authorities; it may be to take steps to have the patient confined; it may be to warn the patient's family or guardian of the potential danger; or it may be to take whatever action seems appropriate under the circumstances. Thus, plaintiffs argue, *Tarasoff* dictates that the therapist has a duty to warn whenever the patient makes specific threats, but they distinguish a duty to control and assert the latter duty arises whenever dangerous behavior by the patient is indicated.⁷⁰

The court also explained the contrary argument advanced by Dr. Hopper, again relying on *Tarasoff*, focusing on the plaintiffs' lack of evidence available to support their claim of liability based on the psychiatrist's special duty arising from his therapeutic relationship with his patient:

It is argued that even according to the allegations in the complaint, Hinckley had no history of violence directed to persons other than himself; he had no history of arrests; no previous hospitalizations arising from any violent episodes; and in fact, he did not appear to be a danger to others. Thus, defendant asserts, this case involves, and plaintiffs have pled, none of the "warning signs" by which Hinckley's conduct or mental state would give rise to a duty on the part of Dr. Hopper.⁷¹

The court rejected liability based on the facts in the case, concluding that the injuries suffered by the plaintiffs were not foreseeable because there were no allegations that Hinckley had ever threatened President Reagan or anyone else.⁷² It conceded that had the defendant probed more deeply in interviewing Hinckley, Dr. Hopper might have uncovered Hinckley's preoccupation with "Jody Foster and the movie 'Taxi Driver'"; that Hinckley was interested in President Reagan and political assassination; and that he had access to firearms.⁷³ The plaintiffs alleged that Dr. Hopper was negligent in failing to discern that

70. *Id.* at 1337.

71. *Id.* at 1336.

72. *Brady*, 570 F. Supp. at 1339.

73. *Id.*

“Hinckley suffered from delusions and severe mental illness.”⁷⁴ It concluded that even if the allegations in the complaint were, in fact, true, the evidence would be insufficient to impose a legal duty on Dr. Hopper to protect the plaintiffs from Hinckley’s unknown intentions.⁷⁵

Finally, the court addressed the overriding policy considerations warranting limitation on the psychotherapists’ duty with respect to patient acts of violence:

In the present case, there are cogent policy reasons for limiting the scope of the therapist’s liability. To impose upon those in the counseling professions an ill-defined “duty to control” would require therapists to be ultimately responsible for the actions of their patients. Such a rule would closely approximate a strict liability standard of care, and therapists would be potentially liable for all harm inflicted by persons presently or formerly under psychiatric treatment. Human behavior is simply too unpredictable, and the field of psychotherapy presently too inexact, to so greatly expand the scope of therapists’ liability.⁷⁶

C. Post-*Tarasoff* Decisions: The Scope of the Duty to Warn

Following the California court’s decision in *Tarasoff* expanding liability of mental health professionals with respect to the duty to warn individuals identified by patients making credible threats of violence, state courts addressed the implications of the decision in their own jurisdictions. Some jurisdictions have rejected the underlying premise of *Tarasoff*, that treating mental health professionals owe a duty of care to third parties for violent actions taken by patients against those third parties when a therapist has actual knowledge of the patient’s threat to commit an act of violence and the identity of the victim of a credible threat is disclosed to the therapist.

For example, in 2009, the Illinois Supreme Court rejected the *Tarasoff* rationale in *Tedrick v. Cmty. Res. Ctr., Inc.*,⁷⁷

74. *Id.*

75. *Id.*

76. *Id.*

77. 920 N.E.2d 220, 228 (Ill. 2009).

essentially applying the same requirement for *privity* the Arkansas court had relied upon in *Chatman v. Millis*.⁷⁸ The case involved allegations that the mental patient's treating therapist failed to warn the patient's wife of the patient's threats toward her prior to her murder.⁷⁹ The court conducted a review of prior Illinois decisions that had fairly consistently held that third persons could not recover for injuries caused by mental patients based on claims of liability against their treating therapists.⁸⁰ It then rested its continuing adherence to preclusion of recovery for claimed therapist negligence causing injuries to third persons by their patients based on the strong public policy interests favoring protection of the confidential relationship between mental health professionals and their patients.⁸¹

The concern for the impact of expanded tort liability upon the confidentiality duty for mental health professionals engaged in the therapeutic relationship remains significant, possibly the singularly most important factor in that expansion. Different

78. See *supra* Part II.A. Courts have traditionally equated the concepts of *privity* and special relationships. See Shelly A. Finger, *Jones v. SEC: Upholding the SEC's Ability to Impose Sanctions in Addition to Those of the NASD*, 51 ADMIN. L. REV. 989, 1004 n.79 (1999). Hence, the *Tedrick* court's focus on whether there was a special relationship between a patient and her physician or the physician and a third party is not far removed from the *Chatman* court's analysis of whether there was *privity* between a physician and a third party.

79. *Tedrick*, 920 N.E.2d at 221.

80. *Id.* at 224-25. The *Tedrick* court cited prior decisions in *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 398-99 (Ill. 1987) (recovery against physician claimed strictly liable by third party passenger injured in automobile accident caused when discharged patient under influence of prescribed psychiatric medication and alcohol recovery not available under state law where plaintiff claimed physician did not warn patient of effects of medication, but no special relationship existed between physician and passenger); and *Doe v. McKay*, 700 N.E.2d 1018, 1022 (Ill. 1998) (denying recovery based on father's claim that psychologist's negligence caused daughter to erroneously believe father had sexually molested her as a child, injuring father/daughter relationship where no relationship existed between father and therapist with respect to this specific allegation). *Id.* at 223. In *Kirk*, moreover, there was no allegation that the treating physician was aware of any threat to the safety of the passenger, or allegation that the discharged patient was known to have violent propensities. *Id.* The claim was grounded in strict liability, rather than negligence, in an apparent effort to address the lack of evidence of the physician's malpractice or actual negligence. *Id.* at 223-24.

81. *Id.* at 224. The court, citing its earlier *Doe* opinion, explained that "[t]he problem of divided loyalties, [and the concerns about compromising patient confidentiality], argue strongly against imposing on therapists a duty of care toward nonpatients." *Id.* (internal quotations omitted).

courts have weighed the competing values represented by confidentiality and foreseeability of patient-caused injury, as illustrated by the decisions in *Tarasoff* and *Tedrick*, and within the same jurisdiction over time, as illustrated by the Arkansas Supreme Court decisions in *Chatman v. Millis* and *Fleming v. Vest*. State legislatures have also addressed these concerns, with a majority of states recognizing the conflict, typically moving toward favoring a duty to prevent injury over maintenance of a strict adherence to the confidentiality obligation.

Professor Mark A. Rothstein has observed that while the impact of *Tarasoff* was initially seen in judicial decisions in a number of jurisdictions, legislative action has dramatically increased its influence on mental health professionals, although in particularly non-uniform approaches:

In reviewing the state statutes, it is clear there is no single *Tarasoff* duty, but 51 jurisdiction-specific duties. As of 2014, 29 states have laws mandating the reporting of serious threats, 16 states and the District of Columbia have permissive reporting laws, four states have no duty to report, and one state (Georgia) has its own unique law.

Some state statutes apply different standards to different professionals (e.g., psychologists, social workers). Other state laws differ on the circumstances when warnings or other actions are appropriate or vary in the individuals or entities that must be protected. Finally, some states grant immunity from liability if the mental health professional complies with certain statutory requirements.⁸²

82. Mark A. Rothstein, *Tarasoff Duties After Newton*, 42 J. L. MED. & ETHICS 104, 106 n.23-30 (2014) (citing *Mental Health Professionals' Duty to Warn*, NAT'L. CONFERENCE OF STATE LEGISLATURES (Sept. 28, 2015), <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx> [<https://perma.cc/HT32-96TZ>]). Professor Rothstein is the Herbert F. Boehl Chair of Law and Medicine and the Director of the Institute for Bioethics, Health Policy and Law at the University of Louisville School of Medicine in Kentucky. Mark A. Rothstein, UNIV. OF LOUISVILLE, <https://louisville.edu/bioethics/directory/mark-a.-rothstein> [<https://perma.cc/MD5H-PVP9>]. For a list of states having statutes referenced in the article, see Appendix A.

Other jurisdictions have embraced the *Tarasoff* court's reasoning judicially, in whole or in part.⁸³ Once a state court adopts the basic rule that foreseeability would determine the scope of duty owed third persons by mental health professionals in the course of their therapeutical activities, the issue of scope itself became critical. Three Iowa decisions in which the state supreme court did not expressly adopt *Tarasoff* illustrate the point.

1. *Recovery Based on the Patient's Intervening Criminal Act Contrary to Public Policy*

First, the Iowa Supreme Court faced a rather bizarre claim in *Cole v. Taylor*,⁸⁴ a 1981 decision. The court summarized the issue: "whether a patient may recover in tort from her psychiatrist on a claim that, in his professional capacity, he negligently failed to prevent her from committing murder."⁸⁵ The plaintiff/patient argued that her psychiatrist was negligent in failing to take appropriate action to prevent the murder of her ex-husband once she disclosed her threats to kill him.⁸⁶

Cole made three different, but interrelated arguments in suing her psychiatrist after she was convicted⁸⁷ of her ex-husband's murder: "that the defendant failed in his treatment of her, that he failed to restrain her by hospitalization, and failed to warn her former husband of any impending danger."⁸⁸ The third claim clearly implicated the *Tarasoff* theory of duty on the part of the treating mental health professional, but the court, noting that it had not adopted *Tarasoff* as applicable in Iowa law,⁸⁹ rejected her reliance on the California court's reasoning on the facts. *Tarasoff* addressed the duty a therapist owes to a third person, there, the murder victim, and does not afford a basis for

83. See *Nasser v. Parker*, 455 S.E.2d 502, 504-05 (Va. 1995); see also *Leonard v. Latrobe Area Hosp.*, 625 A.2d 1228, 1230-32 (Pa. 1993).

84. 301 N.W.2d 766, 767 (Iowa 1981).

85. *Id.* at 766.

86. *Id.* at 767.

87. *Id.*

88. *Id.*

89. *Cole*, 301 N.W.2d at 767-68.

recovery for the patient who perpetrates the violence in acting upon her threats.⁹⁰

Clearly, Cole's reliance on *Tarasoff* liability did not fit the facts of the case, as the majority observed, but her ex-husband's estate could have argued for liability under *Tarasoff*, yet did not do so. In an odd sense, then, Cole's assertion of this theory of liability served the same purpose as a third-party claim in which the defense argues that any compensation owed to the plaintiff due to injury should be assessed indirectly against the third party because it was their negligence that actually caused the injury. The estate could have brought an action against Dr. Taylor using the *Tarasoff* theory of liability and likely forcing the Iowa court to either embrace that decision or reject it directly on the merits.

But, while the court noted "a certain strength" in the plaintiff's arguments,⁹¹ it nevertheless rejected Cole's claims of negligence on Dr. Taylor's part on the basis of public policy because the cause of injury was the plaintiff's own illegal act.⁹² With respect to her claim that Dr. Taylor was negligent in failing to restrain her through involuntary hospitalization, the "certain strength" in her arguments might be seen as more plausible, assuming that the illegal act itself—the murder of her ex-husband—could have been prevented through hospitalization, had she been able to demonstrate that her act was excused as a result of mental impairment at the time it was committed. In fact, however, Cole's trial jury convicted her,⁹³ rejecting her claim of diminished capacity⁹⁴ and the Iowa Supreme Court affirmed her conviction on direct appeal.⁹⁵

Despite the potential for recognition of Cole's claims of negligence as logically flowing from the duty principle, the Iowa court decided against recovery by the patient against a therapist

90. *Id.*

91. *Id.* at 768.

92. *Id.*

93. *State v. Cole*, 295 N.W.2d 29, 29 (Iowa 1980).

94. *Id.* at 30, 35. Iowa recognizes the defense of diminished capacity, as Justice Harris explained citing IOWA R. CRIM. P. 10 (10)(b), now Rule 2.11(11)b(1). *Id.* at 40 (Harris, J., dissenting). Iowa law defines the defense of insanity statutorily, IOWA CODE ANN. § 701.4 (West 2016), but diminished capacity or diminished responsibility are based on common law and not addressed by statute. *See Anfinson v. State*, 494 N.W.2d 496, 502 n.6 (Iowa 2008).

95. *Cole v. Taylor*, 301 N.W.2d 766, 768 (Iowa 1981).

when the injury to the third person results from the patient's own criminal act.⁹⁶ Instead of accepting the logic and extending liability in such situations, the court rejected it in favor of public policy designed to prevent those who cause injury from profiting from their violent or illegal acts.⁹⁷

2. No Recovery When Intended Victim Was Already Aware of Threat

Second, in *Estate of Votteler*,⁹⁸ the court was called upon to consider whether the mental health professional should be held liable for failure to warn an identified victim who was involved with the patient's estranged husband, Donald, of the patient's threats against her.⁹⁹ Following the death of the patient's psychiatrist, the victim, Ramona, filed an action against his estate, claiming negligence in his failure to interview Donald to determine the credibility of the patient's threats against her, alleging that Dr. Votteler's professional expertise would have been important in leading Donald to protect her against Lola, Donald's wife and the psychiatrist's patient.¹⁰⁰ The evidence, however, was unequivocal in showing that both Ramona and Donald were well aware of Lola's propensity for violence, even without a professional assessment from Dr. Votteler, including this reference to the record by the court:

In order to keep Donald from going out at night, Lola occasionally threatened him with a two by four, and hid or burned his clothing. She threatened to kill herself and

96. The court explained, "Here plaintiff's responsibility for her criminal conduct was established by her conviction in the murder prosecution which we affirmed. It is that very criminal act which she claims as her damages, an element of recovery in this suit." *Id.*

97. *Id.*

98. 327 N.W.2d 759, 760 (Iowa 1982).

99. *Id.* at 760-61. The patient, Lola, was also acquainted with Ramona, the victim, who was injured when Lola drove "an automobile over her" in a local park. *Id.* at 760.

100. *Id.* at 761. The court explained the core of the allegation that Dr. Votteler was responsible for Ramona's claimed failure to appreciate the significance of Lola's threats:

In contending Dr. Votteler should have warned Donald that Lola was dangerous, plaintiff insists that neither her knowledge of Lola's violent nature nor the threats alarmed her. She contends she would have taken the situation seriously only if a warning originated with a professional like Dr. Votteler.

Id.

subsequently attempted suicide. Once she burned Donald with a cigarette and another time beat him with an iron pipe. When he obtained medical treatment for his beating injuries, the physician advised him to stay away from Lola because she was “crazy.” Lola threatened to kill Donald and plaintiff more than once. The last threat was made the night before the assault with the car in the park, when she caught up with them after a car chase. Prior to that event, she had tried to run Donald down with her car on one occasion and to run down both Donald and plaintiff on two other occasions.¹⁰¹

In rejecting liability, the Iowa court noted the decision in *Tarasoff*,¹⁰² but declined to expressly adopt its reasoning as applicable to Iowa tort law. Instead, the court explained that regardless, it would not find liability on the record before it.¹⁰³

101. *Id.* The evidence also showed that Lola had also threatened to kill Ramona when Ramona and Lola’s sister earlier had initiated a civil commitment proceeding that ended up with Lola’s voluntary commitment, during which Dr. Votteler had treated her. *Id.*

102. 551 P.2d 334 (Cal. 1976). The Iowa court declined to adopt and apply *Tarasoff* in a later decision, *Estate of Long ex rel. Smith v. Broadlawns Med. Ctr.*, 656 N.W.2d 71, 80 (Iowa 2002), where the claim for malpractice was predicated on the murder of a patient’s wife by a mental patient’s release from hospitalization necessitated by complex diagnosis of disorders or symptoms, including post-traumatic stress disorder, polysubstance abuse, initially including hallucinations and flashbacks. *Id.* at 77-78. The cause of action was actually based upon failure of the institution to notify the patient’s wife of his discharge so that she could leave the marital residence before he was able to confront her again. *Id.* He was discharged from Broadlawns to travel to a center for chemical dependency, but subsequently left that facility:

[He] went to a local pawnshop, pawned his watch, and bought a bus ticket back to Des Moines. Gerald returned to the marital residence, perhaps to lie in wait for Jillene. When Jillene returned to the home that evening, Gerald shot her several times, killing her.

Id. at 78. Interestingly, the court again expressly declined to hold that *Tarasoff* would apply in this Iowa case: “We have not previously adopted the duty principles enunciated in *Tarasoff* and do not do so at this time.” *Id.* at 80. Still, the court upheld the finding of negligence based on the failure to notify the patient’s wife of his discharge, but found *Tarasoff* inapplicable based on its conclusion that the “special relationship” underlying that decision existed between the patient and treating institution, but that the wife’s death was attributable to the special relationship created by Broadlawns’ promise to warn the patient’s wife of her husband’s discharge, which was necessitated by her actual knowledge of her husband’s propensity for violence. *Id.* at 80-81.

103. *Estate of Votteler*, 327 N.W.2d at 760.

The court found that while the victim, Ramona, and the patient's estranged husband, Donald, both had actual knowledge of the patient's threats to commit violence, there was no evidence that Dr. Votteler actually had any such knowledge himself.¹⁰⁴ Instead, the court characterized her claim:

Plaintiff's theory of action assumes Dr. Votteler lacked actual knowledge of Lola's violent propensities. She alleges he had a duty to ask appropriate questions of Donald to elicit that information. Then, according to her theory, Dr. Votteler should have warned Donald of Lola's dangerousness and Donald in turn should have warned her. She acknowledges that a warning from Donald alone or from persons other than Dr. Votteler would have done no good.¹⁰⁵

The court rejected this attempt to create a duty on Dr. Votteler's part designed to bring the case within the *Tarasoff* rationale, explaining that under these facts, plaintiff's theory attenuates the *Tarasoff* rule beyond the breaking point. The court went on to say, "Even if we were to adopt that rule, we could not allow recovery in a case like this. Nor has any other jurisdiction done so."¹⁰⁶ Once the intended victim of the patient's threat has actual knowledge of the threat, the rationale for imposing liability based on the mental health professional's duty to warn under *Tarasoff* fails.¹⁰⁷

3. No Liability to the Public Generally

Third, in *Leonard v. State*,¹⁰⁸ the Iowa Supreme Court addressed the problem posed by the claim that the mental health professionals were negligent in failing to warn of the potential for violence committed by a mental patient where there was no identifiable victim of any threat made by the patient.¹⁰⁹ In *Tarasoff*, an important factor in the court's decision was that the

104. *Id.*

105. *Id.* at 761.

106. *Id.* at 762.

107. See *Boulanger v. Pol*, 900 P.2d 823, 835-36 (Kan. 1995) (citing *Estate of Votteler* and holding that no liability attaches when the victim was already aware of threat).

108. 491 N.W.2d 508, 508-09 (Iowa 1992).

109. *Id.* at 511.

therapists knew that Tatiana was Poddar's intended victim so that it was not unreasonable to expect notification to her of his threats, thereby permitting her to take action to avoid injury.¹¹⁰ In contrast, the facts in *Leonard* gave no indication that anyone had any reason to believe Leonard was personally threatened by the potentially violent patient, Parrish.¹¹¹

Diagnosed with Bi-Polar Disorder, Parrish had been discharged from a mental health facility after reaching "maximum inpatient psychiatric benefits," according to the discharge summary.¹¹² He returned to work as a demolition contractor with directions to continue outpatient therapy and hired plaintiff Leonard to work for him.¹¹³ Following a day when the two men spent their time drinking, rather than working, they returned to Parrish's residence where he subsequently beat Leonard severely about his head and body and left him unconscious and locked inside his house.¹¹⁴ Parrish was subsequently convicted of kidnapping and attempted murder.¹¹⁵

Leonard brought his action against the state and its mental health facility under the Iowa Tort Claims Act,¹¹⁶ alleging negligence, specifically asserting that "the defendants failed to provide Parrish with proper care and treatment and that they subsequently discharged him knowing that he posed a threat to those with whom he might come in contact."¹¹⁷ What Leonard was able to show was that Parrish had a lengthy history of psychiatric hospitalizations and criminal charges for minor, but

110. *Tarasoff II*, 551 P.2d at 340.

111. *Leonard*, 491 N.W.2d at 511.

112. *Id.* at 509-10.

113. *Id.* at 510.

114. *Id.*

115. *Id.*

116. IOWA CODE ANN. § 669.1 (Westlaw 2016). Under the Act, individuals injured as a result of negligence on the part of a state employee may recover "under circumstances where the state, if a private person, would be liable to the claimant for such damage, loss, injury, or death." IOWA CODE ANN. § 669.2(3)(a) (Westlaw 2016). In contrast, Arkansas does not provide a civil remedy for actions by the State or its officials or employees acting within the course of their official duties, insulating those potential defendants to civil liability pursuant to the constitutional doctrine of sovereign immunity. ARK. CONST. art. 5, § 20; ARK. CODE ANN. § 19-10-305 (2007). Instead, a party injured by the State may proceed by filing a claim with the Arkansas Claims Commission. ARK. CODE ANN. § 19-10-201 *et seq.* (2007).

117. *Leonard v. State*, 491 N.W.2d, 508, 510 (Iowa 1992).

somewhat violent offenses. What he could not demonstrate was that the State and its mental health professional employees had a basis for knowing that he was an intended victim of Parrish, and in circumstances in which it would be reasonable to conclude that, in fact, he was not an intended victim at all,¹¹⁸ but was assaulted only because he was with Parrish during his employer's intoxication.

The Iowa court's opinion never mentioned *Tarasoff*, but clearly addressed the broader question of the scope of the mental health professional's duty to protect third persons from injuries committed by their patients. Acknowledging the existence of the special relationship that exists between therapists and patients, the court framed this question:

There can be little doubt that a special relationship existed between Parrish and his treating physician at MHI. His continuing involuntary commitment only serves to reinforce that bond. Therefore MHI had a duty to control Parrish's conduct, or at least not negligently release him from custody. But the Restatement rules cited above do not answer the precise question before us: Does the duty to refrain from negligently releasing dangerous persons from custody run from the custodian to the public at large or only to the reasonably foreseeable victims of the patient's dangerous tendencies?¹¹⁹

The *Leonard* court recognized a singular significant factor in the post-*Tarasoff* development of professional negligence law that would bear directly on the likely consideration of liability in *Fleming v. Vest*. That is, as explained succinctly by the court, the liability of a treating therapist might include a duty to warn

118. *Id.* at 511.

119. *Id.* (citing RESTATEMENT (SECOND) OF TORTS §§ 315, 319 (AM. LAW. INST. 1965), which address the exceptions to the general common law rule that a person has "no duty to control the conduct of a third person"). Section 319 recognizes an exception to the general rule: "One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm." RESTATEMENT (SECOND) OF TORTS § 319. The court also noted the Restatement's illustration of this proposition: "[T]he liability of a hospital to a person infected by a diseased patient who is negligently released, and the liability of an insane asylum for injury caused by the negligent release of a homicidal maniac. RESTATEMENT (SECOND) OF TORTS § 319 cmt. a, illus. 1, 2." *Leonard*, 491 N.W.2d at 511.

“foreseeable victims of the patient’s dangerous tendencies,” without warranting an expansion of this limited basis for recovery to encompass a general duty to protect against any injury caused by a patient, regardless of actual knowledge of the circumstances surrounding an assaultive, or negligent, act committed by the patient.¹²⁰ The latter approach could virtually impose a duty predicated on strict liability in which the therapist assumes virtually all liability for the actions of the patient or, liability without proof of foreseeable injury, or perhaps liability without proof of any deviation from the recognized standard of care. Recognition that liability can be imposed without proof of negligence or foreseeability would likely emasculate—if not eliminate—all mental state-based professional practice.

The court observed that judicial consideration of the duty of mental health practitioners to respond to potential patient violence targeting third persons had resulted in diverse approaches in response.¹²¹ Some courts had addressed liability based on duty to protect or warn by basically imposing liability on professionals for failure to protect or warn the public at large or, to classes of potential victims,¹²² while other courts had limited recovery based on the duty to warn of patient violence that could reasonably be anticipated by the treating therapist.¹²³

120. *Id.* The *Leonard* court noted the lack of evidence that the treating professionals had any reason to discern that Parrish posed a threat to a class of persons including Leonard, particularly endangered by Parrish’s release other than “the public at large.” *Id.*

121. *Id.*

122. *E.g.*, *Perreira v. State*, 768 P.2d 1198, 1201 (Colo. 1989) (liability based on negligent release of violent mental patient who killed police officer, without specific intended victim, therapist still under duty to assess patient’s propensity for violence and protect others by restraining patient for longer period); *Naidu v. Laird*, 539 A.2d 1064, 1072-73 (Del. 1984) (holding that psychiatrists have an affirmative duty to exercise reasonable care in the treatment, evaluation, and discharge of inpatients and that the affirmative duty includes a duty to control the patient and a duty to warn third parties); *Durflinger v. Artilles*, 673 P.2d 86 (Kan. 1983) (subsequently limited to liability based on release of involuntarily committed mental hospital patients in *Boulanger v. Pol*, 900 P.2d 823 (Kan. 1995)).

123. *E.g.*, *Hamman v. Cty. of Maricopa*, 775 P.2d 1122, 1127-28 (Ariz. 1989) (applying *Tarasoff* where therapist could have reasonably identified violent patient’s family as most likely potential victims, warranting liability even if no specific threat against identified target disclosed); *Petersen v. State*, 671 P.2d 230, 236-37 (Wash. 1983) (liability based on release of patient who had previously demonstrated dangerousness when driving while intoxicated when released overnight and danger known to therapist who should have foreseen dangerous to others).

The court noted that other jurisdictions imposed liability only for injuries sustained by third persons specifically identified in patient threats.¹²⁴

On the facts presented, specifically the lack of any knowledge that Leonard would be victimized by Parrish, the Iowa court rejected the argument that the liability for the patient's violence should extend to the public generally.¹²⁵ The court reasoned that imposing liability for decisions to discharge or release involuntarily, concluding: "the risks to the general public posed by the negligent release of dangerous mental patients would be far outweighed by the disservice to the general public if treating physicians were subject to civil liability for discharge decisions."¹²⁶

In contrast, in *Lipari v. Sears, Roebuck & Co.*,¹²⁷ the federal district court was called upon to assess whether the Nebraska Supreme Court would impose liability upon a mental health provider whose patient had killed the plaintiff and wounded the patient's wife with a shotgun when he found them together at an Omaha nightclub.¹²⁸ The plaintiff's estate brought an action against Sears, which had sold the shotgun to the patient,¹²⁹ which then brought a third party action against the Veteran's

124. *E.g.*, *Furr v. Spring Grove State Hosp.*, 454 A.2d 414, 420-21 (Md. Ct. Spec. App. 1983) (following *Tarasoff* and strictly limiting recovery to situations involving a known victim disclosed to therapist); *McIntosh v. Milano*, 403 A.2d 500, 511-12 (N.J. Super. Ct. 1979) (discussing *Tarasoff* and finding liability where specific victim identified in patient's threat was disclosed to therapist).

125. *Leonard v. State*, 491 N.W.2d, 508, 511-12 (Iowa 1992).

126. *Id.* (relying on *Sherrill v. Wilson*, 653 S.W.2d 661, 666-67 (Mo. 1983)).

127. 497 F. Supp. 185 (D. Neb. 1980).

128. *Id.* at 187.

129. *Id.* The plaintiff alleged that Sears knew or should have known that the purchaser of the shotgun "had been adjudged mentally defective or had been committed to a mental institution." *Id.* Although some claim of knowledge would appear logically necessary as an element of the negligence claim, the problem of actual notice of impairment remains a significant issue when discussions of responsibility for avoiding injury to third persons from the actions of mental patients are raised. *Id.* at 194 n.9. It seems highly unlikely that in 1980 Sears would have had any knowledge or reason to have knowledge that the purchaser represented a threat to anyone due to mental impairment. In *Lipari*, Sears apparently declined to settle the plaintiff's claim, accepting the cost of litigation and possibility of setting unfavorable precedent. *Id.* at 187 (filing a third-party complaint against the United States under the Federal Torts Claims Act, alleging that the United States was liable to Sears under the doctrines of contribution and indemnity for any damages).

Administration, which had treated the patient for mental health issues, alleging its negligence was the cause of injury:

[B]ecause the V.A. knew or should have known that [the patient] was dangerous to himself and others, and because the V.A., despite this knowledge, failed “to take those steps, and to initiate those measures and procedures customarily taken or initiated for the care and treatment of mentally ill and dangerous persons by mental health professionals practicing in the community.”¹³⁰

The plaintiffs then added the United States as a necessary party in the action against VA,¹³¹ stating a claim under the Federal Tort Claims Act.¹³² Because the claims arose in Nebraska, the District Court looked to Nebraska law in discerning whether the state would recognize a duty imposed upon psychiatrists to avoid injury to third persons due to patient violence. However, the absence of state law on the point led the court to consider whether Nebraska would impose such a duty in a proper case.¹³³

Looking to *Tarasoff* and the New Jersey decision in *McIntosh v. Milano*,¹³⁴ the *Lipari* Court focused on the consideration of the special relationship existing between mental health providers and their patients, concluding that the Nebraska courts would recognize a duty for those professionals to avoid potential injury to third persons.¹³⁵ The court also predicated its reasoning on an older Nebraska decision imposing a duty on a physician to violate patient confidence in order to prevent the spread of a contagious disease.¹³⁶

130. *Id.*

131. *Id.*

132. *Id.*

133. *Lipari*, 497 F. Supp. at 188.

134. 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979) (holding that psychiatrists have a duty to warn a person after determining that their patient posed a physical threat to that person).

135. *Id.* (observing that the “Tarasoff-McIntosh rule imposing an affirmative duty on psychotherapists was the courts’ adoption of the special relationship analysis of the Restatement (Second) of Torts § 315.”).

136. *Id.* at 191 (citing, *inter alia*, *Simonsen v. Swenson*, 177 N.W. 831, 832 (Neb. 1920)).

In rejecting the Government's argument that imposition of a duty to prevent danger to third persons involves too great a burden upon mental health professionals to determine which patients are predisposed to act violent, the Lipari Court cited numerous federal decisions in which such a duty had been found. It explained: "The argument of the United States ignores the fact that psychiatrists and mental hospitals have been held liable for failing to predict the dangerous propensities of their patients."¹³⁷ Also noting that the Nebraska Supreme Court had similarly held that hospitals owe a duty to third persons upon learning of potential patient dangerousness to others,¹³⁸ the court concluded: "These cases from Nebraska and other jurisdictions clearly show that the difficulty in predicting dangerousness has not caused the Nebraska Supreme Court or other courts to deny the existence of a cause of action for the negligence of the doctor or hospital."¹³⁹

The *Lipari* Court, however, also recognized the significant burden imposed on mental health professionals in assessing risk of violence in patients, relying on the limiting perspective in *Tarasoff*, focusing on the best practices for patient evaluation in determining breach of duty, rather than predicating liability on the mere fact that the professional engaging in a proper approach to the risk assessment erred, in hindsight.¹⁴⁰ The court concluded: "Under this standard, a therapist who uses the proper psychiatric procedures is not negligent even if his diagnosis may have been incorrect. Given this protection, the [c]ourt is of the opinion that the difficulty in predicting dangerousness does not justify denying recovery in all cases."¹⁴¹

137. *Id.* (citing *Hicks v. United States*, 511 F.2d 407, 415-17 (D.C. Cir. 1975); *Eanes v. United States*, 407 F.2d 823 (4th Cir. 1969); *White v. United States*, 317 F.2d 13, 17 (4th Cir. 1963); *Johnson v. United States*, 409 F. Supp. 1283, 1292-94 (M.D. Fla. 1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978); *Greenberg v. Barbour*, 322 F. Supp. 745 (E.D. Pa. 1971); *Merch. Nat'l Bank & Trust Co. v. United States*, 272 F. Supp. 409, 417-19 (D.N.D. 1967); *Baker v. United States*, 226 F. Supp. 129, 132-35 (S.D. Iowa 1964), *aff'd*, 343 F.2d 222 (8th Cir. 1965)).

138. *Id.* (citing *Foley v. Bishop Clarkson Mem'l Hosp.*, 173 N.W.2d 881, 884-85 (Neb. 1970)).

139. *Lipari*, 497 F. Supp. at 191.

140. *Id.* at 192 (citing *Tarasoff II*, 551 P.2d at 344-45).

141. *Id.*

The *Lipari* Court also addressed the issue limiting *Tarasoff* liability, the requirement for disclosure of an indentified prospective victim of patient violence as critical to imposition of a duty upon the mental health professional to warn the prospective victim.¹⁴² It explained that other courts had expanded the scope of potential victims to whom mental health professionals owe a duty to warn or protect, concluding that Nebraska would adopt a broader formulation than the limited approach taken by the California courts.¹⁴³ But it also imposed the burden upon the plaintiffs to demonstrate that they were within the class of persons whom the VA mental health professionals could reasonably have foreseen the unreasonable risk of injury necessary for imposition of the duty to prevent harm.¹⁴⁴

The *Lipari* litigation demonstrates the two different aspects of the duty to prevent patient violence injuring third persons common in such cases. *Tarasoff* cases arise in the context of actual disclosures of intent to injure, including the identity of the prospective victim.¹⁴⁵ In those cases, warnings from the provider to the victim directly, or through law enforcement, may prove effective in preventing injury, although this will not always necessarily prevent ultimate commission of an act of violence injuring the third person. The second aspect of duty lies in the ability of the mental health professional or institution to take action to prevent potential injury to third persons, including non-identified individuals, through emergency hospitalization or involuntary civil commitment.¹⁴⁶ Even recourse to this remedy does not permanently isolate the patient,

142. *Id.* at 194 (noting that in *Mavroudis v. Super. Ct. for Cty. of San Mateo*, 162 Cal. Rptr. 724, 729 (1980), *Tarasoff* liability was expressly limited to situations in which the treating professional had been told the identity of the patient's prospective victim).

143. *Id.*

144. *Lipari*, 497 F. Supp. at 194-95 ("These cases illustrate the importance of foreseeability in defining the scope of a person's duty to exercise due care. Thus, the plaintiffs and third-party plaintiff must prove that the risk created by the V.A.'s negligence was such that, under the circumstances, the V.A.'s employees could have reasonably foreseen an unreasonable risk of harm to the Liparis or a class of persons of which the Liparis were members.").

145. *Id.* at 194.

146. *Tarasoff II*, 551 P.2d at 351.

of course, or prevent the patient from eventually regaining freedom and engaging in violence toward others.

The different approaches taken by courts confronted with issues of psychotherapist liability based on violent acts committed by patients against third persons, following the California holding in *Tarasoff*, demonstrate the diverse response to novel claims or emerging legal doctrines when considered by different courts. This reflects a reality of the common law system in which legal principles are traditionally announced by courts in the context of individual cases, rather than by legislative action designed to shape the parameters of legal rights generally.

III. *FLEMING v. VEST*: *TARASOFF* INFLUENCES ARKANSAS LAW

Arkansas courts have yet to fully embrace the underlying principle of *Tarasoff*—that mental health professionals owe a duty of care to third persons with regard to injuries caused by the acts of their patients—although the published decision in *Fleming v. Vest*,¹⁴⁷ issued in late 2015, clearly suggests that *Chatman v. Millis* is in the process of being overruled, if only by implication thus far.

There are reasons to question the ultimate impact *Tarasoff* will have in the long-run because *Fleming v. Vest* rests on somewhat shaky foundation. It is sufficiently weakened by the procedural context in which the Arkansas Court of Appeals reached its decision applying the underlying principles of *Tarasoff* such that it is necessary to consider the procedural issues in assessing the strength of *Tarasoff* in resolving claims in

147. 2015 Ark. App. 636, 475 S.W.3d 576. Judge Harrison, in his concurring opinion, notes the following:

This case brings Arkansas to an important judicial crossroads: will our courts continue to expand the Act's definition of what constitutes a "medical injury" and thus pull more providers into the Act's orbit? Or will they begin taking a more nuanced approach, especially in cases where a medical-care provider's patient commits an intentional harm upon a third person, and more carefully analyze whether a provider can be sued in tort at all?

Id. at 14, 475 S.W.3d at 584-85 (Harrison, J., concurring).

Arkansas cases.¹⁴⁸ Significantly, the decision of the circuit court in granting the defense's motion to dismiss¹⁴⁹ following remand from the court of appeals serves to demonstrate the difficulty plaintiffs will likely face in using *Tarasoff* as a basis for liability against mental health providers.

Moreover, it is important to note that *Tarasoff* represents only one theory of liability for mental health professionals based on failure to warn third persons of potential injury based on disclosed threats of a patient. However, to the extent that *Tarasoff* recognizes duty to third persons based on foreseeability of injury, it has opened the door to a broader understanding of the impact of mental health professionals' decision-making on those outside the therapist/patient relationship who also interact with the patient. The decision in *Fleming v. Vest* rests on the perception that mental health professionals can reasonably be expected to appreciate the broad impact their treatment decisions—and the underlying problems leading their patients to seek or be ordered into treatment—may have on others who might otherwise be viewed as innocent or unknowing with respect to patient thinking that may be misguided, delusional, perverse or simply dangerous.¹⁵⁰

148. *Id.* at 7, 475 S.W.3d at 581 (basing a major part of decision on the statute of limitation).

149. Order, *Fleming v. Vest*, No. CV2011-164-III (Garland Cty. Cir. Ct. Aug. 15, 2016), http://circuit051.courtconnect.net/docsdms/Default.aspx?A=106/ck_image.present?DMS_ID=55087f66-350a-4fa2-856f-1f9d7d191952 [<https://perma.cc/E6RZ-SNEE>].

150. Mental health clinicians are called upon to assess the potential for their patients to commit acts of violence in the future. *See, e.g.*, BRUCE J. COHEN, THEORY AND PRACTICE OF PSYCHIATRY 445 (2003) (“While clinicians are not able to *predict* whether a given individual will engage in future acts of violence with a high degree of certainty, they *are* capable of assessing whether that individual is high, medium, or low *risk* for engaging in future violence.”). Dr. Cohen is the Director of the Forensic Psychiatry Residency Training Program at the University of Virginia. *Bruce J Cohen, MD*, U. OF VA. HEALTH SYS., <https://uvahealth.com/findadoctor/profile/bruce-j-cohen> [<https://perma.cc/7UCB-REJV>].

In evaluating the relationship of mental health diagnoses and perpetrators of mass shooting violence, Dr. Dewey Cornell, a clinical psychologist and faculty associate at the Institute of Law, Psychiatry and Public Policy at the University of Virginia, writes in this guest editorial that mental illness is not a common factor in recent acts of mass violence, while noting that statistical evidence shows that incidents of mass violence are actually decreasing, not increasing over the past twenty years. Dewey G. Cornell, *Gun Violence and Mass Shootings—Myths, Facts and Solutions*, WASH. POST (June 11, 2014),

The developing state of tort law following *Chatman v. Millis* may have foreshadowed the potentially broad reach applied by the majority in *Fleming v. Vest*, as evidenced by the factual context underlying the litigation in *Jean-Pierre v. Plantation Homes of Crittenden Cty.*¹⁵¹ *Jean-Pierre* was a 2002 decision rendered by the Arkansas Supreme Court focusing on a procedural issue in the litigation, rather than on the issue of professional liability.¹⁵² A patient under the care of Plantation Homes, doing business as Southwoods—a residential care facility for the mentally handicapped—left the institution and

<http://www.washingtonpost.com/news/the-watch/wp/2014/06/11/gun-violence-and-mass-shootings-myths-facts-and-solutions/> [https://perma.cc/2S8F-X5UY]. He explains:

It seems intuitive that anyone who commits a mass shooting must be mentally ill, but this is a misuse of the term “mental illness.” Mental illness is a term reserved for the most severe mental disorders where the person has severe symptoms such as delusions or hallucinations. Decades of mental health research show that only a small proportion of persons with mental illness commit violent acts, and together they account for only a fraction of violent crime. Some mass shooters have had a mental illness. Most do not.

Id. Dr. Cornell points out, however, that mental health intervention is an important factor in preventing mass shootings:

In case after case of mass shootings, we learn later that family members, friends, and even mental health professionals were concerned that someone needed help. Predicting violence is difficult, but identifying that someone needs assistance is not so difficult. This is where we need to readjust our focus and concentrate on helping people in distress. This approach requires not only a change in police policy but community mental health services that are oriented around prevention.

Id. For further commentary on the scope of expectation for mental health professionals to anticipate patient violence, see *infra* notes 277, 278, 284 and accompanying text.

151. 350 Ark. 569, 89 S.W.3d 337 (2002). Plantation Homes did business as Southwoods Residential Care Facility. *Id.* at 569, 89 S.W.3d at 338.

152. *Id.* at 572-73, 89 S.W.3d at 339. The issue before the state supreme court involved the physician’s liability on a third-party claim brought by BHS, which had employed Dr. John-Pierre, alleging that he was negligent—BHS having been subject to cross-claim by Southwoods in the event it was found negligent. *Id.* at 572, 89 S.W.3d at 339. Southwoods cross-claimed against BHS, claiming that Mrs. Mills’ injuries, if established, resulted from negligence on the part of BHS and Dr. Jean-Pierre. *Id.* at 572, 89 S.W.3d at 339. Southwoods settled the claim with the Mills estate for \$775,000. *Jean-Pierre*, 350 Ark. at 573, 89 S.W.3d at 339. Southwoods then filed a motion for default judgment against the doctor. *Id.* at 573, 89 S.W.3d at 339. Although BHS filed an answer denying liability, which should have served to protect Dr. Jean-Pierre, appellate counsel essentially defaulted his defense by changing their specific theory of the case from that argued in the trial court, leaving the psychiatrist to indemnify Southwoods in the amount of \$775,000. *Id.* at 574, 89 S.W.3d at 340.

stole a car, killing another individual, Mrs. Mills, in a head-on collision.¹⁵³ Her estate sued Behavioral Health Services (BHS), with whom the care facility contracted to provide medical and psychiatric health services alleging negligence “for failing to take appropriate steps to control Wilder, despite its recognition that he posed a high risk for dangerous actions.”¹⁵⁴ Her estate further alleged that Southwoods was negligent “in failing to maintain control over Wilder and in admitting him to its facility without adequately evaluating the degree of risk he posed.”¹⁵⁵

The negligence theory rested on the assertion that it was foreseeable to the care facility, its contracting party for psychiatric services, and Dr. Jean-Pierre, that the patient posed a threat to commit actions dangerous to third persons such as Mrs. Miller.¹⁵⁶ While the court’s focus was entirely upon the procedural technicalities in the litigation in terms of imposing the costs of Southwoods’ settlement of the Estates’ claim for damages, the theory for recovery necessarily raised the questions of foreseeability and duty toward third persons who might foreseeably be injured by the actions of the patient in the care of both the institution and the psychiatrist who contracted to provide care for the patient. In settling the claim, the care facility effectively conceded liability based upon this theory of duty owed to third persons by those providing mental health services to impaired patients.¹⁵⁷

The published decision in *Mills* did not directly advance the development of Arkansas professional liability law because it addressed only the procedural aspects of the default judgment taken against the treating psychiatrist and his unsuccessful appeal; only in its very brief summary of the theories of negligence argued by the Estate of Mrs. Mills in its suit did it raise the specter of liability to third persons under state law.¹⁵⁸ Before addressing those arguable insufficiencies, however, the facts in the case should be considered.

153. *Id.* at 572, 89 S.W.3d at 338.

154. *Id.* at 572, 89 S.W.3d at 339.

155. *Jean-Pierre*, 350 Ark. at 572, 89 S.W.3d at 339.

156. *Id.*

157. *Id.* at 573, 89 S.W.3d at 339. Perhaps ironically, the patient’s name was “Haywood Wilder.” *Id.* at 572, 89 S.W.3d at 338.

158. *Id.* at 572, 89 S.W.3d at 339.

A. The Factual Scenario Underlying the Decision in *Fleming v. Vest*

The murder underlying the lawsuit against Dr. Vest was committed by the psychiatrist's patient, Lands, resulting in the death of Fleming when Lands shot him on April 19, 2010.¹⁵⁹ Fleming's wife, Jane, filed suit as personal representative of his estate, alleging that Dr. Vest was negligent in his treatment of Lands, who had been acquitted years earlier based on impaired mental state, and as an insanity acquittee, Lands was effectively in custody of the Arkansas State Hospital following the acquittal, eventually being released from in-patient treatment on a five-year conditional release.¹⁶⁰ His treatment had been transferred to Garland County Counseling Services with Dr. Vest assuming responsibility for Fleming's treatment.¹⁶¹ The majority then explained Fleming's treatment:

There he was diagnosed with bipolar disorder and began treatment. In 2009, appellee became his treating psychiatrist and, in order to determine the appropriate medication regimen, began to withdraw the level of pharmaceuticals administered to Lands. The final time appellee met with Lands before the death of Scott Fleming was on February 24, 2010.¹⁶²

Although *Fleming v. Vest* arises in the context of a third person's death caused by a mental patient which the plaintiff alleged resulted from the therapist's negligence, the theory of negligence is significantly different than that asserted in *Tarasoff*. There was no claimed breach of duty based on the patient's threat and, in fact, the opinion does not even suggest that Dr. Vest knew of Scott Fleming or any relationship between Fleming and his patient, Lands, that would have required him to warn Fleming of Lands' propensity for violence.

159. *Fleming v. Vest*, 2015 Ark. App. 636, at 1, 475 S.W.3d 576, 578.

160. *Id.* at 1-2, 475 S.W.3d at 576, 578.

161. *Id.* at 2, 475 S.W.3d at 578.

162. *Id.*

B. The Court's Holding and Split in Thinking Among the Panel Judges

At the outset, the theory of negligence upon which Fleming's claim against Dr. Vest was based is broader than that addressed in *Tarasoff*. It reflects an important departure from *Tarasoff* and related cases in which the foreseeability question is paramount because it is the injury to the third person, whether based on the patient's disclosed victims in the context of threats, or on the injudicious release of the patient hospitalized for treatment that triggers liability.

The question of the psychiatrist's liability would not necessarily arise because any other person suffered an injury. The patient, Lands, could himself have had a cause of action based upon Dr. Vest's diagnostic strategy in reducing his medications if that practice were, itself, a departure from the recognized standard of care and he could demonstrate injury as a result. But in the factual context in which *Tarasoff* and cases in which the premature release from hospitalization provides the basis for the negligence claim, it is the injury to someone other than the patient upon which the negligence claim rests.¹⁶³

1. *The Issue Before the Appellate Court*

As the court briefly summarized, Fleming's Estate claimed that Dr. Vest's treatment decisions, including the reduction in pharmaceuticals, were responsible for his patient's act in killing Fleming.¹⁶⁴ That this was the basis for the negligence claim is important in the context of the case. It goes to the heart of the physician's standard of care because it addresses the mental health professional's primary obligation toward the patient—to engage in an acceptable course of action in treatment designed to cure or address the symptoms of the patient's mental illness or impairment.¹⁶⁵ In *Tarasoff* and in the institutional discharge

163. See *Tarasoff II*, 551 P.2d at 340 (“When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”).

164. *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580.

165. See generally AM. PSYCHIATRIC ASS'N, APA COMMENTARY ON ETHICS IN PRACTICE 2 (2015), <https://www.psychiatry.org/psychiatrists/practice/ethics>

cases, negligence may be found based on a failure to consider what might otherwise be viewed as unforeseen consequences of a breach of the standard of care.¹⁶⁶ Liability rests on the proposition that for the mental health professional, such consequences are not unforeseen under the circumstances.¹⁶⁷

In contrast, the triggering factor for foreseeability analysis in *Tarasoff* is the patient's violent threat disclosed in the course of evaluation or treatment.¹⁶⁸ Similarly, with respect to the injudicious discharge of an involuntarily committed patient for treatment, the dangerousness factor is implicit because involuntary civil commitment itself is dependent on proof of some dangerousness and not simply mental illness or other disorder.¹⁶⁹

But specifically, the disposition of the negligence theory asserted by Fleming's estate was not the primary question considered by the court of appeals. Instead, the issue that led to the trial court granting summary judgment was primarily whether the plaintiff had brought their action against Dr. Vest within the required period of time or was barred by the application of the statute of limitations.¹⁷⁰ Typically, an action for negligence brought in an Arkansas court must be commenced within the three year period of limitations prescribed by statute.¹⁷¹ But in the case of a claim based upon negligence on the part of a professional covered by the Arkansas

[<https://perma.cc/U6KV-RUPE>] (noting that "[t]he physician-patient relationship is the cornerstone of psychiatric practice, and its goal is to promote patient health and well-being.").

166. See, e.g., *Taylor v. Smith*, 892 So. 2d 887, 896 (Ala. 2004) (holding the director of a methadone-treatment center owed a duty not to discharge patients under the influence of liquid methadone when it was foreseeable that the patient would be operating a motor vehicle).

167. See *id.* at 892 (explaining that the risk of a motor vehicle accident was entirely foreseeable to the director of the methadone-treatment center).

168. *Tarasoff II*, 551 P.2d at 345.

169. *Addington v. Texas*, 441 U.S. 418, 426 (1979); ARK. CODE ANN. § 20-47-207(c) (2014) ("A person shall be eligible for involuntary admission if he or she is in such a mental condition as a result of mental illness, disease, or disorder that he or she *poses a clear and present danger to himself or herself or others.*") (emphasis added).

170. *Fleming v. Vest*, 2015 Ark. App. 636, at 2-3, 475 S.W.3d 576, 578.

171. ARK. CODE ANN. § 16-56-105 (2005).

Medical Malpractice Act,¹⁷² the time period is shorter, and the action must be brought within two years.¹⁷³

Fleming's Estate initially brought suit against Lands, Community Counseling Services, and CCS's insurer on August 16, 2010,¹⁷⁴ adding Dr. Vest as a defendant on April 19, 2011, two years after Fleming's death.¹⁷⁵ The action was brought under the state's wrongful death statute.¹⁷⁶ The limitations problem arose because Dr. Vest had last met with Lands as his treating psychiatrist on February 24, 2010.¹⁷⁷ That is, if the two year limitations period applicable to medical malpractice actions proved controlling, the trial court's grant of summary judgment in favor of Dr. Vest was correct and the Estate's claim against him personally was time-barred.

The key to the limitations issue was whether the Estate's claim against Dr. Vest rested on medical malpractice, or on the broader theory of negligence that underlies the statutory action for wrongful death. The Medical Malpractice Act has a specific provision that applies:

“Medical injury” or “injury” means any adverse consequences arising out of or sustained in the course of the professional services being rendered by a medical care provider to a patient or resident, whether resulting from negligence, error, or omission in the performance of such services; or from rendition of such services without informed consent or in breach of warranty or in violation of contract; or from failure to diagnose; or from premature abandonment of a patient or of a course of treatment; or from failure to properly maintain equipment or appliances

172. ARK. CODE ANN. § 16-114-201(1) (Supp. 2015) (“Action for medical injury” means all actions against a medical care provider, whether based in tort, contract, or otherwise, to recover damages on account of medical injury as defined in this section.”).

173. ARK. CODE ANN. § 16-114-203(a) (2006); *see* Davis v. Parham, 362 Ark. 352, 361-62, 208 S.W.3d 162, 167-68 (2005) (holding that two year limitations period under malpractice statute controls over three year limitations period provided in Wrongful Death Act, ARK. CODE ANN. § 16-62-102(c) (Supp. 2015), when medical negligence is alleged as the cause of death).

174. *Fleming*, 2015 Ark. App. 636, at 2, 475 S.W.3d at 578.

175. *Id.* at 2, 475 S.W.3d at 578.

176. ARK. CODE ANN. § 16-62-102(c) (Repl. 2006) (three year limitation for wrongful death suits).

177. *Fleming*, 2015 Ark. App. 636, at 2, 475 S.W.3d at 578.

necessary to the rendition of such services; or otherwise arising out of or sustained in the course of such services.¹⁷⁸

This phrasing in the statutory definition, “any adverse consequences,” is the source of some confusion as to what the General Assembly may actually have intended, although it may well lead properly to the conclusion that liability to third persons is included whenever they suffer adverse consequences arising from the professional services of “medical providers,” a term also defined by the statute¹⁷⁹ that includes mental health professionals.¹⁸⁰ The inclusion of the word “any” in the phrase *any adverse consequences* would provide the definitional lynchpin to an argument that liability for professional negligence in diagnosis and treatment runs beyond any injury or consequence sustained by the medical provider’s patient.

Although the disposition of the liability issue by the Arkansas Court of Appeals recognizes that mental health professionals may be held liable for foreseeable injuries caused to third persons by their patients,¹⁸¹ the majority and concurring opinions in the case reflect far different approaches to resolving questions about the nature of liability. Both Judge Brown’s majority opinion, joined by Judge Abrahamson, and Judge Harrison’s concurring opinion rest on the acceptance of imposing liability on the mental health professional for

178. ARK. CODE ANN. § 16-114-201(3) (2006).

179. The statute defines medical care provider to include virtually the entire range of treating professionals and treating institutions:

“Medical care provider” means a physician, certified registered nurse anesthetist, physician’s assistant, nurse, optometrist, chiropractor, physical therapist, dentist, podiatrist, pharmacist, veterinarian, hospital, nursing home, community mental health center, psychologist, clinic, or not-for-profit home health care agency licensed by the state or otherwise lawfully providing professional medical care or services, or an officer, employee or agent thereof acting in the course and scope of employment in the providing of such medical care or medical services.

ARK. CODE ANN. § 16-114-201(2) (2006).

180. ARK. CODE ANN. § 20-45-201(4) (2014) (“‘Mental health services provider’ means a licensed certified social worker, licensed marriage and family therapist, licensed professional counselor, physician, psychologist, or registered nurse who provides mental health services.”).

181. See *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580.

negligence, generally.¹⁸² However, the two opinions reflect far different approaches to the source of liability governing the action for Fleming's death.

a. *The Majority Opinion*

Judges Brown and Abrahamson found that the negligence theory urged linking Fleming's death to Dr. Vest's diagnostic protocol squarely placed the action within the ambit of the Arkansas Medical Malpractice Act.¹⁸³ They relied on the Arkansas Supreme Court's decision in *Dodson v. Charter Behavioral Health Sys. of N.W. Ark., Inc.*,¹⁸⁴ where the court held that the fatality and injury sustained by the two plaintiffs, Drain and Dodson respectively, as a result of a traffic accident involving a psychiatric patient fell within the scope of professional negligence:

[The patient had been an] in-patient at Charter Vista Hospital in Fayetteville. Her diagnosis was severe depression, and she was placed on a suicide watch. According to a Psychiatric Evaluation completed by Dr. Stephen Dollins on March 9, 1994, she had suicidal ideations with a plan of driving in front of a truck to make her death look like an accident.¹⁸⁵

In what is, again, a procedurally complex case, the supreme court rejected the plaintiffs' argument on appeal that the case involved only an allegation of ordinary negligence based on the negligence of the patient in causing the fatal accident, observing, "Medical negligence permeates this case,"¹⁸⁶ and later, "failure to diagnose Harrison as suicidal and to provide proper services to prevent her death lay at the heart of the appellants' cause of action."¹⁸⁷

182. *Id.* at 10-11, 475 S.W.3d at 582-83 (Harrison, J., concurring) (noting that the liability of the doctor should turn on a theory of a duty owed to the non-patient third-party).

183. *Id.* at 5, 475 S.W.3d at 580.

184. 335 Ark. 96, 983 S.W.2d 98 (1998).

185. *Id.* at 99, 983 S.W.2d at 100.

186. *Id.* at 102-03, 983 S.W.2d at 102 (rejecting the plaintiff's argument that the case was only one of ordinary negligence because every allegation against the defendant "centered on a breakdown in medical care between the hospital and its patient.").

187. *Id.* at 104, 983 S.W.2d at 102.

The accident killing Drain and injuring Dodson occurred while the patient was en route to Charter Vista to obtain treatment following a call made to a Charter Vista Mobile Assessment Team employee, Minkel, in which the patient reported suicidal thoughts resulting in an aborted attempt.¹⁸⁸ Minkel assessed the seriousness of the patient's intent and, finding her rational, advised her to drive to the hospital for treatment, an approach with which the treating psychiatrist agreed.¹⁸⁹ The patient's death in the automobile accident was ruled a suicide.¹⁹⁰

Prior to trial, the plaintiffs dismissed their complaint against the treating psychiatrist without prejudice.¹⁹¹ At trial, the trial court granted a directed verdict in favor of Charter, finding that the trial evidence did not establish negligence on the part of its employee, Minkel, having earlier rejected Charter's argument that it owed no duty to its patient based on her suicide.¹⁹² This means that the trial court found that Charter Vista did owe a duty to the third persons killed and injured in their patient's suicidal accident—the suicide finding as to cause of death establishing that her action was intentional and not the result of such negligence that it would not have been foreseeable—based on knowledge of her impaired mental state.¹⁹³

However, the supreme court did not reach an ultimate question regarding duty to third persons,¹⁹⁴ upholding the trial court's directed verdict based on its conclusion that the testimony offered by the plaintiff's expert witness failed to establish that either the treating psychiatrist or Charter Vista MAT employee, Minkel, breached a duty of care in their treatment of the patient.¹⁹⁵ Without expert opinion that there had been a breach of the standard of care, the jury could not have

188. *Id.*

189. *Dodson*, 335 Ark. at 100-01, 983 S.W.2d at 101.

190. *Id.* at 101, 983 S.W.2d at 101.

191. *Id.*

192. *Id.* at 99-102, 983 S.W.2d at 100-01.

193. *Id.* at 101-03, 983 S.W.2d at 101-02.

194. *Dodson*, 335 Ark. at 103, 983 S.W.2d at 102 (“The trial court found that there was a special relationship and that a duty was owed, but we do not view that finding as determinative of whether this is a medical negligence case.”).

195. *Id.* at 102-04, 983 S.W.2d at 100-01.

returned a verdict reflecting a finding of malpractice, or professional negligence, rendering the issue of the scope of the medical provider's duty to the accident victims moot.¹⁹⁶

Nevertheless, *Dodson* certainly implies that the standard of care would include the duty to protect third persons from foreseeable injuries and Judge Brown's majority opinion rests comfortably on this assumption based on the court's explicit finding that the claim brought by *Dodson* was governed by the Medical Malpractice Act.¹⁹⁷ Summarizing the specific allegations of deficient performance by Charter Vista that the plaintiffs had included in their complaint, the supreme court explained, "All of these allegations are centered on a breakdown in medical care between the hospital and its patient."¹⁹⁸

Once the majority concluded that the case was governed by the malpractice statute, the two-year statute of limitations would have appeared to preclude recovery on the claim against Dr. Vest asserted more than two years after Fleming's death. But the majority relied on an exception to the strict application of a two-year term for filing when the medical provider has engaged in a "continu[ous] course of treatment" for the patient.¹⁹⁹ The majority relied on the supreme court's explanation of this approach, which predated adoption of the Medical Malpractice Act, in *Tullock v. Eck*.²⁰⁰ In *Tullock*, the court explained the "continuous treatment" doctrine relied on Arkansas medical malpractice actions following adoption of the Medical Malpractice Act:

In contrast to the so-called continuing tort theory, based on a single negligent act with on-going injury, the continuous treatment doctrine becomes relevant when the medical negligence consists of a negligent act, followed by a continuing course of treatment for the malady which was the object of the negligent treatment or act.²⁰¹

196. *Id.*

197. *Id.* at 102-03, 983 S.W.2d at 102.

198. *Id.* at 103, 983 S.W.2d at 102.

199. *Fleming v. Vest*, 2015 Ark. App. 636, at 7 n.13, 475 S.W.3d 576, 581 n.13 (citing *Tullock v. Eck*, 311 Ark. 564, 570, 845 S.W.2d 517, 521 (1993)).

200. *Id.* at 569-71, 845 S.W.2d at 520-21.

201. *Id.* at 570, 845 S.W.2d at 521.

In distinguishing the two theories, “continuing tort,” and “continuous treatment,” the court explained that the former was predicated on proof that the physician’s negligence resulting in an ongoing injury, such as a misdiagnosis followed by cancer, would permit assertion of the negligence claim only after discovery of the injury by the patient.²⁰² Application of continuing tort theory would have imposed a discovery rule for triggering the limitations period, which the court found inconsistent with the legislative intent in the adoption of the Medical Malpractice Act and its two year limitations period.²⁰³

Judges Brown and Abrahamson concluded that the “continuous treatment” rule applied to Fleming’s Estate’s claim against Dr. Vest based on the fact that the psychiatrist continued to monitor Lands during the reduction in his medications following the February, 2010, visit; that Dr. Vest had no intention of abandoning his patient; and, in fact, had scheduled an appointment for Lands sometime after April 21, 2010.²⁰⁴ This evidence led the majority to find that Dr. Vest could be found to still be engaged in treatment of Lands after that date—critical for application of the limitations period governing the Fleming claim—in holding that the claim was not barred by the malpractice statute’s two-year statute of limitations. They pointed out, however, that the issue of continuous treatment was an unresolved factual issue that had to be resolved by the jury at trial.²⁰⁵

Perhaps, ironically, the majority opinion appears to have glossed over some of the elements of the malpractice claim most important to mental health professionals. The irony lies in the fact that the majority must have realized how dramatic its decision might prove to be in expanding tort liability for a major group of medical professionals, yet issued an opinion supporting that expansion without addressing core issues facing those professionals and their necessary understanding of an additional duty to be imposed upon practice decisions.

202. *Id.* at 569-70, 845 S.W.2d at 520-21.

203. *Id.*

204. *Fleming*, 2015 Ark. App. 636, at 8, 475 S.W.3d at 582.

205. *Id.* at 8, 475 S.W.3d at 582.

For example, this is not strictly a *Tarasoff* claim because it did not involve a failure to warn the third person allegedly injured due to the psychiatrist's negligence. There was no evidence referenced in the majority opinion that Lands threatened Fleming or anyone else, or even expressed any particular hostility toward others. One would have expected the majority to explain how the foreseeability requirement—the heart of a tort action—could be demonstrated based on the evidence developed in the trial court. If the record included such evidence, the majority failed, whether deliberately or inadvertently, to reference it in the opinion.

In the absence of some proof that Dr. Vest could reasonably have been expected to anticipate that his patient would engage in violence toward any third person, the majority almost suggests that foreseeability is not implicit in any duty imposed upon the treating mental health professional. Without evidence of knowledge of a patient's propensity to engage in violence, or disclosure of an intended victim, a departure from proof of foreseeability threatens imposing liability strictly,²⁰⁶ without any showing of negligence on the part of the mental health professional.

b. *The Concurring Opinion*

Judge Harrison's concurring opinion in *Fleming v. Vest*²⁰⁷ reflects a dramatic departure from the majority with respect to the fundamental question of whether the negligence claim should be viewed as governed by the Medical Malpractice Act, in which event the two year limitations issue was critical to the ability of the plaintiff to sustain its claim. In contrast to the majority, he concluded that the claim did not involve medical malpractice at all and should not be governed by the Act. Consequently, he argued that the two year limitations period mandated for medical malpractice claims did not apply and, thus, the Estate's filing against Dr. Vest was timely, falling

206. *Brady v. Hopper*, 570 F. Supp. 1333, 1339 (D. Colo.) (noting that imposition of liability without consideration of foreseeability of the patient's violent actions would result in a duty exposing the mental health professional to strict liability, without proof of fault).

207. *Fleming*, 2015 Ark. App. 636, at 10-14, 475 S.W.3d at 583-85 (Harrison, J., concurring).

within the three year limitations generally applicable in Arkansas tort actions.²⁰⁸ Judge Harrison wrote an analysis of the claim:

This case is not one for medical malpractice because it does not truly probe whether Dr. Vest properly treated a person with whom he had a doctor-patient relationship. This case turns, at least in part, on whether Dr. Vest owed a legal duty to control or confine patient Lands so as to protect Fleming, who was not a patient. That strikes me as being a fundamentally different question that needs an analytical framework apart from the Act.²⁰⁹

In finding that the fatal injury inflicted by Lands, the patient, was not an “adverse consequence” of the treatment rendered by Dr. Vest, Judge Harrison observed that this characterization would expand the concept of liability for malpractice too far, that “[e]very legal concept should have its practical limit.”²¹⁰ He argued his point even further:

A troublesome point with applying the Medical Malpractice Act in this case is that the shooting itself must arguably be the actionable “adverse consequence.” Because until Lands shot Fleming, the latter man was not “injured” by Dr. Vest’s treatment of Lands. Yet how can the violent, intentional act that Lands committed against Fleming equate to a medical injury? To so conclude injects a legal fiction into an area of the law where one is not needed to carry out the general assembly’s intent, in real-world affairs. The law of unintended consequences may have just been triggered. Applying the Act in a case like this one arguably undermines the general assembly’s main reason for promulgating the Act, because it seems to expand the potential tort liability that medical-care providers could face.²¹¹

208. *Id.* at 10, 475 S.W.3d at 583.

209. *Id.* at 11, 475 S.W.3d at 583.

210. *Id.*

211. *Id.* at 11, 475 S.W.3d at 583-84.

He then resurrected the still-viable decision in *Chatman v. Millis*²¹² to argue that medical malpractice claims should be “tether[ed]” to the provider/patient relationship, and relied on the court of appeal’s holding in *Thompson v. Sparks Reg’l Med. Ctr.*, issued in 2009.²¹³

In *Thompson*, however, the court of appeals considered a claim based on the defendant Sparks’ refusal to admit the plaintiff for emergency treatment because she had previously been admitted at another hospital, St. Edward Mercy Medical Center, which did not have a plastic surgeon available on call to treat the patient’s injuries.²¹⁴ Plaintiff then sought treatment at Sparks, which did have a plastic surgeon on call;²¹⁵ the surgeon refused to treat the plaintiff because she had already been admitted at St. Edwards where he had lost his privileges and was, thus, unable to treat her there.²¹⁶ When plaintiff’s father sought to have Sparks agree to admit her for treatment, he was advised by a nurse that she did not authority to admit a patient, nor to require a physician to treat a patient.²¹⁷ She did, however, advise the father that if the plaintiff presented at the Sparks’ emergency room, she would be treated, but the plaintiff never sought admission at Sparks through the emergency room. She was eventually treated at St. Edwards.²¹⁸

The plaintiff sued Sparks under the Emergency Medical Treatment and Active Labor Act for refusal to admit her as a patient²¹⁹ and also claimed recovery under the Medical Malpractice Act.²²⁰ The court of appeals concluded that she

212. *Fleming*, 2015 Ark. App. 636, at 13, 475 S.W.3d at 584 (citing *Chatman v. Millis*, 257 Ark. 451, 453, 517 S.W.2d 504, 505 (1975)).

213. *Id.* (citing *Thompson v. Sparks Reg’l Med. Ctr.*, 2009 Ark. App. 190, at 5, 302 S.W.2d 35, 38).

214. *Thompson*, 2009 Ark. App. 190, at 1-2, 302 S.W.3d at 36.

215. *Id.*

216. *Id.*

217. *Id.* at 2, 302 S.W.3d at 36.

218. *Id.*

219. *Thompson*, 2009 Ark. App. 190, at 1, 3-4, 302 S.W.3d at 37-38 (holding that plaintiff could not sustain her action under the Act, commonly referred to as the “anti-dumping statute” that prevents hospitals from refusing to treat or accept transfer of a patient needing the special services available at the transferee institution. She was offered the option of admission through the Sparks emergency room, but did not avail herself of this option, remaining at St. Edward for treatment.).

220. *Id.* at 5-6, 302 S.W.3d at 38.

could not sustain an action for malpractice against Sparks, explaining, “Because it is undisputed that Sparks never provided ‘professional services,’ the plain reading of the statute does not impose liability on it for Thompson’s alleged injuries.”²²¹

Thompson v. Sparks Reg’l Med. Ctr. is factually dissimilar from the claim urged in *Fleming v. Vest*. Despite the broad interpretation of the Medical Malpractice Act with regard to liability of medical providers, its language cannot be reconciled with an absence of any treatment by a provider whatsoever. The key provision defines “medical injury” or “injury” as “any adverse consequences” resulting from “negligence, error or omission” in provision of medical services; violation of informed consent; failure to properly diagnose; premature abandonment of a patient; failure to maintain equipment used in delivery of medical services; or “otherwise arising out of or sustained in the course of such services.”²²² Thompson’s could not reasonably arise from any definition of “medical injury” under the statute.

Judge Harrison, thus, argued that Fleming’s claim would fail under the Medical Malpractice Act essentially because it did not result from an injury he sustained as a patient.²²³ But, in contrast to the facts in *Thompson*, it did rest precisely on an allegation of “error, negligence or omission” on Dr. Vest’s part in reducing his patient’s medication for diagnostic and treatment purposes.

Consistent with subsection (3),²²⁴ the treatment decision might have permitted recovery for Fleming’s “injury” based on any of several bases for liability: whether there was *error* in undertaking this approach for an outpatient not subject to continuing observation; whether there was *negligence* in failing to appreciate possible risk that withdrawal of medication might lead to patient becoming violent; or whether there was *omission* in failing to more carefully or regularly monitor the patient’s

221. *Id.* at 6, 302 S.W.3d at 38.

222. ARK. CODE ANN. § 16-114-201(3) (Supp. 2015). For complete text of subsection (3), see *supra* note 178.

223. *Fleming v. Vest*, 2015 Ark. App. 636, at 2, 475 S.W.3d 576, 578.

224. ARK. CODE ANN. § 16-114-201(3) (Supp. 2015).

progress and possible symptoms during the period of withdrawal of decrease or withdrawal of medication.²²⁵

The negligence allegation in *Fleming v. Vest* was rooted in the claim that the decision to reduce medication for Lands led to Fleming's fatal injury, as the majority explained, "in order to determine the appropriate medication regimen, [Dr. Vest] began to withdraw the level of pharmaceuticals administered to Lands."²²⁶ Without the reference to the professional relationship between Lands and Dr. Vest, there could be no duty on the part of Dr. Vest to protect Fleming in any sense because there is no general duty to prevent anyone else from injuring a third person—the exceptions being when there is a special relationship between the actor and person causing the injury to the third person or the actor assumes the responsibility for protecting the third person.²²⁷ Nothing in the facts related by either the majority or concurring judges would have established the element of duty required to support a claim of negligence.

Judge Harrison's reference to the law of unintended consequences might not only have reflected his concern that the majority's approach unreasonably expanded the language of the Malpractice Act beyond the General Assembly's intent in adopting, but a recognition that responsibility for Fleming's death simply could not be placed on Dr. Vest on the record before the trial court when it granted summary judgment.

In invoking *Tarasoff* as authority on the question of the scope of duty imposed by law on mental health professionals, Judge Harrison did not discuss the rather significant factual contexts in which *Tarasoff* and *Fleming v. Vest* respectively arose. Of critical importance is that *Tarasoff* responded to a situation in which the therapist had actual knowledge of the patient's threats directed at a known potential victim, his estranged girlfriend.²²⁸ In *Fleming*, however, the theory of liability does not rest on the therapist's failure to warn an identified victim, but rather on the random act of the psychiatric

225. ARK. CODE ANN. § 16-114-201(3).

226. *Fleming*, 2015 Ark. App. 636, at 2, 475 S.W.3d at 578, 580 ("Here, the allegation was that Scott Fleming's death occurred because of the professional services (or lack thereof) being provided to Samuel Lands by appellee.").

227. *Id.* at 13, 475 S.W.3d at 584.

228. *Tarasoff II*, 551 P.2d at 341.

patient resulting in the murder of an unidentified victim based on an alleged defect in practice constituting negligence.²²⁹

To hold Dr. Vest accountable, it would be necessary to adopt the duty to warn the public generally, not limiting the mental health provider's responsibility to situations in which the patient is known to threaten a prospective, identifiable victim. This was the general duty to protect the public that the Iowa Supreme Court had rejected in *Leonard*.²³⁰ Judge Harrison clearly opposes the use of the Medical Malpractice Act to expand liability of physicians and, in this case, mental health providers, as evidenced by his concluding remarks arguing that the case should be remanded to the trial court for consideration of the liability of Dr. Vest as a matter of negligence generally:

I express no opinion on the merits of the complaint, nor whether a duty in tort exists. My point here is solely that the Medical Malpractice Act—and the law that goes hand-in-glove with it—does not apply. So I would not apply the Act's two-year limitations period or the continuous-treatment doctrine. It also means that the circuit court should be directed to address, as a matter of law, whether a tort-based duty runs from Dr. Vest to Fleming apart from the Act. How it would determine whether a duty exists apart from the Act is for the parties to argue and the circuit court to decide.²³¹

Remanding for the trial court to determine whether the injury to Fleming could properly provide the basis for liability beyond the ambit of the Medical Malpractice Act would necessarily have further delayed any final resolution of the contested issue. The problem lies in the fact that the Act does broaden the theory of provider liability in the use of the phrase "any adverse consequences." Despite Judge Harrison's point that the state supreme court's decision in *Dodson v. Charter Vista* did not have a "clear holding"²³² that would govern

229. *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580.

230. *Leonard v. State*, 491 N.W.2d 508, 512 (Iowa 1992).

231. *Fleming*, 2015 Ark. App. 636, at 14, 475 S.W.3d at 585.

232. *Id.* at 11, 475 S.W.3d at 583. The *Dodson* court had declined to embrace the trial court's finding that Charter Vista owed a duty to the plaintiff based on the special

Fleming's Estate's claim, the court's disposition did not include any express rejection of the Medical Malpractice Act as the basis for liability that one might have expected if the intent of the General Assembly was clearly to limit physician liability with respect to third persons, as opposed to patients.²³³

C. The Complex Procedural Context

Judge Harrison characterized, and quite artfully explained, the issues before the court in *Fleming v. Vest*:

This case brings Arkansas to an important judicial crossroads: will our courts continue to expand the Act's definition of what constitutes a "medical injury" and thus pull more providers into the Act's orbit? Or will they begin taking a more nuanced approach, especially in cases where a medical-care provider's patient commits an intentional harm upon a third person, and more carefully analyze whether a provider can be sued in tort at all?²³⁴

The case arose in the context of an appeal to the Arkansas Court of Appeals from the trial court's decision granting summary judgment to the defendant, rather than from a verdict rendered by a jury or trial court having heard the case fully on the merits.²³⁵ As a consequence, the decision rendered by the panel of the court of appeals, an intermediate appellate court, must be viewed in light of the procedural consequences of disposition by summary judgment, rather than following a trial on the merits, and the limited appellate review involved in considering the trial court's action in granting judgment for the defendant summarily.²³⁶

1. *The Unaddressed Issue of Proximate Cause*

The majority opinion by Judge Brown did not address the ultimate question for a negligence determination, whether the

relationship with their patient and that the duty to the third party was owed by Charter for the acts of their patient. *Dodson*, 335 Ark. at 103, 983 S.W.2d at 102.

233. *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580.

234. *Id.* at 14, 475 S.W.3d at 584-85.

235. *Id.* at 1, 475 S.W.3d at 578.

236. *Id.* at 3, 475 S.W.3d at 578-79.

actions of the defendant were the *proximate cause* of the fatal injury suffered by Fleming. The court of appeals, in an earlier case alleging medical malpractice, *Dodd v. Sparks Reg'l Med. Ctr.*,²³⁷ had upheld the trial court's judgment for defendant physicians based on the plaintiff's claim that they had been negligent in essentially failing to prevent the suicide of their patient.²³⁸ The plaintiff had been unable to offer expert testimony that the physician defendants were negligent in their diagnosis or treatment of the patient, and the court held, "In malpractice cases, a defendant is entitled to summary judgment when it is shown that the plaintiff has no qualified expert to testify as to the applicable standard of care."²³⁹

The *Dodd* court also found that the evidence was insufficient to support a claim based on ordinary, instead of medical, negligence based on the defendant hospital's failure to remove a different door stop in the patient rooms because patient's suicide was committed by hanging herself after being able to close the door using the stop.²⁴⁰ The expert testimony offered by a nursing supervisor and a nurse explained that suicidal individuals seek privacy to facilitate commission of their acts and had the nurse known the doorstop had been left in the patient's room, she would have removed it.²⁴¹

Despite the expert testimony, the *Dodd* court ruled that the evidence was insufficient to establish that any failure to remove the doorstop was the proximate cause for the patient's suicide.²⁴² The court explained its ruling:

Proximate cause is that which in a natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury and without which the result would not have occurred. This traditional tort standard requires proof that "but for" the tortfeasor's negligence, the plaintiff's injury or death would not have occurred. Proximate causation becomes a question of law if reasonable minds

237. 90 Ark. App. 191, 196, 204 S.W.3d 579, 582 (2005).

238. *Id.* at 200, 204 S.W.3d at 585.

239. *Id.* at 198, 204 S.W.3d at 584.

240. *Id.* at 200, 204 S.W.3d at 584.

241. *Id.*

242. *Dodson*, 90 Ark. App. at 200, 204 S.W.3d at 585.

could not differ as to the result. As applied here, it was appellant's burden to demonstrate that the removal of the door-stop would have prevented Ms. Dodd from committing suicide.²⁴³

Thus, even though Dr. Vest's medication reduction decision might have been characterized as constituting negligent practice or deviation from the accepted standard of care, expert opinion on that issue did not necessarily demonstrate that his patient, Lands, would not have killed Fleming "but-for" the psychiatrist's diagnostic strategy. Certainly, Lands could have simply stopped taking any medication as an out-patient and experienced some psychological lapse leading to his violent act against Fleming. In fact, as the majority noted, Lands was in the care of Dr. Vest as a consequence of having been acquitted by reason of mental disease or defect on charges of "battery, escape, resisting arrest, assault, and fleeing," suggesting a propensity for violence prior to his hospitalization.²⁴⁴

Whether the action sounded in medical malpractice, as the majority found,²⁴⁵ or in ordinary negligence, as argued in the concurrence,²⁴⁶ the facts related by the court fail to demonstrate that Fleming's Estate could ever meet the burden imposed by the law of establishing that Dr. Vest's diagnostic protocol was the proximate cause of Fleming's death at the hands of the patient. Judge Harrison was explicit in preferring to remand the case to the trial court for resolution of this issue,²⁴⁷ while the majority proceeded on the impact of the limitations period on the claim depending on whether it was governed by the Medical Malpractice Act or ordinary negligence principles.²⁴⁸

The decision of the court of appeals in failing to address even the possibility that Fleming's Estate could meet its burden of proving proximate cause on the state of the record on appeal, leaves open a major unanswered question on the facts of this case. This is not *Tarasoff*, resting on evidence of a disclosed

243. *Id.* (internal citations omitted).

244. *Fleming v. Vest*, 2015 Ark. App. 636, at 1-2, 475 S.W.3d 576, 578.

245. *Id.* at 5, 457 S.W.3d at 580.

246. *Id.* at 14, 457 S.W.3d at 585 (Harrison, J., concurring).

247. *Id.* at 14, 457 S.W.3d at 585.

248. *Id.* at 5, 457 S.W.3d at 580.

threat and identified victim, but a case of unforeseen consequences. Whether the treating psychiatrist could ever be held liable in such circumstances remains an important, unresolved issue, likely to spill over into many situations in which mental health providers are required to make diagnostic decisions that could, in theory or abstractly, render them liable for damages—liable for damages they did not cause directly, but were caused by their patients.

2. *The Questionable Precedential Value of the Panel Decision*

Briefly, the problems posed by the parameters of the decision in *Vest* are apparent, not the least being that the decision represents the analysis of only a three judge panel of the Arkansas Court of Appeals²⁴⁹ rather than a seminal statement offered by the Arkansas Supreme Court, the court of last resort in the state.²⁵⁰ Because the intermediate appellate court's decision was not tested by petition for review in the supreme court²⁵¹ or by certification by the lower court on an important novel interpretation of Arkansas law,²⁵² it is not as forceful as it would be had it been the decision of the supreme court.

It is the supreme court, of course, that almost always engages in decision-making that reflects a major shift in state law by the judicial branch.²⁵³ For example, the state supreme court announced such a shift in law in *Aka v. Jefferson Cty.*

249. *Fleming*, 2015 Ark. App. 636, at 1, 10, 475 S.W.3d at 576-77.

250. *See Foster v. Hill*, 372 Ark. 263, 267, 275 S.W.3d 151, 155 (2008) (discussing the court's inherent superintendent control over lower courts, enabled so that the court can "fulfill its role as the court of last resort in the state.").

251. ARK. SUP. CT. R. 2-4(c) (authorizing a litigant to petition for review by the supreme court of a decision rendered by the court of appeals where an issue meets the test of Rule 1-2(b) setting forth the jurisdiction of the state supreme court, including, *inter alia*; "(1) issues of first impression . . . (4) issues of substantial public interest, [and] (5) significant issues needing clarification or development of the law, or overruling of precedent . . .").

252. ARK. SUP. CT. R. 1-2(d) (authorizing the court of appeals to certify a case to the state supreme court for review on direct appeal when the case "involves an issue of significant public interest or a legal principle of major importance").

253. *See, e.g., Jegley v. Picado*, 349 Ark. 600, 638, 80 S.W.3d 332, 353-54 (2002) (recognizing a person's right to engage in consensual, adult, homosexual activity under the Arkansas Constitution, precluding criminal prosecution for sodomy).

Hosp. Ass'n,²⁵⁴ holding that a fetus is a “person” within the meaning of the Arkansas Wrongful Death Statute,²⁵⁵ and overruling its prior precedent in *Chatalain v. Kelley*.²⁵⁶ The court exercised its jurisdiction on certification by the court of appeals based on the importance of the issue as a matter of first impression,²⁵⁷ extending liability of medical professionals to include negligence resulting in death during the delivery of a baby whose death was claimed to have been caused by various failures on the part of the obstetrician and other physicians.²⁵⁸ Of particular importance to physicians and litigants in other cases, the *Aka* Court made its new rule overruling *Chatalain v. Kelley*, applicable to benefit the appellant in *Aka* and, prospectively, only to all cases arising after the rule was announced in the *Aka* decision.²⁵⁹

In contrast, in the wake of *Fleming v. Vest*, litigants and practitioners do not enjoy the degree of certainty that may be relied upon when the state supreme court has rendered the key decision determining the rights of parties in future litigation as would have been true had the decision been issued by the state supreme court. It is possible that the majority anticipated that its decision would be reviewed by the supreme court and that any

254. 344 Ark. 627, 641-42, 42 S.W.3d 508, 517-18 (2001).

255. *Id.* at 640, 42 S.W.3d at 516; ARK. CODE ANN. § 16-62-102 (Supp. 2015).

256. 322 Ark. 517, 525, 910 S.W.2d 215, 219 (1995).

257. *Aka*, 344 Ark. at 633, 42 S.W.3d at 512 (“The Court of Appeals certified this first-impression case for us to consider appellant’s arguments urging the reversal of precedent.”).

258. *Id.* The specific claims of negligence against the physicians included “unnecessarily inducing his wife’s labor, failing to discontinue the induction, failing to perform a cesarean section, failing to resuscitate her or the unborn baby, and failing to obtain informed consent.” *Id.* The father, as special representative of his wife and child’s estates, also sued the hospital alleging negligence in failing to properly train and supervise the medical staff. *Id.* The mother also died during the birth procedure, but potential liability under the statute for her death was not an issue in this appeal. *Id.*

259. *Id.* at 642-43, 42 S.W.3d at 19 (explaining that the court’s policy on retroactive application of new rules or principles was to “make the new rule applicable only to the case at bar and to causes of action arising after the decision becomes final,” acknowledging that “no matter how a new rule of law is applied, the benefit of the new decision is denied to some injured persons.” Thus, other potential litigants whose claims of malpractice would have arisen prior to the announcement of the new rule finding that a fetus is a person under the wrongful death statute would not be able to rely on *Aka* to support the legal theory underlying their claims. Otherwise, other potential defendants would have not had fair notice of the scope of the professional duty owed in factually similar situations.).

deficiency in its reasoning would be corrected. That did not happen, perhaps leaving mental health providers, patients, litigants and counsel to wonder whether the imposition of a duty to protect third persons without notice of who might be reasonably expected to be within the ambit of that duty to protect will ultimately prove to be a correct statement of professional duty under Arkansas law.²⁶⁰

3. *Review of Summary Judgment, Rather Than Trial Verdict*

Third, the decision does not, in a sense, directly address the questions of duty or liability because they arise in the context of summary judgment practice and rest, in significant part, on the resolution of the procedural issue as to when the applicable statute of limitations is triggered by a patient's act of violence injuring a third person. The two opinions of the court of appeals judges rest on significantly different approaches to the resolution of the limitations issue, rather than on any ultimate determination of the extent of the duty mental health professionals may owe to third persons injured as the result of patient violence.

Summary judgment practice does not serve to establish final statements of law.²⁶¹ It is a remedy that is applied in two different contexts relevant to the issue of professional

260. Similarly, the state supreme court might view the "continuous treatment" exception to the strict application of the two year limitations period for medical malpractice claims differently than the majority in the court of appeals did. While reliance on the "continuous treatment" theory was not required to address a limitations problem on the facts of the case, it fit precisely in the factual framework in *Dodson v. Charter Behavioral Health Sys. of N.W. Ark., Inc.*, 335 Ark. 96, 100-01, 983 S.W.2d 98, 100-01 (1998), where the patient's suicidal traffic accident resulting in injury and death to third persons in another vehicle occurred as the patient was travelling to the hospital for emergency treatment at the direction of the mental health provider. The supreme court might distinguish *Dodson* based on the vaguely referenced future appointment Lands had scheduled with Dr. Vest, in terms of the proper "continuous treatment." *Fleming*, 2015 Ark. App. 636, at 7-8, 475 S.W.3d at 581. But, it is highly likely that the supreme court would view the factual contexts similar in holding that *Fleming's Estate* could expect to rely on "continuous treatment" to avoid the two year limitations bar.

261. See *Rohner v. Union Pac. R.R. Co.*, 225 F.2d 272, 274 (10th Cir. 1955) ("The intended purpose of the summary judgment provision is to enable the trial court to readily dispose of cases on matters of law where it becomes evident no material controversy of fact remains.").

negligence raised in *Fleming v. Vest*.²⁶² It may serve to provide a determination by the trial judge that regardless of the evidence that the plaintiff may be able to develop, the jurisdiction's legal precedents or statutory authority simply do not afford a plaintiff a right to recover on the legal theory presented.²⁶³ In *Fleming*, the panel concluded that Arkansas law would recognize a cause of action based on the failure of a mental health professional to prevent injury to a third person based on the violent propensities of a patient which were known or should have been known by the therapist.²⁶⁴

Alternatively, summary judgment may be ordered by the trial court when the plaintiff relies on a cause of action or theory of recovery recognized in the jurisdiction, but simply is unable to produce sufficient evidence upon which relief could be granted.²⁶⁵ Once the plaintiff is able to produce supporting evidence—in this case expert opinion that the defendant therapist failed to exercise the appropriate standard of care required under the circumstances—the plaintiff has met their burden and the case must be decided on the merits at trial by the jury, or court, sitting as the fact-finder in the case.²⁶⁶

What the disposition in *Fleming* does not clarify is whether the theory of negligence asserted, relating to the psychiatrist's decision to reduce medication as a diagnostic tool would constitute a proper foundation for the negligence action. It serves merely to show that the plaintiff was able to offer expert opinion that Dr. Vest's approach reflected an improper departure from the acceptable standard of care in Arkansas practice. Thus,

262. See, e.g., 2015 Ark. App. 636, at 3, 475 S.W.3d at 579.

263. For instance, in *Sowers v. St. Joseph's Mercy Health Ctr.*, 368 Ark. 466, 468, 247 S.W.3d 514, 516-17 (2007), the plaintiff sued for injuries suffered during her discharge from defendant hospital while being transported by hospital employees in a wheel chair to an automobile. The defendant was not subject to suit based on the application of the state's charitable immunity statute prohibiting liability for institutions protected by this doctrine. *Id.* The issue before the state supreme court was an issue of law and the summary judgment granted by the trial court was subject to review *de novo* on appeal. *Id.*

264. *Fleming*, 2015 Ark. App. 636, at 5, 475 S.W.3d at 580.

265. "Summary judgment should only be granted when it is clear that there are no genuine issues of material fact to be litigated, and the moving party is entitled to judgment as a matter of law. The purpose of summary judgment is not to try the issues, but to determine whether there are any issues to be tried." *Id.* at 3, 475 S.W.3d at 578.

266. *Id.*

while the plaintiff was able to offer evidentiary support for the negligence claim, Arkansas courts arguably might still reject the opinion offered in the action as definitive on the question of negligence, just as jurors or the court could consider the expert opinion and reject it as sufficiently probative to warrant a verdict for the plaintiff, particularly if the plaintiff's expert testimony is controverted by credible expert opinion reaching the contrary conclusion. The Arkansas Medical Malpractice Act, moreover, requires the plaintiff to offer supporting expert opinion on most questions of standard of care and negligence.²⁶⁷ The opinions in *Fleming* do not address the scope of expert opinion offered by the plaintiff's expert with respect to causation with regard to Fleming's injury and, perhaps, any opinion in this respect would be beyond the expertise of the expert. Even given the assessment of risk of violence and departure from the standard of care, without any evidence that Fleming was personally at risk of the violent act of Lands, it would seem that an opinion on the likelihood that a fatal injury to Fleming would be foreseeable to the treating therapist would only amount to speculation and be subject to objection.

IV. CONCLUSION

267. The Plaintiff's burden of proof:

In any action for medical injury, when the asserted negligence does not lie within the jury's comprehension as a matter of common knowledge, the plaintiff shall have the burden of proving:

- (1) By means of expert testimony provided only by a medical care provider of the same specialty as the defendant, the degree of skill and learning ordinarily possessed and used by members of the profession of the medical care provider in good standing, engaged in the same type of practice or specialty in the locality in which he or she practices or in a similar locality;
- (2) By means of expert testimony provided only by a medical care provider of the same specialty as the defendant that the medical care provider failed to act in accordance with that standard; and
- (3) By means of expert testimony provided only by a qualified medical expert that as a proximate result thereof the injured person suffered injuries that would not otherwise have occurred.

ARK. CODE ANN. § 16-114-206(a)(1)-(3) (2006). The Act is consistent with prior case law requiring expert testimony to establish standard of care in medical malpractice cases. *See, e.g., Fuller v. Starnes*, 268 Ark. 476, 477-78, 597 S.W.2d 88, 88-89 (1980); *Eady v. Lansford*, 351 Ark. 249, 254-255, 92 S.W.3d 57, 60-61 (2002).

Arkansas mental health providers can hardly welcome debate arising in the context of litigation over the scope of their duty to protect third persons from the criminal or violent acts of their patients. The court of appeals disposition in *Fleming v. Vest* certainly suggests that there is sentiment for increasing the liability of mental health professionals under the state's Medical Malpractice Act.²⁶⁸ With respect to victim warning claims, such as one of the theories of negligence asserted in *Tarasoff*, the legislation expanding immunity for Arkansas mental health providers who take action under Act 1212, was expressly characterized as being designed to impose a "duty to warn" third persons or law enforcement of the providers affirmative duty to warn.²⁶⁹ That reference to a *duty to warn* does not appear in the statute, as adopted.²⁷⁰

At least three theories for liability of mental health providers may be discerned from the cases. First, *Tarasoff* clearly addressed liability based on a duty to warn third persons of potential harm based on disclosure by patients of an intention to commit acts of violence against identified potential victims.²⁷¹ The extension of immunity for providers warning law enforcement, in addition to the traditional remedy of emergency hospitalization for involuntary commitment determinations, both applicable under Section 20-45-202 of the Arkansas Code,²⁷² clearly contemplates that providers are under a duty to take action to avert injuries to third persons when patients make credible threats against others and perhaps to the public, generally.²⁷³

Second, in a number of cases, an alternative theory of liability is urged based on the claimed negligence in commitment and discharge decisions, as the *Tarasoff* plaintiffs alleged.²⁷⁴ To a significant extent, liability of providers for these decisions will be addressed by immunity afforded by state law for those involved in emergency or involuntary commitment

268. *Fleming*, 2015 Ark. App. 636, at 4-5, 7, 9, 475 S.W.3d 576, 579-82.

269. Act 1212, 2013 Ark. Acts 4964.

270. ARK. CODE ANN. § 20-45-202 (2014). For a discussion, see *supra* note 4.

271. *Tarasoff II*, 551 P.2d at 340.

272. ARK. CODE ANN. § 20-45-202.

273. ARK. CODE ANN. § 20-45-202.

274. *Tarasoff II*, 551 P.2d at 342-44.

decisions.²⁷⁵ Courts have been reluctant to impose liability for discharge decisions, particularly where imposition of liability would require recognition of the mental health professional's duty to the public at large.²⁷⁶

The plaintiffs in *Brady v. Hopper*, predicated one theory of provider negligence on the psychiatrist's claimed failure to seek hospitalization to protect the third person victims of Hinckley's violent acts.²⁷⁷ The court, however, cautioned against attempts to impose liability based on this theory in similar cases:

In the present case, there are cogent policy reasons for limiting the scope of the therapist's liability. *To impose upon those in the counseling professions an ill-defined "duty to control" would require therapists to be ultimately responsible for the actions of their patients.* Such a rule would closely approximate a strict liability standard of care, and *therapists would be potentially liable for all harm inflicted by persons presently or formerly under psychiatric treatment.* Human behavior is simply too unpredictable, and the field of psychotherapy presently too inexact, to so greatly expand the scope of therapists' liability.²⁷⁸

Nevertheless, failure to control claims based on failure to seek hospitalization or improper release of confined individuals will likely continue to prove enticing because the notion that patient violence will be addressed most effectively if patients remained confined in mental health facilities is superficially so plausible.²⁷⁹ However, statutory immunity necessarily limits

275. ARK. CODE ANN. § 20-47-227 (2014). Such immunity serves to protect even negligence, but not gross negligence, malice or bad faith when an emergency hospitalization attempt fails, as reflected in the *Tarasoff* court's reference to the emergency hospitalization effort undertaken by Poddar's therapists as "bungled." See *supra* note 48 and accompanying text.

276. See *Leonard v. State*, 491 N.W.2d 508, 511 (Iowa 1992) ("Does the duty to refrain from negligently releasing dangerous persons from custody run from the custodian to the public at large or only to the reasonably foreseeable victims of the patient's dangerous tendencies?").

277. 570 F. Supp. 1333, 1335 (D. Colo. 1983).

278. *Id.* at 1339 (emphasis added).

279. *Foucha v. Louisiana*, 504 U.S. 71 (1992) (noting one of the problems with the assumption that confinement based on the involuntary commitment process (preemptive confinement) will serve to protect third persons lies in the constitutional limitation that

recovery possibility on such claims,²⁸⁰ typically undertaken by private practitioners who operate with benefit of the statutory immunity or public practitioners who also enjoy sovereign immunity protection or statutory immunity based upon their employment with the state.²⁸¹

The third category of negligence claims is broader than those based on the duty to warn a specific, identified, victim of a patient's threats. It centers around the failure to hospitalize or the premature release of a violent mental patient.²⁸² This claim is based on the same theory of medical malpractice defined in *Fleming v. Vest*, in which the treating provider's course of action, in terms of diagnosis and treatment, is challenged as falling below the standard of care recognized for their profession.²⁸³ The language of the Arkansas Medical Malpractice Act, providing that "any adverse consequence" resulting from services rendered by medical care providers, as designated in the statute, whether resulting from "negligence, error, or omission in the performance of such services" describes an extremely broad range of challenges that may support a claim for injury sustained in the diagnosis and treatment of the patient.²⁸⁴

The difficulty with this third and very general approach to malpractice for mental health professionals is that it may serve to impose a duty that may ultimately compromise the diagnostic and treatment decisions made by mental health professionals using the best professional judgment in treating patients who are often severely impaired. Recall the characterization of the plaintiffs' claims in *Brady v. Hopper*, the Hinckley assassination attempt case:

precludes confining individuals based solely upon prediction that they are likely to engage in violence without proof of mental disorder).

280. ARK. CODE ANN. § 21-9-203(a) (2004).

281. ARK. CODE ANN. § 21-9-203(a) (providing statutory immunity for state actors or employees is likely to cover all professionals employed at the Arkansas State Hospital, the Department of Corrections, or other public mental health providers.).

282. *Fleming v. Vest*, 2015 Ark. App. 636, at 5, 475 S.W.3d 576, 580.

283. *Id.*; see *supra* note 267 (setting forth the statutory requirement for proving a violation of the standard of care for the medical professional in ARK. CODE ANN. § 16-114-206(a) (Supp. 2015)).

284. ARK. CODE ANN. § 16-114-201(3) (Supp. 2015).

The gravamen of plaintiffs' complaint is that if Dr. Hopper had properly performed his professional duties, he would have controlled Hinckley's behavior; therefore, Hinckley would not have made the presidential assassination attempt. Specifically, plaintiffs assert that the prescription of valium and biofeedback therapy, coupled with the advice that Hinckley's parents "cut him off", aggravated Hinckley's condition and actually contributed to his dangerous propensity. Further, plaintiffs assert that Dr. Hopper should have consulted with another psychiatrist regarding his form of treatment, and that Dr. Hopper should have taken steps to have Hinckley confined. Finally, plaintiffs allege that Dr. Hopper should have warned Hinckley's parents of their son's extremely dangerous condition, and that he should have warned law enforcement officials of Hinckley's potential for political assassination.²⁸⁵

Judge Moore rejected the argument that Dr. Hopper should be held to a standard of care in which the mental health provider's liability would unreasonably be expanded far beyond the recognized capability of those professionals to foresee every potential injury that might hypothetically be sustained by persons other than their patients.²⁸⁶ Yet, that is precisely the problem posed in *Fleming v. Vest*. Even assuming, *arguendo*, that Dr. Vest could reasonably be criticized for his decision to reduce his patient's medications in an effort to determine what the appropriate dosage should be in light of his particular impairment, the lack of any identifiable potential victim as a result of the patient's commission of a violent, criminal act, may simply be seen as asking too much of psychiatry and the other mental health professions.

The California decision in *Tarasoff* provided a starting point for the examination of the extent or scope of therapist liability to third persons, but its limitations have been highlighted in subsequent cases.²⁸⁷ *Tarasoff* itself arises from

285. 570 F. Supp. 1333, 1335 (D. Colo. 1983).

286. *Id.* at 1339 (holding that injuries sustained by plaintiffs were not foreseeable and, consequently, outside scope of psychiatrist's duty).

287. See *Tarasoff II*, 551 P.2d at 342-46; see also *Menendez v. Super. Ct. of L.A. Cty.*, 834 P.2d 786, 794 (Cal. 1992).

the specific facts of the disclosed threat of violence toward an identified victim and the resulting duty of the mental health professional aware of the threat.²⁸⁸ It does not involve fact situations that would require a broader theory of a duty to protect against “any adverse consequences” that might flow from negligence or error on the part of a therapist in the treatment of a patient. Yet, the division in analysis evident in the two opinions issued in the case focuses directly on whether the Act should be construed liberally to provide for liability to third persons injured by the criminal actions of their patients. Alternatively, it may ultimately be construed more conservatively in restricting physician liability to only those suffering injuries reasonably foreseeable, where the potential for injury to a third person is identified to the treating therapist.

The question of whether liability should be expanded to include the public generally will likely remain unresolved until a case arises in which the mental health professional’s departure from the acceptable standard of care or failure to act prove so egregious that injury to even unidentifiable victims will warrant imposition of liability.²⁸⁹ But the answers to the questions left open by the court’s decision in *Fleming* will not be addressed in further litigation in the case because no appeal was taken from the circuit court’s order dismissing the plaintiff’s claims against Dr. Vest for failure to state a claim for relief upon which relief could be granted under Arkansas law.²⁹⁰ In the motion to dismiss, the defendant specifically argued the following:

Arkansas law does not impose a duty upon health professionals to protect unidentified non-patient third parties under the circumstances of this case. Arkansas’ statutory law, common law precedent, and its recently codified public policy all cut squarely against the Plaintiff’s cause of action in this case.²⁹¹

Whether Dr. Vest’s point was well-taken awaits the judgment of future litigation since *Fleming’s Estate* did not

288. See *Tarasoff II*, 551 P.2d at 339-42, 343-44.

289. See *infra* Appendix B.

290. See *supra* note 149.

291. Motion to Dismiss at 1, *Fleming v. Vest*, 2015 Ark. App. 636, 475 S.W.3d 576 (No. CV2011-164-III).

appeal from the order dismissing the action.²⁹² However, with respect to the “recent codification of public policy,” it is strongly arguable that the broad imposition of immunity for reporting patient threats contained in Arkansas Code Annotated §§ 20-45-201 to -202 represents an expression of public policy favoring *expanded* liability for injury caused by mental health patients.²⁹³ The explicit language of the House Bill reflects political sentiment favoring expanded liability:

“AN ACT TO REQUIRE A MENTAL HEALTH SERVICES PROVIDER TO WARN A LAW ENFORCEMENT AGENCY OF A CREDIBLE THREAT BY A PATIENT; AND FOR OTHER PURPOSES.”
Subtitle “TO REQUIRE A MENTAL HEALTH SERVICES PROVIDER TO WARN A LAW ENFORCEMENT AGENCY OF A CREDIBLE THREAT BY A PATIENT.”²⁹⁴

The rather broad reading of the Medical Malpractice Act by the majority in *Fleming* will necessarily require further litigation to establish the precise parameters of the duty owed to third persons. And that, of course, assumes that there are “precise parameters” waiting to be discerned by the Arkansas appellate courts.

292. See *Fleming v. Lands Docket Report Results*, AOC PUBLIC COURT CONNECT, [https://caseinfo.aoc.arkansas.gov/cconnect/PROD/public/ck_public_qry_doct.cp_dktrpt_frammes?backto=P&case_id=26CV-11-164&begin_date=&end_date=\[https://perma.cc/42KD-87EM\]](https://caseinfo.aoc.arkansas.gov/cconnect/PROD/public/ck_public_qry_doct.cp_dktrpt_frammes?backto=P&case_id=26CV-11-164&begin_date=&end_date=[https://perma.cc/42KD-87EM]).

293. See Act 1212, 2013 Ark. Acts 4964; see also *supra* note 4.

294. Act 1212, 2013 Ark. Acts 4964.

Appendix A

The states reported by the National Conference of State Legislatures as having mandatory reporting statutes are Alabama, Arizona (duties vary for different professions), California, Colorado, Delaware (duties vary for different professions), Idaho, Illinois (duties vary for different professions), Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin.²⁹⁵

States having permissive reporting laws are Alaska, Arkansas, Connecticut, District of Columbia, Florida, Hawaii, Kansas, Mississippi, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, West Virginia, and Wyoming.²⁹⁶ The District of Columbia also has a permissive reporting statute.²⁹⁷

The four states with no duty to report are Maine, Nevada, North Carolina, and North Dakota.²⁹⁸ The Georgia Code of Ethics of the State Board of Examiners of Psychologists allows discretionary disclosure of confidential information to protect the client, psychologist, or others from harm.²⁹⁹ Despite Georgia's lack of statutory authority, it is important to note that Georgia case law has established that "where the course of treatment of a mental patient involves an exercise of 'control' over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient."³⁰⁰ Arizona,

295. *See Mental Health Professionals' Duty to Warn*, NAT'L. CONFERENCE OF STATE LEGISLATURES (Sept. 28, 2015), <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx> [<https://perma.cc/HT32-96TZ>].

296. *Id.*

297. *Id.*

298. *Id.*

299. GA. COMP. R. & REGS. 510-4-.02 § 4.05 (2015).

300. *Bradley Ctr., Inc. v. Wessner*, 287 S.E.2d 716, 721 (Ga. Ct. App. 1982).

Delaware, and Illinois apply different standards to different professionals.³⁰¹

Delaware law provides that mental health providers must warn against threats to clearly identified victims as well as clearly identified property.³⁰² By contrast, Maryland law provides that mental health providers only must warn against threats against specific victims or groups, but may do so regardless of whether the patient's intent to harm was expressed in speech, conduct, or writing.³⁰³ The states granting immunity if the mental health professional complies with certain statutory requirements are Alabama, Arizona, California, Colorado, Delaware, Louisiana, Maryland, Michigan, Minnesota, Nebraska, New Hampshire, Tennessee, Virginia, and Washington.³⁰⁴

The National Conference of State Legislatures report does not include a reference to the then-recently adopted statutory immunity scheme provided in ARK. CODE ANN. §§ 20-45-201 to -202. The General Assembly passed the bill expanding immunity for mental health providers during its 2013 General Session.

301. *See supra* note 295.

302. DEL. CODE ANN. tit. 16, § 5402 (West 2016).

303. MD. CODE ANN., CTS. & JUD. PROC. § 5-609 (West 2016).

304. *See supra* note 295.

Appendix B

Consider, for instance, the following hypothetical and whether the psychiatrist should be held liable for the injury suffered by the passengers of AVIAN AIR Flight 292:

Jones, a veteran commercial airline pilot employed by AVIAN Airways, lost his wife to a long bout with cancer a number of years ago. He took a period of leave during the grieving period, spending significant time working through his grief during counseling sessions with his wife's surviving sister, Dr. Smith, a psychiatrist. He returned to work and was again a highly-rated pilot with Avian until about two years ago when he experienced a startling encounter with what he believed to be an alien craft while on a late-night flight over the Rocky Mountains. He reported the incident to Avian, but advised his co-pilot, a younger person with far less seniority, to deny having witnessed the same events. Avian pressed Jones not to discuss the reported sighting with the press or, in fact, anyone, and began to monitor his work carefully.

Jones, unable to shake the experience, began to suspect that Avian would force him to retire or face the possibility of being terminated. He sought counseling once again from his sister-in-law, Dr. Smith, explaining to her that if he sought professional assistance using his group insurance, Avian would use this as an excuse to fire him. She agreed to see him on a professional, but non-paying basis. Over the next two years, she found that he was growing paranoid and anxious, seemingly reliving the UFO encounter much like a PTSD episode, and also growing increasingly suspicious of his supervisors and others at Avian. He came to distrust the co-pilot, whom he believed Avian had recruited to spy on him.

Dr. Smith prescribed a low dosage of an anti-anxiety drug for Jones, suggesting that he might want to take a leave of absence while he addressed his feelings of paranoia, but he saw this as the worst possible option, given Avian's plan to "silence him." He had begun spending large amounts of time researching UFO sites on the internet and watching programs about UFOs on cable television. At one point he attended a seminar on UFO-related topics sponsored by a local group. His

focus on UFO events grew to dominate his off-hours thinking, but his performance on the job remained superior.

During the last few sessions with Dr. Smith, Jones expressed concern about the UFO threat to national security, complaining about government cover-ups and, then, claims of actual involvement with aliens at secret military/research bases, like Dulce, New Mexico. He told her that he believed no one would take the UFO/alien threat seriously until a commercial liner had actually been destroyed in flight by an unidentified entity, then laughed and said, "Thank God that's never happened."

Dr. Smith was worried by her brother-in-law's suggestion, and then wrote a prescription for a stronger anti-anxiety agent, advising him to take the drug in the event he experienced another distressing incident. Subsequently, Jones flew several round trips without incident.

Several weeks later, however, Jones was the pilot of a 747, once again flying over the Rockies at night on AVIAN Air Flight 292. Suddenly, the jet lost altitude and crashed into the Sangre de Christos in Northern New Mexico. The last audio message received from Flight 292 included this:

"Unidentified object, silvery, lights. . . . strobing.

"Too close. Maybe they'll believe me now.

"Closing.

"Oh God, it's going to hit us Oh God, save us."

The jet then crashed. An autopsy showed that Jones had apparently taken a substantial quantity of the anti-anxiety drug Dr. Smith had prescribed and it had remained in his system.

Jones had told his brother that he had seen Dr. Smith for counseling and that he was taking psychiatric meds she had prescribed for him. He had also told his brother about his belief that UFOs were preparing to attack aircraft and military bases and that he had been unable to get anyone in the government to take his claims and evidence seriously. The brother contacted Federal investigators almost immediately after learning of the crash. The families of the 174 individuals who died in the crash have learned that Jones had been in therapy with Dr. Smith and almost all have retained counsel who have given notice to AVIAN Air of their intent to sue.

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