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Tort Law: Ohio Adopts the Professional Judgement Rule

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TORT LAW: OHIO ADOPTS THE PROFESSIONAL JUDGMENT RULE—*Littleton v. Good Samaritan Hospital & Health Center*, 39 Ohio St. 3d 86, 529 N.E.2d 449 (1988).

I. INTRODUCTION

What standard of conduct should be required of a psychiatrist[1] in order to avoid liability when his patient commits an act of violence against an innocent third party? In the seminal case of *Tarasoff v. Regents of the University of California*,[2] the California Supreme Court determined that a psychotherapist avoids liability to victims of his patient provided that the therapist has exercised " 'that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.' "[3] The *Tarasoff* court thus formulated an objective standard of care, based on a comparison of the therapist's conduct with the conduct of others of his profession, given similar circumstances. The court recognized that the psychotherapist has a duty to take reasonable precautions in order to protect others from his patients' acts of violence.[4] One result of the *Tarasoff* holding is that a victim of a person who has been treated by a psychotherapist may be able to assert a cause of action directly against the therapist.

In medical malpractice actions brought by the patient, Ohio courts have traditionally applied an objective standard of care.[5] This standard has been applied to both general practitioners and medical specialists.[6] The objective standard is based upon the customary practice found within a particular field of medical expertise.[7] Custom is established by

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1. In this article the terms "psychiatrist," "psychotherapist" and "therapist" are used interchangeably. These terms describe the classes of mental health professionals who might be subjected to the duty to take reasonable precautions to protect others from the violent actions of their patients. *See* Goodman, *From Tarasoff to Hopper: The Evolution of the Therapist's Duty to Protect Third Parties*, 3 BEHAVIORAL SCI. & L. 195, 196-97 n.2 (1985).

2. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

3. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (quoting Bardessono v. Michels, 3 Cal. 3d 780, 788, 478 P.2d 480, 484, 91 Cal. Rptr. 760, 764 (1970)).

4. *See id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

5. *See* Bruni v. Tatsumi, 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976); Ault v. Hall, 119 Ohio St. 422, 164 N.E. 518 (1928); Cornell v. Ohio State Univ. Hosp., 36 Ohio Misc. 2d 25, 521 N.E.2d 857 (Ct. Cl. 1987).

6. *See Bruni*, 46 Ohio St. 2d at 127, 346 N.E.2d at 673, (abrogating the locality rule with respect to medical specialists). Under the locality rule, a physician is held to a standard of care as ordinarily exercised by physicians "in good standing in the community in which he resides." Eislein v. Palmer, 7 Ohio Dec. 365, 367 (C.P. Hamilton County 1898).

7. *Bruni*, 46 Ohio St. 2d at 131, 346 N.E.2d at 677.

the use of expert testimony.[8]

In *Littleton v. Good Samaritan Hospital & Health Center*,[9] the Supreme Court of Ohio formulated a new standard of care to determine a psychiatrist's liability to his patient's victims in certain narrowly defined circumstances.[10] This standard of care encompasses a subjective element, reflecting the supreme court's desire to provide a greater degree of deference to the professional judgment of the psychiatrist.

This casenote discusses the negligence elements of duty and standard of care in the area of a psychiatrist's liability to third party victims. The discussion traces the court's application of these negligence elements to the facts of the case. The analysis examines the court's reasoning with respect to the standard of care element.

II. FACTS AND HOLDING

Shortly after giving birth to her daughter, Theresa Pearson exhibited signs of depression.[11] Moreover, Theresa experienced feelings of rejection towards her infant, Carly, and even had impulses to harm her.[12] Theresa's obstetrician referred her for treatment to a psychologist, Elizabeth Wales, Ph.D.[13] Dr. Wales diagnosed Theresa as suffering from post-partum depression.[14] Upon the advice of Dr. Wales, Theresa voluntarily admitted herself to Good Samaritan Hospital as an inpatient on April 30, 1981.[15] She was placed in the open ward of the hospital's Mental Health Unit.[16] Staff psychiatrist, Richard W. Murray, M.D., was in charge of a team of mental health professionals responsible for Theresa's treatment.[17] Theresa was released on May 8, 1981.[18]

Dr. Wales was in charge of Theresa's post-release care.[19] After her discharge from the hospital, Theresa's husband, Greg, observed Theresa pulling covers over the head of her sleeping baby, saying she wished her baby were gone.[20] Theresa later told Dr. Wales that she believed that Carly was not Greg's baby, and was afraid that Greg

8. *Id.*
9. 39 Ohio St. 3d 86, 529 N.E.2d 449 (1988).
10. *Id.* at 99, 529 N.E.2d at 460.
11. *Id.* at 87, 529 N.E.2d at 451.
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.* at 88, 529 N.E.2d at 451.
19. *Id.*
20. *Id.*

would leave her if she told him.[21] These incidents led Dr. Wales to recommend that Theresa reenter the hospital.[22] Theresa was readmitted on May 29, 1981.[23]

During the second hospitalization Theresa expressed concern on numerous occasions that she might hurt Carly.[24] The most significant such expression occurred on June 1. A nurse made a note in the hospital record that Theresa had stated that she was planning to give Carly a fatal injection.[25] Three hours later, following a hypnosis session, the same nurse made a second note that Theresa had retracted her previous threat against Carly.[26] After reviewing the nurse's notes, Dr. Murray, who was in charge of Theresa's inpatient treatment, did not talk with Theresa about these statements. In Dr. Murray's judgment, Theresa's conflicting statements indicated that she did not have a fixed objective to harm Carly.[27]

A few days later a family meeting was held to formulate a post-release treatment plan for Theresa.[28] For one year after Theresa's discharge, Carly would be cared for by her paternal grandparents.[29] The family was instructed that Theresa was never to be left alone with Carly.[30] Although the family members present at the meeting were warned that Theresa had the potential to harm Carly, they were not told of Theresa's specific threat of June 1 to kill Carly.[31] Greg later testified that his understanding of the doctor's instructions was that Theresa was not to be left alone with Carly for long periods of time, i.e., two or three hours.[32]

Theresa was discharged from Good Samaritan on June 5, 1981.[33] Dr. Murray's diagnosis at the time of release was that Theresa was suffering from recurrent depression.[34] Dr. Murray later testified that, in his best medical judgment, he did not believe Theresa had a fixed purpose or plan to hurt Carly, and that the care plan adequately protected

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21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.*
27. *Id.* at 88, 529 N.E.2d at 452.
28. *Id.*
29. *Id.* at 89, 529 N.E.2d at 452. The grandparents were separated. The grandfather, Carl Pearson, was living with Sue Bookwalter. They had agreed to share responsibility for Carly with the grandmother. *Id.*
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.*
34. *Id.*

Carly by separating her from Theresa.[35] Moreover, Theresa demanded that she be discharged from the hospital.[36] Therefore, Dr. Murray saw no grounds for involuntary commitment.[37]

Between June 5 and June 19, Theresa had contact with Carly, but only in the presence of others.[38] On June 19, Sue Bookwalter, who was watching Carly, took her to Theresa's house at Theresa's request.[39] Greg had assured Sue that it would be all right to permit Theresa to watch Carly for a couple of hours.[40] After Sue left Theresa's house, Theresa administered a fatal overdose of aspirin to Carly.[41]

Catherine Littleton, as administratrix of Carly's estate, brought a negligence action against Dr. Murray and Good Samaritan Hospital.[42] The complaint was later amended to include Dr. Wales as a party defendant.[43] The complaint alleged that Carly's death was the proximate result of their negligence in releasing Theresa from the hospital.[44]

At the end of plaintiff's evidence, defendants' motion for a directed verdict was denied.[45] The jury returned a verdict against Dr. Murray and Good Samaritan Hospital in the amount of $1.8 million.[46] These defendants moved for a new trial on grounds that the verdict was against the manifest weight of the evidence, and, in the alternative, moved to remit the verdict to $50,000.[47] The court remitted the verdict to $300,000, and ordered a new trial on the sole issue of damages in the event that plaintiff refused the remittitur.[48] Plaintiff appealed and defendants cross-appealed.[49]

The court of appeals found that the trial court properly denied the defendants' motion for a directed verdict.[50] The Ohio Supreme Court

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35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.* at 90, 529 N.E.2d at 453.
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.* A survivorship claim and wrongful death action were brought against defendants. Suit was filed on November 18, 1982. *Id.*
43. *Id.* On March 22, 1985, plaintiff moved to amend her complaint to add Theresa as a new party plaintiff. The trial court overruled the motion. *Id.*
44. *Id.*
45. *Id.* at 91, 529 N.E.2d at 454.
46. *Id.* The jury found Greg Pearson negligent, but found that his negligence was not a proximate cause of Carly's death. No negligence was found on the part of Dr. Wales, Theresa, or Carl Pearson. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.* The appellate court affirmed on all issues except the remittitur amount. "Finding the trial judge applied an inaccurate definition of 'mental anguish' in determining the remittitur, the court remanded the cause for a redetermination of the remittitur amount." *Id.*

heard the case pursuant to the allowance of a motion and cross-motion to certify the record.[51]

The Ohio Supreme Court reached the following holding with respect to the standard of care required of a psychiatrist in order to avoid liability in cases of this type.

> Where there are professional standards of care a psychiatrist is required to conform to the standards at all times or suffer liability. Where there are no professional standards, a psychiatrist must exercise good faith judgment based on a thorough evaluation of all relevant factors. Professional standards will be used to determine which factors are relevant and whether an evaluation was thorough.[52]
>
> Therefore, we hold that a psychiatrist will not be held liable for the violent acts of a voluntarily hospitalized mental patient subsequent to the patient's discharge if (1) the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge, or (2) a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant factors, and a good faith decision was made by the psychiatrist that the patient had no violent propensity, or (3) the patient was diagnosed as having violent propensities and, after a thorough evaluation of the severity of the propensities and a balancing of the patient's interests and the interests of the potential victims, a treatment plan was formulated in good faith which included discharge of the patient.[53]

The supreme court reversed the judgment of the court of appeals[54] and remanded the case for a new trial on all issues, based on the professional judgment standard of care set forth in the holding.[55]

III. BACKGROUND

A. The Psychiatrist's Duty to Protect Others From a Patient's Acts of Violence

Duty may be defined as "an obligation to which the law will give recognition and effect to conform to a particular standard of conduct toward another."[56] " 'The problem of duty is as broad as the whole law of negligence and . . . no universal test for it has ever been

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51. *Id.*

52. *Id.* at 99, 529 N.E.2d at 460. The paragraph immediately preceding the holding is included for reasons which will become apparent in the analysis.

53. *Id.*

54. *Id.* at 101, 529 N.E.2d at 462.

55. *Id.* The court also affirmed the dismissal of plaintiff's motion to add Theresa as a party plaintiff. The court based this decision on its interpretation of R. Civ. P. 15(c), which governs the relation back of amended pleadings. *Id.* at 100, 529 N.E.2d at 461.

56. Goodman, *supra* note 1, at 207 (quoting W. PROSSER, HANDBOOK OF THE LAW OF TORTS 324 (1971)).

formulated.' "[57]

Generally the law does not impose a duty to take precautionary action to protect another, even if it appears that such action is necessary to protect the other from imminent danger.[58] Since a legally recognized duty is a necessary element of the tort of negligence, no liability will attach in the absence of such a duty.[59] However, where a special relationship exists between either the defendant and the wrongdoer, or the defendant and the potential victim, a duty may be imposed.[60] Such a special relationship exists when one takes charge of a person whom he knows or should know is likely to harm others if not controlled.[61]

The California Supreme Court was the first to apply the foregoing concepts in formulating the duty of a psychotherapist to protect potential victims of his patients.[62] In *Tarasoff v. Regents of the University of California,*[63] a psychotherapist's patient killed a young woman with whom he had formed a fantasized attachment, after communicating his homicidal ideations to the therapist.[64] The patient had been treated on a voluntary outpatient basis.[65] The *Tarasoff* court reasoned that the therapist should not escape liability merely because the existing legal concept of a therapist's duty to exercise reasonable care under the circumstances extends only to his patients.[66] The court relied upon decisions holding that a physician's duty extends beyond the doctor-patient relationship to protect others from unreasonable risks of harm.[67] It gave as an example the case of a doctor who treats a patient with a contagious disease.

> [T]he 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 disclose a contagious disease, or, having diagnosed the illness, fails to warn members of the patient's family.[68]

Drawing upon this analogy to the contagious disease cases, the

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57. *Id.* (citing W. PROSSER, HANDBOOK OF THE LAW OF TORTS 325 (1971)).
58. *See* RESTATEMENT (SECOND) OF TORTS § 314 (1965).
59. *See* W. KEETON, PROSSER AND KEETON ON TORTS 30 (5th ed. 1984).
60. Perreira v. State, 768 P.2d 1198, 1208 (Colo. 1989).
61. RESTATEMENT (SECOND) OF TORTS § 319 (1965).
62. *See* Goodman, *supra* note 1, at 203.
63. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
64. *Id.* at 430, 551 P.2d at 339-40, 131 Cal. Rptr. at 19.
65. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.
66. *Id.* at 436, 551 P.2d at 344, 131 Cal. Rptr. at 24.
67. *Id.*
68. *Id.* at 436, 551 P.2d at 345, 131 Cal. Rptr. at 24 (citations omitted).

Tarasoff court held that a therapist has a duty to take protective actions for the benefit of the potential victim of his patient.[69]

> 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. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever steps are reasonably necessary under the circumstances.[70]

The *Tarasoff* court established the existence of the therapist's duty to potential victims of his patients after balancing several factors. These factors included:

> the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injuries suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the available cost and prevalence of insurance for the risk involved.[71]

In the court's view, the most important consideration in establishing duty is foreseeability.[72]

After *Tarasoff*, other courts began to recognize the existence of such a duty.[73] In jurisdictions where the issue has arisen, there has

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69. *Id.* at 439, 551 P.2d at 345, 131 Cal. Rptr. at 24-25.

70. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

71. *Id.* at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22 (quoting Merril v. Buck, 58 Cal. 2d 552, 562, 375 P.2d 304, 310, 25 Cal. Rptr. 456, 462 (1962)).

72. *Id.* "Foreseeability is based on common sense perceptions of the risks created by various conditions and circumstances and 'includes whatever is likely enough in the setting of modern life that a reasonably thoughtful person would take account of it in guiding practical conduct.' " Perreira v. State, 768 P.2d 1198, 1209 (Colo. 1989) (quoting Taco Bell, Inc. v. Lanon, 744 P.2d 43, 48 (Colo. 1987)).

73. *See, e.g.*, Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980) (therapist-patient relationship gave rise to an affirmative duty to take reasonable precautions in order to protect potential victims of patient); *Perreira*, 768 P.2d at 1198 (psychiatrist required to exercise due care in determining the potential danger to the public before releasing involuntarily committed patient); Bradley Center, Inc. v. Wessner, 250 Ga. 199, 296 S.E.2d 693 (1982) (duty to exercise reasonable care for protection of others where physician exercised "control" over mental patient likely to cause harm to others); Durflinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983) (physician required to exercise due care for protection of the public in recommending release of mental patient); Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983) (psychiatrist owed duty of reasonable care to those foreseeably endangered by patient); McIntosh v. Milano, 168 N.J. Super. 466, 489, 403 A.2d 500, 511-12 (1979) (psychiatrist may have duty to take reasonable care to protect potential victims of patient where patient presents a probable danger to such

been a trend toward acceptance of a *Tarasoff* type of doctrine.[74] Jurisdictions which recognize the type of duty established in *Tarasoff* have also focused on foreseeability as the key factor in establishing this duty.[75] In analyzing foreseeability the courts have focused on two factors: the status of the patient[76] and the relative ability to identify the potential victim.[77]

1. Status of the Patient

The status of the patient (i.e. inpatient versus outpatient status) indicates to some extent the degree of control which a psychiatrist has over his patient's actions.[78] One court has described the correlation between patient status and the therapist's degree of control over the patient in terms of a continuum.[79] The theory is that a therapist's duty to control should attach more readily in patient settings where the therapist has a greater ability to control his patient's conduct.[80]

At one end of the continuum are cases involving outpatient treatment.[81] Generally, where the patient seeks therapy on an outpatient basis, the therapist has limited opportunities to observe the patient.[82] The therapist has even less opportunity to control the patient's behavior in the outpatient context.[83] Therefore, some courts have limited the therapist's duty to potential victims to situations where the outpatient makes a specific threat against a person who is readily identifiable.[84]

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persons); Schuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (1988) (psychiatrist had duty to warn third party where potential harm to that person was reasonably foreseeable).

74. *See* Goodman, *supra* note 1, at 223.

75. *See id.* "Those jurisdictions adopting *Tarasoff* have sometimes broadened the duty, but more often have applied the Thompson restriction of only warning a specific potential victim of a specific threat." *Id.* (For a discussion of Thompson v. County of Alameda, see *infra* notes 92-97 and accompanying text.); *see, e.g.*, Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 194 (D. Neb. 1980) (agreeing with a number of decisions following *Tarasoff* which "limited the scope of the therapist's duty to identifiable victims"). The *Lipari* court thus limited the therapist's liability "to those persons *foreseeably* endangered by the [defendant's] negligent conduct." *Id.* (emphasis added).

76. *Perreira*, 768 P.2d at 1209.

77. Note, *The Psychotherapist's Calamity: Emerging Trends in the Tarasoff Doctrine*, 1989 B.Y.U. L. REV. 261, 267.

78. *Perreira*, 768 P.2d at 1209.

79. *Id.*

80. *See* Note, *supra* note 77, at 270.

81. *Perreira*, 768 P.2d at 1209.

82. *Id.* at 1210.

83. *Id.*

84. *Id.* In *Hasenei v. United States*, 541 F. Supp. 999 (D. Md. 1982), defendant's psychiatrist was found not liable for an automobile accident caused by his patient, who had been undergoing treatment at the defendant's outpatient clinic. The court held that the relationship between the psychiatrist and this outpatient:

did not give [the psychiatrist] the right or the ability to control [the patient's] conduct. In the absence of such a relationship, [the psychiatrist] owed no duty to plaintiffs to control

At midpoint in the continuum are cases involving voluntary inpatient psychiatric treatment.[85] "The distinction between out-patients and in-patients is important because of the degree of control the psychotherapist has over an in-patient vis-a-vis an out-patient. The ability of the psychotherapist to control the actions of an in-patient far exceeds the psychotherapist's ability to control a casual out-patient."[86] Thus, courts seem more willing to impose a duty on the psychiatrist for the protection of potential victims where the patient's mental condition is such that he commits himself to inpatient treatment.[87]

At the other end of the continuum are those cases where the patient has been involuntarily committed to a mental health facility by court order.[88] Here the psychiatrist has adequate opportunity to learn of the patient's condition, including any tendency towards violence.[89] The treating physician also may exercise his discretion to prolong the patient's confinement in the interest of the safety of any potential victims.[90] Since the involuntary nature of the commitment may be indicative of a more acute stage of mental illness than is generally found in the patient who voluntarily commits himself, courts seem more willing to impose a duty upon psychiatrists to control the violent actions of involuntary patients than voluntary patients.[91]

[his patient's] conduct, particularly since his own assessment, deemed competent by this Court . . ., carried with it a lack of prediction of any identifiable danger posed by [the patient] to any person.

Id. at 1012; *see also* Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984) (therapist found not liable where outpatient John Hinckley shot the plaintiff during his attempt to assassinate President Reagan). *But see* McIntosh v. Milano, 168 N.J. Super. 466, 489, 403 A.2d 500, 511-12 (1979), (The court imposed a duty upon a psychiatrist treating in an outpatient setting "to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when [the psychiatrist determines]. . . that the patient is or may present a probability of danger to that person.").

85. *Perreira,* 768 P.2d at 1211.

86. Note, *supra* note 77, at 270.

87. *See, e.g.,* Bradley Center, Inc. v. Wessner, 250 Ga. 199, 200, 296 S.E.2d 693, 694 (1982). In *Bradley*, defendant's voluntarily admitted inpatient was issued a weekend pass, even though treatment revealed that the patient would likely cause harm to his wife if given the opportunity. While exercising his pass, the patient shot and killed both his wife and her paramour. *Id.* The court held that the defendant had a duty to protect the patient's wife against unreasonable risks of harm. *Id.* The court reasoned that the inpatient treatment of the husband involved "an exercise of 'control' over him by a physician" who was made aware of the patient's propensity for violence towards his wife. *Id.* at 201, 296 S.E.2d at 695.

88. *Perriera,* 768 P.2d at 1212. "The involuntary commitment of a mentally ill person to a state mental health facility creates a special relationship substantially different in kind from the relationship existing between a treating psychiatrist and a voluntary patient." *Id.* at 1216.

89. *Id.* at 1212.

90. *Id.*

91. *E.g.,* Durflinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983) In *Durflinger*, a psychiatrist was held liable for the negligent release of an involuntarily committed patient with a history of violence who, shortly after his release, killed two relatives. The court emphasized that the com-

2. Identity of the Victim

Where a mental patient shows a propensity towards violence, but does not express an intent to harm a specific person, the therapist is necessarily limited as to what he can do to protect others from potential acts of violence by his patient. In *Thompson v. County of Alameda,*[92] the California Supreme Court limited the psychiatrist's duty set forth in *Tarasoff* to those potential victims who are "readily identifiable." In *Thompson,* a juvenile delinquent under the defendant's custody threatened to kill a young child in his neighborhood.[93] He did not identify his potential victim, however.[94] The juvenile killed the plaintiff's son within twenty-four hours after his release.[95] The *Thompson* court refused to impose a duty to warn on the psychiatrist because the victim was not "readily identifiable."[96] The California Supreme Court reasoned that the lack of a specific threat made the threat less credible and also made warnings more difficult as a practical matter.[97]

Of those courts which have adopted the duty formulated in *Tarasoff,* most have applied the *Thompson* requirement of a readily identifiable victim.[98] Although this requirement was initially well accepted,[99] some courts now have rejected it altogether.[100]

3. Patient Status and the Readily Identifiable Victim: Determining the Existence of a Duty

Where courts recognize a psychiatrist's duty to potential third party victims, liability is most likely to be imposed where an inpatient has identified a specific potential victim. The rationale for this position lies in the concept of foreseeability, which has traditionally been inextricably linked to the concept of duty.[101] One court has stated that "liability extends to third parties where it is foreseeable that one's conduct may cause harm to another. . . ."[102]

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mitment itself required continued hospitalization and treatment until the patient no longer posed a danger to himself or to others. *Id.* at 492, 673 P.2d at 94.

92. 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

93. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72.

94. *Id.*

95. *Id.*

96. *Id.* at 754, 614 P.2d at 734, 167 Cal. Rptr at 77.

97. *Id.* at 753-55, 614 P.2d at 735, 167 Cal. Rptr at 77.

98. Goodman, *supra* note 1, at 223; *see, e.g.,* Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984); Durflinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983); Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983).

99. Note, *supra* note 77, at 267.

100. *E.g.,* Perreira v. State, 768 P.2d 1198 (Colo. 1989); Schuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (1988).

101. *See Schuster,* 144 Wis. 2d at 237, 424 N.W.2d at 165.

102. *Id.* In considering the case of the involuntarily committed patient, one court has ob-

A therapist should be able to foresee the potential for violence where the patient has required involuntary commitment and has made threats against a specific person, in contrast to the outpatient who has perhaps shown violent tendencies directed at no one in particular. Courts are generally more reluctant to impose a duty on therapists in the latter instance because of the difficulty in foreseeing both the likelihood of harm and the ultimate victim.[103] In this context it is interesting to note that of those jurisdictions which have relaxed the specific victim requirement, nearly all have done so only in cases involving inpatients.[104] Therefore, it appears that courts consider the interaction of both of these factors in delineating the psychiatrist's duty to potential victims of his patient.

B. Determining the Proper Standard of Care

Once a court recognizes a psychiatrist's duty to potential third party victims, it must then define the appropriate standard of care in order to determine whether there has been a breach of the duty. The cases fall generally into two groups: those holding to an objective standard of care, and those applying some sort of subjective standard.

1. Objective Standard

Tarasoff, which first recognized the duty of a therapist to potential third party victims, set forth an objective standard of care based upon a reasonableness test.[105] The court described the standard of care as follows:

> Once a therapist does in fact determine, or under applicable standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of reasonable care under the circumstances.[106]

The objective standard of care set forth in *Tarasoff* is simply an

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served that "[t]he absence of specific threats or overt violent behavior, however, is not necessarily conclusive on the issue of a patient's lack of propensity for violent conduct." *Perreira*, 768 P.2d at 1214.

103. *See, e.g., Thompson*, 27 Cal. 3d at 741, 614 P.2d at 728, 167 Cal. Rptr. at 70.

104. *See, e.g.*, Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980); Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983). The only exception appears to be *Schuster*, where the court rejected the requirement of a readily identifiable victim in the case of an outpatient. *Schuster*, 144 Wis. 2d at 237-38, 424 N.W.2d at 165.

105. *Tarasoff*, 17 Cal. 3d at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25.

106. *Id.*

application of the traditional negligence standard to the therapist-patient-victim relationship. Of those jurisdictions which have confronted this issue of the standard of care owed by a psychiatrist to a patient's potential victim, most have followed the precedent established by *Tarasoff*, and have adopted an objective standard of care.[107]

2. Subjective Standard

Whereas an objective standard of care is essentially a comparative standard of conduct, a subjective standard of care focuses on the actor's judgment.

Ever since the 1898 case of *Pike v. Honsinger*,[108] New York has applied a subjective standard of care in all medical malpractice cases.[109] This standard has been termed the professional judgment rule.[110] Since the rule had been applied to medical specialists as well as general practitioners, it was perhaps only logical that New York courts would apply the rule to a psychiatrist's liability to third parties. This is what was done in *St. George v. State*.[111] In *St. George*, the patient had been confined in a state mental hospital for the criminally insane.[112] After the patient's release, he killed plaintiff's decedent, who was a stranger to the patient.[113] The court held that the state, as the employer of doctors and physicians whose honest error of professional judgment resulted in discharge of an inmate, was not liable.[114] The court summarized its rationale as follows:

> Future human behavior is unpredictable, and it would place an unreasonable and unfair burden upon the state if it were to be held responsible in damages for everything that a person does after he has been discharged or released from one of its state institutions, even though the release was through an error of judgment, unless there is something more present than is contained in this record.[115]

Another form of the subjective standard can be found in *Currie v.*

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107. *E.g.*, Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); *Lipari*, 497 F. Supp. at 185; Perreira v. State, 768 P.2d 1198 (Colo. 1989).

108. 155 N.Y. 201, 49 N.E. 760 (1898).

109. *See* Littleton v. Good Samaritan Hosp. & Health Ctr., 39 Ohio St. 3d 86, 95 n.11, 529 N.E.2d 449, 457 n.11 (1988). These New York decisions included: Centeno v. State, 40 N.Y.2d 932, 358 N.E.2d 520, 389 N.Y.S.2d 837 (1976); Fiederlein v. New York Health & Hosps. Corp., 80 A.D.2d 821, 437 N.Y.S.2d 321 (1981), *aff'd*, 56 N.Y.2d 573, 435 N.E.2d 398, N.Y.S.2d 181 (1982); Cameron v. State, 37 A.D.2d 46, 322 N.Y.S.2d 562 (1971), *aff'd*, 30 N.Y.2d 596, 282 N.E.2d 118, 331 N.Y.S.2d 30 (1972); Taig v. State, 19 A.D.2d 182, 241 N.Y.S.2d 495 (1963).

110. *Littleton*, 39 Ohio St. 3d at 95 n.11, 529 N.E.2d at 457 n.11.

111. 283 A.D. 245, 127 N.Y.S.2d 147 (1954).

112. *Id.* at 246, 127 N.Y.S.2d at 148.

113. *Id.* at 246, 127 N.Y.S.2d at 149.

114. *Id.* at 248, 127 N.Y.S.2d at 150.

115. *Id.* at 248, 127 N.Y.S.2d at 150-51.

United States.[116] The court in *Currie* adopted a "psychotherapist judgment rule."[117] The factual issue in *Currie* focused on the therapist's decision of whether to involuntarily commit a mentally ill outpatient.[118] After the therapist decided against commitment, the patient subsequently murdered a co-worker.[119] While the *Currie* court refused to impose an objective standard of care, the court did identify factors to be used in determining whether or not a proper judgment had been rendered by the therapist.[120]

> Under such a "psychotherapist judgment rule," the court would not allow liability to be imposed on therapists for simple errors in judgment. Instead, the court would examine the "good faith, interdependence and thoroughness" of a psychotherapist's decision not to commit a patient. Factors in reviewing such good faith include the competence and training of the reviewing psychotherapists, whether the relevant documents and evidence were adequately, promptly and independently reviewed, whether the advice or opinion of another therapist was obtained, whether the evaluation was made in light of the proper legal standards for commitment, and whether other evidence of good faith exists.[121]

The court looked to the considerations underlying the business judgment rule to arrive at its holding.

> In the business judgment rule, courts defer to the decisions of disinterested directors absent bad faith or self-interest. Many of the considerations cited as justifications for the business judgment rule are applicable to the present case. For example, as with business decisions, the court is not particularly qualified to review commitment decisions involving mental health and dangerousness. . . . Finally, policy considerations favor giving psychotherapists, as well as corporate directors, significant discretion to use their best judgment . . . .[122]

The analogy to the business judgment rule is incomplete. The rule applies to directors discharging their fiduciary duties[123] to the corporation.[124] Where an outside third party alleges negligence on the part of a director, the business judgment rule does not apply. The director in this instance would be responsible to such a party according to the basic

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116. 644 F. Supp. 1074 (M.D.N.C. 1986), *aff'd*, 836 F.2d 209 (4th Cir. 1987).
117. *Id.* at 1083.
118. *Id.* at 1079.
119. *Id.* at 1076-77.
120. *Id.* at 1083.
121. *Id.*
122. *Id.*
123. H. HENN & J. ALEXANDER, LAWS OF CORPORATIONS AND OTHER BUSINESS ENTERPRISES § 242 (3d ed. 1983).

principles of tort law.[125]

The application of the rationale of the business judgment rule to the therapist-patient relationship would seem to be limited to malpractice actions brought by the patient. "[S]hareholders to a very real degree voluntarily undertake the risk of bad business judgment."[126] When they buy into the company, shareholders entrust the directors with its operation. Similarly, a patient entrusts his care to his psychiatrist when he enters into the doctor-patient relationship. Here it is plausible to grant a measure of deference to the psychiatrist's professional judgment when the patient alleges negligence. It does not follow that the judgment of the psychiatrist should be granted this same degree of deference where the injured party is one who did not voluntarily enter into a relationship with the psychiatrist.

Regardless of whether or not the analogy to the business judgment rule strictly applies to the psychiatrist's duty to potential third party victims, the holding of *Currie* does represent a compromise. "That compromise is a heightened standard of culpability required for liability."[127] Althouth the psychotherapist judgment rule is a subjective standard of care, it attempts to incorporate elements of an objective standard by identifying certain factors which are to be considered in determining whether the therapist comported with the standard of care required to absolve himself from potential liability.[128]

3. Policy Considerations Underlying the Objective and Subjective Standards

The tension between the objective and subjective standards reflects competing policy considerations. These policy considerations encompass the interests of the patient, the therapist, potential victims, and society as a whole.

The inherent difficulty of predicting violent behavior,[129] coupled with the degree of variability exhibited by psychiatrists in clinical practice,[130] favors a standard of care which allows the therapist a substantial degree of freedom in exercising his professional judgment. Where the therapist has made an informed decision to release a patient who later harms another, it seems unfair to hold the therapist liable merely

125. *See id.* § 234.

126. Joy v. North, 692 F.2d 880, 885 (2d Cir. 1982), *cert. denied*, 460 U.S. 1051 (1983).

127. *Currie*, 644 F. Supp. at 1083.

128. *Id.* at 1084.

129. Wettstein, *The Prediction of Violent Behavior and the Duty to Protect Third Parties*, 2 BEHAVIORAL SCI. & L. 291, 312 (1984).

130. *Id.* at 310.

because the decision in retrospect turned out to be the wrong one.[131]

On the other hand, the indemnity rights of the victim should not be sacrificed at the expense of providing the therapist with a greater margin of error. The public also relies on a therapist's decision to release a patient who has shown a tendency towards violence.[132] If such a patient upon release commits a horrendous act of violence, both the victim and society should be allowed to judge the therapist's decision by considering those professional standards which the therapist should have followed in reaching his decision.[133]

Aside from the patient's typical wish for a speedy release, the modern practice of psychiatry itself tends to favor the early release of patients.[134] Moreover, by confining a patient against his will the therapist is faced with a potential action by the patient for wrongful confinement.[135] In this respect society has a dual interest. First, society has an interest in the patient's timely release, and the return to a normal productive life. Second, society shares the interest of the potential victim in seeing that a patient who has exhibited violent tendencies is not released prematurely.[136]

Once a decision is made to release the patient, the issue of whether or not to warn the potential victim arises. The apparent interest is one of patient confidentiality.[137] With respect to the therapeutic alliance established between doctor and patient, nurtured throughout the course of treatment, the interest of the patient may be even greater.[138] When the therapist warns a potential victim of the patient's violent propensities, this may be seen by the patient as a breach of trust as well as confidentiality.[139] Whatever progress the patient has achieved is at risk.[140] Nevertheless, these interests of the patient must be balanced against the rights of the potential victim.[141] A warning prior to the

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131. *St. George*, 283 A.D. at 248, 127 N.Y.S.2d at 150.

132. *See* Beigler, *Tarasoff v. Confidentiality*, 2 BEHAVIORAL SCI. & L. 273, 277 (1984).

133. *Id.*

134. *See* Johnson v. United States, 409 F. Supp. 1283 (M.D. Fla. 1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978), *cert. denied*, 451 U.S. 1018 (1981). "It is sound psychiatric practice to emphasize outpatient therapy rather than lengthy custody and supervision. Modern psychiatry has recognized the importance of making every reasonable effort to return a patient to an active and productive life." *Id.* at 1293.

135. Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV. 255, 265 (1988).

136. *See id.* at 268-69 for a discussion of these conflicting interests.

137. *See* Beigler, *supra* note 132, at 277.

138. *Id.* at 279.

139. *Id.*

140. *See id.*

141. "In deciding the extent to which a patient should be released from restrictions, the treating physician must exercise his judgment and balance the various therapeutic considerations together with the possible dangers." Johnson v. United States, 409 F. Supp. 1283 (M.D. Fla.

patient's release seems especially appropriate where an identified potential victim has already suffered injury as a result of the patient's past acts of violence.

In *Littleton v. Good Samaritan Hospital & Health Center*,[142] the Ohio Supreme Court confronted these competing policy issues.

IV. ANALYSIS

A. *The Court's Approach to Its Holding*

The *Littleton* court approached the case in terms of the essential negligence elements. Although the court did apply the elements of duty, standard of care, and proximate cause to the facts of the case, the focus of the opinion was on the standard of care.

This section first traces the court's application of the above negligence elements. The discussion then shifts to an analysis of the court's reasoning.

1. Duty

This element was undisputed between the parties, and presented no problems to the court.[143] Because a "special relation" was found to exist within the meaning of the Restatement of Torts, the court found that Dr. Murray had a duty to take reasonable precautions to protect Carly from his patient's violent propensities.[144]

As mentioned above,[145] courts generally seem more willing to recognize the existence of a duty in cases where there has been inpatient treatment and where the victim is readily identifiable. This case meets both criteria. Not only was the victim identifiable, but her identity was known to Dr. Murray during his treatment of her mother. The court did not address the extension of this duty to potential victims who were not readily identifiable. The court did indicate that it would not presently decide whether this duty would extend to outpatient settings.[146]

2. Standard of Care

The *Littleton* court first cited the rule of *Bruni v. Tatsumi*[147] which established an objective standard of care for medical specialists in malpractice actions. Next the court stated defendants' four conten-

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1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978), *cert. denied*, 451 U.S. 1018 (1981).

142. 39 Ohio St. 3d 86, 529 N.E.2d 449 (1988).

143. *Id.* at 92, 529 N.E.2d at 455.

144. *Id.* at 93, 529 N.E.2d at 455.

145. *See supra* notes 92-105 and accompanying text.

146. *Littleton*, 39 Ohio St. 3d at 92 n.3, 529 N.E.2d at 455 n.3.

147. 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976).

tions in support of their argument for adopting a subjective standard.[148]

The court then discussed both the professional judgment rule of the New York courts and the psychotherapist judgment rule of *Currie*.[149] This was important in laying the groundwork for the holding, which represents both a balancing approach with respect to competing policy arguments,[150] and a synthesis of the professional judgment rule and the good faith aspect of the psychotherapist judgment rule.[151]

3. Proximate Cause

Because the basis of the jury's verdict was never tested, the court could not identify a specific negligent act from the record. Therefore, the court did not attempt to resolve the proximate cause issue.[152]

B. Analysis of the Court's Reasoning with Respect to the Standard of Care Element

1. The Opinion Does Not Mention *Leverett v. State*, a Case Relied upon by the Court of Appeals

The court declined to discuss the case of *Leverett v. State*,[153] which was discussed at some length in the court of appeals opinion.[154] In *Leverett*, a state mental hospital released and later refused to readmit a mental patient.[155] This former patient shot and killed plaintiff's decedent three months after his release.[156] The court held that:

> a hospital may be held liable for the negligent release of a mental patient only when the hospital, in exercising medical judgment, knew or should have known that the patient, upon his release, would be very likely to cause harm to himself or others. Such likelihood must be more than a mere possibility and not based on hindsight.[157]

The rationale in *Leverett* was based on a balancing approach, and was quoted in the *Littleton* court of appeals opinion most likely because of the similarity between the two cases.[158]

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148. *Littleton*, 39 Ohio St. 3d at 93-94, 529 N.E.2d at 456-57.
149. *Id.* at 95-96, 529 N.E.2d at 457-58.
150. *Id.* at 97, 529 N.E.2d at 459.
151. *See infra* notes 175-84 and accompanying text.
152. *Littleton*, 39 Ohio St. 3d at 100, 529 N.E.2d at 461.
153. 61 Ohio App. 2d 35, 399 N.E.2d 106 (1978).
154. Littleton v. Good Samaritan Hosp. & Health Ctr., Nos. 9872, 9886 (Ohio Ct. App. May 28, 1987) (LEXIS, States library, Ohio file).
155. 61 Ohio App. 2d at 36, 529 N.E.2d at 107.
156. *Id.*
157. *Leverett*, 61 Ohio App. 2d at 41, 399 N.E.2d at 110.
158. Both cases involved the alleged negligent release of an inpatient from a hospital. *See id.* at 36, 399 N.E.2d at 107.

> Both private and public hospitals are faced with the extremely difficult task of balancing the interests of a patient who would benefit from permanent or periodic release, the interests of society in treating mental illness and returning the patient to a normal, productive life, and the interests of society in keeping a dangerous, mentally ill person off the street. The uncertainties inherent in analyzing and treating the human mind, let alone the decision of when a person is "cured" and no longer a danger, renders the decisions of skilled doctors highly discretionary and subject to rebuke only for the most flagrant, capricious, and arbitrary abuse. Nevertheless, the public has a need, and a right, to rely on the professional decisions made in these hospitals as having been made reasonably and in good faith; hospitals have such a duty in making these decisions.[159]

The holding in *Leverett* indicates a change from the objective standard in the earlier case of *Bruni*.[160] The holding imposes the requirement that a hospital must know, or should know, that a patient upon his release would be *very likely* to cause harm before liability will attach.[161] In altering the standard of care, the court of appeals considered competing policy considerations. These policy considerations are also present in *Littleton*.

There are two possible reasons why the *Littleton* court did not discuss *Leverett*. First, the court may not have been able to determine whether the court of appeals based its decision on *Leverett* or *Tarasoff*. Second, in *Leverett* the hospital not only released a dangerous mental patient, but also refused to readmit him. Despite these differences, it appears that the supreme court should have at least addressed *Leverett*, since (1) the case concerned the negligent release of a mental patient, (2) similar policy considerations were involved, and (3) the holding did represent a departure from the strict objective standard of care.

2. Defendants' Contentions

The defendants posed four contentions, which the supreme court apparently found to be persuasive in deriving a new standard of care.

First, "psychiatrists are unable to predict their patients' potential for violence with any degree of accuracy."[162] For purposes of this discussion this point can be conceded. The accuracy of this contention is assumed arguendo in considering the defendant's second contention.

"Second, because a reasonable psychiatrist of 'ordinary skill and training' cannot make an accurate prediction of a patient's violent be-

159. *Id.* at 40, 399 N.E.2d at 110.

160. *See Bruni*, 46 Ohio St. 2d 127, 346 N.E.2d 673.

161. *See Leverett*, 61 Ohio App. 2d at 41, 399 N.E.2d at 110.

162. *Littleton*, 39 Ohio St. 3d at 93, 529 N.E.2d at 456.

havior, it can never be said that a given prediction exhibited a lack of 'ordinary skill.' "[163] The gist of this contention is that, because violent behavior is inherently unpredictable, there is no standard with which to measure a patient's propensity for violence. Absent such a standard, there can be no means of comparison in order to form a basis for an objective standard of care.

Even if this contention were accurate, the lack of a standard with which to measure violent tendencies does not necessarily lead to the conclusion that the psychiatrist has no professional standards to guide him in his decision to release a patient who has exhibited violent tendencies. Therapists have specified a number of variables which contribute to the assessment of a patient as dangerous.[164]

In a survey of 2,875 therapists, 7 out of 10 respondents believed that 90-100% of their colleagues would agree with their conclusion that a patient was dangerous.[165] This implies that therapists themselves believe that there are objective standards for evaluating dangerousness.[166] Since the survey shows that most therapists seem to agree that there are common professional standards to be employed in evaluating dangerousness, it is difficult to fault a court for imposing an objective standard of care.[167] Therefore, while the therapist cannot be expected to predict whether or not a patient will harm a known potential victim, he should at least consider those specific variables upon which other therapists rely in assessing dangerousness prior to his release of that patient.[168]

The absence of a standard with which to predict violent behavior is not of itself a reason to change from an objective standard of care, because the objective standard considers "the circumstances." This is supported by cases from other states,[169] which have continued to adhere to an objective standard of care, but have allowed for the inherent

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163. *Id.* at 93-94, 529 N.E.2d at 456.

164. Wettstein, *supra* note 129, at 311.

> When therapists have been asked to specify what variables contribute to the assessment of a patient as dangerous, they reported a variety of considerations: delusional and impaired thinking, current criminal charge . . . present offense, cues during interview, criminal record childhood pathology, social and family circumstances . . . mental state, personality, personal history, social environment, nature of offense, and criminal record . . . .

Id. (citations omitted).

165. Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 464.

166. *Id.*

167. *Id.*

168. Although certain variables have been identified, Wettstein believes it is difficult to determine if clinical standards for the prediction of violent behavior exist in any mental health context. Wettstein, *supra* note 129, at 311.

169. *See* cases cited *supra* note 73.

unpredictability of violent behavior as a "circumstance" in determining the proper standard of care in cases of this type. The problem of second-guessing a psychotherapist's judgment was addressed in *Tarasoff*.[170]

> We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] *under similar circumstances.*" Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.[171]

Although the absence of specific standards for assessing a patient's potential for violence presents a problem in defining a standard of care, courts following the approach in *Tarasoff* consider this inherent problem as one of the "circumstances."[172] Instead of abrogating the objective standard, these courts essentially enlarge the scope of the objective standard by looking to the broad range of reasonable practices within which psychiatrists themselves might differ.[173] Therefore, instead of adopting a subjective standard, the *Littleton* court could have applied the objective standard of care enunciated in *Bruni*, while broadening the standard based upon a wide range of clinically accepted means of assessing a patient's propensity toward violence.

Defendants' third contention was that "modern psychiatry favors the early release of mental patients."[174] For purposes of this discussion this point can be conceded, since the court recognized that this consideration must be balanced against the safety of potential victims.[175]

Fourth, "the standard of care required for voluntary hospitalization should reflect the [Ohio] General Assembly's wisdom in formulat-

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170. 17 Cal. 3d at 425, 551 P.2d at 334, 131 Cal. Rptr. at 14.

171. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr at 25 (emphasis added) (quoting Bardessono v. Michels, 3 Cal. 3d 780, 788, 478 P.2d 480, 484, 91 Cal. Rptr. 760, 764 (1970)).

172. *See* Givelber, *supra* note 165, at 464.

173. *See, e.g.*, Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975). "The standard to be applied, however, must take into consideration the uncertainty which accompanies a psychiatric analysis. . . . The concept of 'due care' in appraising psychiatric problems, assuming proper procedures are followed, must take account of the difficulty often inevitable in definitive diagnosis." *Id.* at 417.

174. *Littleton*, 39 Ohio St. 3d at 94, 529 N.E.2d at 456.

175. *Id.* at 97, 529 N.E.2d at 459.

ing a standard for involuntary hospitalization."[176] The court found significance in the fact that Ohio Revised Code Section 5122.34 had been amended from a "reasonableness and good faith" requirement to a "good faith" requirement alone.[177] This was the version of the statute in effect on June 5, 1981, the date on which Theresa Pearson was released from Good Samaritan Hospital.

> 5122.34 Liability. Persons acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge or in judicial proceedings of a person under this chapter, do not come within any criminal provisions and are free from any liability to the person hospitalized or to any other person. This section applies to expert witnesses who testify at hearings under this chapter.[178]

The former version of this statute exculpated "persons acting reasonably and in good faith" as contrasted with "persons acting in good faith."[179] The court interpreted this change in language as demonstrating a legislative intent to hold those assisting in the discharge of mental patients to a good faith standard only, and not to a reasonableness standard.[180]

In finding this change in wording to be significant, the court did not discuss the case of *Daniels v. State*,[181] which is the only case opinion on point. While the court of appeals in *Daniels* affirmed the trial court decision on other grounds, the appellate court did correct the trial court's misinterpretation of this statute.

> The good faith standard of Ohio Revised Code Section 5122.34 as quoted above, applies only to the admission, discharge, and judicial order of hospitalization of some person, and not to other medical decisions made in the course of treatment, or in the internal operation of the hospital.
>
> The standard to be applied to decisions made in the course of treatment of a mentally ill person is the same as in other medical malpractice cases: the recognized standard of care of the medical community in the particular kind of case.[182]

The opinion in *Daniels* distinguished admission and discharge proceedings from *medical* decisions in the course of treatment.[183] The lan-

176. *Id.* at 95, 529 N.E.2d at 457.
177. *Id.* at 95 n.8, 529 N.E.2d 457 n.8.
178. OHIO REV. CODE ANN. § 5122.34 (Baldwin 1984).
179. *Littleton*, 39 Ohio St. 3d at 95 n.8, 529 N.E.2d at 457 n.8.
180. *See id.*
181. No. 85 AP-763 (Ohio Ct. App., 10th Dist. July 31, 1986).
182. *Id.*, slip op. at 3.
183. *See id.*

guage of the statute confines its application to persons who "*procedurally or physically* assist in the hospitalization or discharge."[184] It would appear that a decision by a psychiatrist to discharge a mental patient would not be a procedural matter, but would be a medical decision made in the course of treatment. Therefore, according to the opinion in *Daniels*, Ohio Revised Code Section 5122.34 should have no bearing on such medical decisions, and the objective test of *Bruni* should be applied.

The court may have elected to ignore the *Daniels* opinion because in *Daniels* the judgment below was affirmed on other grounds. Thus any interpretation of Ohio Revised Code Section 5122.34 would be considered as mere dictum. Since this was the only case authority on point, however, the interpretation of this statute in *Daniels* should have been addressed by the court.

3. The Holding

The paragraph immediately preceding the holding should be kept in mind when analyzing the holding itself.[185] Essentially, this paragraph states a general rule that where professional standards of care exist, a psychiatrist is required to conform to these standards or suffer liability. This implies that the three-part holding is intended to apply to only those situations for which there are no professional standards.

The holding itself is worded such that a given fact pattern can fit into only one of three categories. The three parts of the holding are designed to fit three basic fact patterns: 1) the patient has not manifested violent tendencies, nor has the psychiatrist any reason to suspect a tendency towards violence; 2) after a thorough evaluation of a patient's propensity for violence, the psychiatrist renders a good faith decision that the patient has no violent propensity; and 3) a diagnosis of violent propensities is assumed. However, after a thorough evaluation of the severity of the violent propensities and a balancing of the various interests involved, the psychiatrist in good faith formulates a treatment plan which includes the discharge of the patient.

The facts of *Littleton* fit the third part of the holding. In this type of fact pattern it is difficult to apply any standard of care in retrospect, because the facts will indicate an initial diagnosis of a tendency towards violent behavior. Therefore, in applying the third part of the holding to the negligent release cases, the ultimate issue will be whether the psychiatrist performed a thorough evaluation of the severity of the patient's propensity for violence. This begs the question: what

184. OHIO REV. CODE ANN. § 5122.34 (Baldwin 1989).

185. *See supra* note 52 and accompanying text.

constitutes a "thorough evaluation"? Answering this question requires an application of the paragraph preceding the holding to the third part of the holding itself. That paragraph indicates that "professional standards will be used to determine which factors are relevant and whether an evaluation was thorough."[186] The effect of the holding appears to be that the objective standard of care will still be used for each facet of the "thorough evaluation," to the extent that a professional standard has been established for a given facet of the evaluation. Even where there are no professional standards in performing a "thorough evaluation," professional standards will be employed to determine which *factors* are *relevant*.

The net effect of this might be seen from the eyes of the jury. For a given fact pattern to fit the third part of the holding, it will be assumed that the psychiatrist's initial diagnosis revealed violent tendencies. Because the objective standard will still be employed to the extent that professional standards exist, expert testimony will be presented on all aspects of the "evaluation" for which professional standards have been established. It appears that the jury will still have to make the ultimate determination as to whether or not the psychiatrist performed a "thorough evaluation." This problem of applying the third part of the holding is illustrated by the dissenting opinion.[187]

The basis of the dissent was not an objection to the majority's formulation of a new standard of care; rather, the dissent would have found liability on the part of Dr. Murray even in the application of the majority holding.[188] This is perhaps indicative of the problem a jury might have in determining whether a psychiatrist performed a "thorough evaluation" prior to the release of a patient who then commits an act of violence. It will be difficult for the jury to disregard the psychiatrist's initial diagnosis of a tendency towards violence in deciding whether a "thorough evaluation" was performed prior to the release of the patient.

V. CONCLUSION

By adopting a professional judgment rule, the Ohio Supreme Court has attempted to give a higher degree of deference to a psychiatrist's sensitive decision of whether or not to release an inpatient who has exhibited violent tendencies. However, the holding is worded such that the objective standard of care remains operative to a certain ex-

186. *Littleton*, 39 Ohio St. 3d at 99, 529 N.E.2d at 460.
187. *Id.* at 101, 529 N.E.2d at 462.
188. *Id.* at 102, 529 N.E.2d at 463.

tent. This dual character of the holding could make it difficult to apply in practice.[189]

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189. On remand, the jury applied the professional judgment rule and once again found negligence on the part of Dr. Murray. A verdict was returned in favor of plaintiff in the amount of one million dollars. Littleton v. Good Samaritan Hosp. & Health Ctr., No. 82-3227 (C.P. Montgomery County Dec. 13, 1989).