

**State of Michigan
In the Supreme Court**

Supreme Court No. 77726

**RUBY DAVIS, Administrator
of the Estate of Mable Barnes**

DE YONG-CHUN

**BRIEF OF AMICI CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
MICHIGAN PSYCHOLOGICAL ASSOCIATION
AND
MICHIGAN PSYCHIATRIC SOCIETY
IN SUPPORT OF DEFENDANT-APPEALANT**

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RUBY DAVIS, Administratrix,
of the Estate of Mollie Barnes,
Plaintiff-Appellee,

v.

DR. YONG-OH LHIM,
Defendant-Appellant.

**BRIEF OF AMICI CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
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IN SUPPORT OF DEFENDANT-APPELLANT**

INTEREST OF AMICI

The American Psychological Association (APA) is a voluntary nonprofit, scientific, and professional organization with more than 60,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country.

The Michigan Psychological Association, with over 900 members, is an affiliate of the APA and represents the scientific and professional interests of psychologists within Michigan.

The Michigan Psychiatric Society is a non-profit association of medical doctors who specialize in the field of

psychiatry in Michigan. It is also a "district branch" of the American Psychiatric Association, the largest national association of psychiatrists.

Amici consider this case to be of national importance to psychologists and psychiatrists, and to the public they serve. A decision to impose the dual duty to assess a patient's future dangerousness and to take steps to protect intended victims from their patients' dangerousness is flawed in several respects: (1) The rationale for the duty—protection of the public—is actually disserved by its imposition; (2) the scientific literature in the area overwhelmingly indicates that such predictions cannot be made with any acceptable degree of accuracy by psychotherapists; (3) the imposition of the dual duty conflicts with psychologists' and psychiatrists' obligations not to disclose confidences communicated by the patient; and (4) the duty to warn may have a profound effect on patients' willingness to undergo therapy, on therapists' willingness to treat violent patients, on patients' trust of the therapist, and on the effectiveness of therapy. Thus, this case raises questions of special concern to professional psychologists and psychiatrists and to *amici*.

Amici believe they can offer the Court relevant data and other information that will contribute to a thoughtful resolution of the serious questions confronting it on this appeal.

STATEMENT OF FACTS

Dr. Yong-Oh Lhim, defendant-appellant in this action and a psychiatrist at Northville State Hospital, provided inpatient psychiatric services to John Patterson from July 17, 1975 to August 4, 1975 and from August 21, 1975 to September 3, 1975. The second of these admissions was pursuant to a formal voluntary order. On both occasions Patterson was diagnosed as suffering from schizophrenia. On September 2, 1975, Patterson requested in writing a release from the hospital, and finding no

basis under MCL 330.1401¹ on which to apply for involuntary commitment, Dr. Lhim discharged Patterson from the hospital, as required by MCL § 330.1419,² with instructions for follow-up care.

Subsequent to his discharge, Patterson was seen by another psychiatrist who, like Dr. Lhim, determined that Patterson did not meet the statutory criteria for involuntary hospitalization. Two months after his discharge from Northville and several days after the second psychiatrist had refused to seek Patterson's involuntary commitment, Patterson began firing a gun randomly and, when his mother tried to stop him, she was shot and killed.

Patterson's aunt, plaintiff-appellee in this case, thereupon brought a wrongful death action against Dr. Lhim, alleging that he had negligently discharged Patterson and negligently failed to warn the decedent that Patterson was a danger to her safety. The jury found for the plaintiff and, on appeal, the court of appeals rejected Dr. Lhim's claim of governmental immunity and upheld the jury's award. *Davis v. Lhim*, 124 Mich. App. 291, 335 N.W.2d 481 (1983). On appeal to this Court, the case was remanded to the court of appeals for reconsideration

¹ MCL § 330.1401 provides, in pertinent part, that a "person requiring treatment" under the statute means:

(a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(Emphasis added).

² MCL § 330.1419 provides, in pertinent part:

Except [upon a determination that the patient is a person requiring treatment as defined in subsection 1401 and should remain in the hospital], a formal voluntary patient 18 years of age or over shall not be hospitalized more than 3 days, excluding Sundays and holidays, after he gives written notice of his intention to terminate his hospitalization and leave the hospital.

in light of *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984). On remand, the court of appeals reaffirmed its earlier opinion. *Davis v. Lhim*, 147 Mich. App. 8, 382 N.W.2d 195 (1985).

The court of appeals held that the determinations by Dr. Lhim not to seek involuntary commitment of Patterson and thereby to discharge him as required by MCL § 330.1419, and not to warn his mother of the "threats" made against her, were "ministerial" in nature, and thus were not entitled to governmental immunity. Secondly, the court of appeals held that the jury correctly applied the relevant standard of care in finding Dr. Lhim negligent. Dr. Lhim has appealed both of these holdings.

Amici wish to highlight several salient facts regarding the events leading up to Patterson's care and treatment by Dr. Lhim. First, although Patterson had been treated at Northville State Hospital on several occasions prior to Dr. Lhim's treatment of him, each occasion was pursuant to a voluntary admission by Patterson. Second, there was no evidence of a history of violent behavior on the part of Patterson. Third, the sole evidence adduced at trial of a "threat" by Patterson to his mother was a two-year old entry in emergency room records of Detroit General Hospital reflecting alleged statements made directly to the mother. The note quotes plaintiff-appellee in this case as saying that Patterson "paces the floor and acts strangely and keeps threatening his mother for money." 124 Mich. App. at 306, 335 N.W.2d at 490. Finally, Dr. Lhim was aware of this reported statement from the record, but found no current clinical evidence supportive of the statement during his treatment of Patterson, and determined, in his professional judgment, that the staleness, as well as the context, of the reported statement rendered the possibility of violence too remote to support a finding of future dangerousness, as required for involuntary commitment under Michigan law.

SUMMARY OF ARGUMENT

Amici present substantial data that show that psychiatrists and psychologists are unable to reliably or validly predict the future dangerousness of their patients. In deed, empirical evidence demonstrates that two out of every three predictions are erroneous. In light of these data, there is little justification for the imposition of a duty on psychotherapists to assess the dangerousness of their patients and to take preventive measures based on those assessments. Moreover, the demonstrated inability of psychotherapists to agree on any useful guidelines for such assessments raises serious questions as to the existence of a "standard of care" within the profession which courts purport to apply in cases such as this one. In addition, the imposition of such a duty severely undermines the ability of therapists to foster therapeutic relationships with their patients, and to provide appropriate treatment. Most importantly, a legal duty to prevent violence ultimately would be antagonistic to the public interest purpose and social policy goals it was intended to serve.

Notwithstanding the lack of any meaningful rationale for the imposition of such a duty on psychotherapists, should this Court determine that a general duty to assess dangerousness and take preventive measures is appropriate in some circumstances, the "threat" in this case is sufficiently attenuated, and the absence of any other factors suggestive of Patterson's potential dangerousness to his mother so compelling, that the imposition of liability on Dr. Lhim is wholly unjustified.

Finally, even if the duty advocated by the plaintiff did exist, Dr. Lhim's conduct is immune from tort liability. In *Fisher v. State of Michigan*, 422 Mich. 883, 36 N.W.2d 229 (1985) (By Order), this Court upheld the trial court's ruling that a State employee's mental health decisions were discretionary and hence immune from liability under the rule established in *Ross v. Consumers*

Power Co., 420 Mich. 567, 363 N.W.2d 641 (1984). As the discretion exercised by Dr. Lhim is indistinguishable from that at issue in *Fisher*, Dr. Lhim also is clearly immune from tort liability.

ARGUMENT

I. THERE IS NO PUBLIC POLICY OR EMPIRICAL JUSTIFICATION FOR IMPOSING LIABILITY ON THERAPISTS FOR FAILING TO ACCURATELY PREDICT THEIR PATIENTS' FUTURE DANGEROUSNESS.

This Court has the unparalleled opportunity to halt, if not reverse, a decade of ill-advised, unsound, and empirically unsupportable judicial opinions concerning mental health professionals' duty to take preventive measures in response to threats uttered by their patients. In the view of *amici*, the proper way to resolve this appeal is to reject the basic tort claim raised here by appellee. The Court should flatly hold that mental health professionals are not, by virtue of that status alone, potentially liable to third parties for the violent conduct of their patients. A full examination of the issue makes clear that such a rule of third-party liability is an ineffectual and undesirable means of dealing with the problem of violent actions by mentally disabled persons.

Since the California Supreme Court's decisions in *Tarasoff v. Regents of the University of California*, 13 Cal.3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), *vacated*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), a number of courts have imposed upon mental health professionals the duty to assess the future dangerousness of their patients and, in certain circumstances, to take reasonable care to protect intended victims from such dangers. See, e.g., *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983); *Hicks v. United States*, 511 F.2d 407 (D.C. Cir. 1975); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980); *Knight v. State of*

Michigan, 99 Mich. App. 226, 297 N.W.2d 889 (1980); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (1979). This duty has been construed, variously, to require therapists to seek commitment of their patients whom they determine, or "under applicable professional standards reasonably should [] determine[]," present a serious danger of violence to others, to notify appropriate law enforcement authorities, or to warn intended victims of their patients' dangerousness. *Tarasoff*, 551 P.2d at 345. See generally Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597, 598 (1984).

Notwithstanding the laudatory public safety goals that the imposition of this broad duty was intended to serve, the duty is premised upon faulty assumptions regarding the abilities of mental health professionals to predict with any degree of reliability or validity the future dangerousness of particular individuals. Because mental health professionals do not know which of many patients will commit violent acts, they will react to the threat of liability by "overpredicting" violence and taking preventive steps in a large number of cases. When therapists follow this broad-based approach, their actions have no positive effect on the overall level of public safety and lead to an increase in unnecessary involuntary hospitalization. Moreover, the imposition of this duty on therapists in many cases has the effect of undermining the therapeutic relationship, impeding effective treatment and resolution of the patient's mental disorder, and thereby increasing the very risk the duty was designed to diminish.

A. Mental Health Professionals Can Neither Reliably Nor Validly Predict Dangerousness.

Many recent decisions, in this and other contexts, have recognized the difficulties inherent in therapists' efforts to predict dangerousness.³ The usual response to this recog-

³ See, e.g., *Ake v. Oklahoma*, 105 S. Ct. 1087, 1096 (1985) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely

nition has been to hold therapists to the general "standard of care" for mental health professionals. In anticipating patient violence, therapists must stay "[w]ithin the broad range of reasonable practice and treatment in which professional opinion and judgment may differ." *Tarasoff*, 551 P.2d at 345.⁴

The problem with this approach is that the existence of such a "range" is unsupported by the empirical evidence. The consistent research finding is that mental health professionals fail to predict accurately future violence in two out of three cases,⁵ and that there is no consistent professional standard for predicting violence.⁶ In light of

and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness."); *Barefoot v. Estelle*, 463 U.S. 880, 899, n.7 (1983); *White v. United States*, 244 F. Supp. 127, 131 (E.D. Va. 1965), *aff'd*, 359 F.2d 989 (4th Cir. 1966) (hospital not negligent when it failed to guard patient who escaped and stood in front of train); *Tarasoff v. Regents of University of California*. See also *Barefoot v. Estelle*, 463 U.S. at 921 & n.2 (Blackmun, J., dissenting).

⁴ The *Tarasoff* court stated:

Obviously we do not require that the therapist, in making th[e] determination [of dangerousness], 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."

131 Cal. Rptr. at 20, 551 P.2d at 345 (citations omitted).

⁵ See, e.g., J. MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 713 (1974) [hereafter *Flipping Coins*]; Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972). See also Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 11 (1984).

⁶ See Steadman, *The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC QUARTERLY 84, 96 (1980) ("Nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance."). See also Wenk, Robinson & Smith, *Can Violence Be Predicted?* 18 CRIME & DELINQUENCY 393,

these findings, the "standard of the profession" or the "range of reasonable practice and treatment" is inherently unreliable, and ultimately unworkable, as a standard by which to judge the assessments of other therapists and to impose liability based on those judgments.⁷

Social scientists, psychiatric authorities, and legal commentators are overwhelmingly in agreement that dangerousness cannot be predicted with any acceptable degree of reliability or validity.⁸ Scientific studies clearly demon-

394 (1972) (finding it impossible to identify any subclass of offenders "whose members have a greater-than-even chance of engaging again in an assaultive act.").

⁷ Commenting on the decision in *Tarasoff* to examine "the therapist's prediction of dangerousness" under the ordinary malpractice criterion of "conformity to standards of the profession," Professor Stone writes: "One can only wonder what it means to apply standards to skills which do not exist. As Justice Mosk noted, dependence on such standards 'will take us from the world of reality into the wonderland of clairvoyance.'" Stone, *The Tarasoff Decisions: Swing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 371 (1976) (quoting *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 354 (1976) (Mosk, J., dissenting in part and concurring in part)) [hereafter *Stone*]. See also *Tarasoff*, 551 P.2d at 361 n.6 (Clark, J., dissenting) ("The majority's reliance on the traditional standard of care for professionals . . . is seriously misplaced. The standard of care assumes that to a large extent, the subject matter of the specialty is ascertainable. One clearly ascertainable element in the psychiatric field is that the therapist cannot accurately predict dangerousness, which in turn means that the standard is inappropriate for lack of a relevant criterion by which to judge the therapist's decision. . . . The majority's attempt to apply a normative scheme to a profession which must be concerned with problems that balk at standardization is clearly erroneous."); Note, *Imposing a Duty to Warn on Psychiatrists—a Judicial Threat to the Psychiatric Profession*, 48 U. COL. L. REV. 283, 290-91 (1977) (same).

⁸ "Reliability" refers to the degree of correlation or correspondence of judgment between professionals using the same method. Thus, if representative pairs of therapists, interviewing a representative sample of prospective patients, usually agree that each individual is or is not "dangerous," the judgment of "dangerousness" is said to be reliable. "Validity," by contrast, refers to how accurate the judgment in question is, without regard to the likelihood of agreement among therapists as to that judgment.

strate that predictions of dangerousness of mentally disabled persons are extremely inaccurate and are largely based on speculation.⁹

The American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual (1974) [hereafter *Task Force*] concluded after an exhaustive review of the literature that judgments concerning the long-run potential for future violence and the "dangerousness" of a given individual are "fundamentally of very low reliability." *Task Force* at 23. The Task Force reported that "the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists . . . to reliably predict future violence is unproved." *Id.* at 30. The Task Force found that efforts to predict violence of particular individuals resulted in an unacceptably high rate of "false positives"—i.e., violent behavior was pre-

⁹ See J. MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981); B. ENNIS & R. EMERY, *THE RIGHTS OF MENTAL PATIENTS* 20 (1978); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, 33 AM. PSYCHOLOGY 1099 (1978); Steadman, *Predicting Dangerousness Among the Mentally Ill*, 6 INT'L. J. L. & PSYCHIATRY 381-90 (1983); AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 28 (1974) (90 per cent error rate "unfortunately . . . is the state of the art"). See generally D. SHAPIRO, *PSYCHOLOGICAL EVALUATION AND EXPERT TESTIMONY* (1984); Wettstein, *The Prediction Of Violent Behavior And The Duty To Protect Third Parties*, 2 BEH. SCIENCES AND THE LAW 291 (1984); Scott, *Violence in Prisoners and Patients, Medical Care Of Prisoners And Detainees*, 123 U. PA. L. REV. 439 (1975); Flipping Coins, *supra* note 5, at 750-51; Rector, *Who Are the Dangerous?* BULL. AM. ACAD. PSYCH. & L. 186 (July 1973); Rosenhan, *On Being Sane In Insane Places*, 13 SANTA CLARA L. REV. 379 (1973); Justice & Birkman, *An Effort to Distinguish the Violent from the Nonviolent*, 65 SO. MED. J. 703 (1972); Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIATRY 397 (1972); United States Department of Health, Education and Welfare, HEW NEWS (News Release, August 8, 1974).

dicted for individuals who did not demonstrate any violence within the period of the study. *Id.* at 23-24.¹⁰

Subsequent research has supported the Task Force's findings.¹¹ Professor Monahan,¹² in *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981) [hereafter *CLINICAL PREDICTION*], reported that no procedures used by

¹⁰ This tendency to overpredict violence results not only from the difficulty of identifying factors that suggest future violence but also from the extremely low incidence of violence as a societal phenomenon:

Predictions of dangerousness, like those of suicide, are, with few exceptions, predictions of rare or infrequent events This means that even if the characteristics of such future violent patients could be specified with fairly great accuracy, predictions based upon such characteristics will identify far more "false positives" than "true positives". Even if an index of violence proneness could be developed so as to correctly identify prior to release fifty percent of those individuals who will violate parole by committing violent offenses, the actual employment of such an index would identify eight times as many "false positives" as "true positives". This means that eight of the nine persons retained in prison as a result of application of the index would not have committed such offenses if released.

Task Force at 23-24 (footnotes omitted).

¹¹ See, e.g., Schwitzgebel, *Prediction of Dangerousness and its Implications for Treatment* in *MODERN LEGAL MEDICINE, PSYCHIATRY, AND FORENSIC MEDICINE* 784 (W. Curran, A. McGarry & C. Petty, eds. 1980); Steadman & Coccozza, *Psychiatry, Dangerousness, and the Repetitively Violent Offender*, 69 J. CRIM. LAW & CRIMINOLOGY 226 (1978). See generally *supra* note 9. See also Steadman & Coccozza, *Stimulus/Response: We Can't Predict Who Is Dangerous*, 8 PSYCH. TODAY 32, 35 (Jan. 1975):

Because psychiatrists cannot accurately predict who will become violent, they frequently err. Rather than random errors, however, their inaccurate predictions are consistently on the safe side. They overpredict. They assume that since some patients are dangerous, the one under consideration might be. The result of this practice is that as many as twenty harmless persons are incarcerated for every one who will commit a violent act.

¹² Professor Monahan, a research psychologist on the faculty of the University of Virginia Law School, has been described as the "leading thinker on [the] issue" of the prediction of violence. *Barefoot v. Estelle*, 463 U.S. 880, 920 (1983) (Blackmun, J., dissenting).

psychotherapists had succeeded in reducing the high rate of "false positive" predictions of violent behavior. Even allowing for possible distortions in certain of the research data, Monahan concluded that "it would be fair to [state] that the 'best' clinical research currently in existence indicates that *psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several year period.*" *Id.* at 47.¹³

The notion that mental health professions have expertise in predicting dangerousness of individuals is based, in part, on the popularly held views that mentally disordered individuals are more likely to engage in violent acts than the general population, and that the presence of a mental disorder, *per se*, makes the prediction of violence easier and more accurate than would otherwise be the case. There is no empirical support for these propositions. See D. SHAPIRO, *PSYCHOLOGICAL EVALUATION AND EXPERT TESTIMONY* 157-60 (1984) [hereafter SHAPIRO]; *Flipping Coins*, *supra* note 5, at 716 (and citations contained therein). Professor Monahan has observed that "[t]he most relevant *noncorrelate* of violence is 'mental

¹³ The studies above refer primarily to the inability of psychotherapists to make medium to long-term predictions of the violent behavior of their patients. Although there are very few studies of the reliability and validity of short-term predictions, Professor Monahan has observed that short-term emergency commitment of mentally ill persons predicted to be imminently violent may be exempt from the systematic inaccuracy found in the current research. Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 *AMER. J. PSYCHIATRY* 198 (1978). This difference is due, in part, to the fact that short-term predictions are usually made in the context of specific, and usually acute, mental disorders. See generally Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 *CURRENT PSYCHIATRIC THERAPIES* 55, 58 (J. Masserman ed. 1978). However, even the few studies that exist regarding short-term predictions of "imminent" violence limit the ability to predict to several days. *Id.* Because, under any of these standards, Dr. Lhim's alleged failure to predict in this case was not "short-term," amici rely on the above-cited studies reporting the general inability of psychotherapists to predict future violent behavior by their patients.

illness'." *CLINICAL PREDICTION* at 77 (emphasis added). Indeed, "schizophrenics and other psychotic persons ha[ve] a history of lower violence and fewer incarcerations than [do] other accused persons. . . ." Menzies, Webster & Sepejak, *The Discovery of Dangerousness in a Pre-trial Forensic Clinic*, Paper presented at the Annual Meeting of the American Psychiatric Association (1982).¹⁴

The best indicator of future violence is past violence on the part of the individual—a factor having nothing to do with the patient's mental disorder for which he or she is being treated, and, a factor of which even the most careful therapist may not necessarily be aware. See SHAPIRO at 157; Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 *AM. PSYCHOLOGIST* 224-38 (1978); *CLINICAL PREDICTION* at 71.¹⁵ And in circumstances such as those presented by this case where there is no history of violence on the part of the patient, predictions of dangerousness are extremely difficult, if not impossible.¹⁶

¹⁴ Although therapy patients often express thoughts of violence, they rarely carry them out—the very nature of psychotherapy actuates clients to voice such ideation. Bersoff, *Therapists as Protectors and Policemen: New Roles as a Result of Tarasoff*, 7 *PROF. PSYCHOLOGY* 267 (1976). However, such ideation should not be confused with impulse. Many studies on aggression demonstrate that frequently, expressing violent thoughts in fantasy is precisely what prevents the person from acting on that fantasy. SHAPIRO at 160.

¹⁵ But see T. BLAU, *THE PSYCHOLOGIST AS EXPERT WITNESS* 49-50 (1984) ("Some have suggested that 'the past is a prologue' and that dangerousness can be best predicted from a history of violence. Recent evaluation of the violent history paradigm does not support this concept. It is suggested that violence is frequently due to transitory psychological state[s] that emerge in response to atypical circumstances and is a fairly poor indicator of future violence."). (Citations omitted.)

¹⁶ See Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 *CRIME & DELINQUENCY* 371 (1972):

The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually performed an assaultive act We submit that to properly assess indi-

Other demographic factors that correlate positively with violent behavior include age (a disproportionate amount of crime is committed by persons between the ages of fifteen and twenty);¹⁷ gender (nearly 90 percent of all persons arrested for violent crimes are male);¹⁸ environmental circumstances (family, peer, jobs), as well as the availability of victims, weapons, and alcohol or other drugs. Lanyon, *Psychological Assessment Procedures in Court-Related Settings*, 17 PROF. PSYCHOLOGY 260, 264 (1986). The assessment of these factors and the ability to make predictions of violence based on them is not within the particular expertise of mental health professionals. It is not surprising that much of the research in this area has found that psychotherapists have no greater ability to predict future dangerousness than do non-psychotherapists.¹⁹

Although one study suggests that some psychotherapists believe that they can employ objective professional standards for evaluating the potential likelihood of dangerousness,²⁰ considerable doubt remains that their self-confidence actually reflects their abilities. See Small, *Psychotherapists' Duty to Warn: Ten Years After Tarasoff*,

cations of possible dangerousness in the absence of an actual instance of dangerous acting out requires the highest degree of psychiatric expertise and may well exceed the present limits of our knowledge No one can predict dangerous behavior in an individual with no history of dangerous acting out.

¹⁷ See F. ZIMRING, CONFRONTING YOUTH CRIME: REPORT OF THE TWENTIETH CENTURY FUND TASK FORCE ON SENTENCING POLICY TOWARD YOUNG OFFENDERS (1978).

¹⁸ See W. WEBSTER, CRIME IN THE UNITED STATES—1977 (Federal Bureau of Investigation, 1978).

¹⁹ See, e.g., *Flipping Coins*, supra note 5, at 707, n.43 ("There are a few studies comparing the diagnostic reliability of psychologists and laymen, most of which report no significant difference."). See generally 1 J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 263 (3d ed. 1981).

²⁰ See Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, WIS. L. REV. 443 (1984) [hereafter *Givelber, et al.*].

15 GOLDEN GATE U. L. REV. 271 (1985). In response to this optimistic report, Professor Monahan states:

No one thinks that the prediction of violence is on the verge of attaining a validity comparable to that of the prediction of the weather. . . . There may indeed be a ceiling on the level of accuracy that can ever be expected of the clinical prediction of violent behavior. That ceiling, however, may be closer to 50% than to 5% among some groups of clinical interest.

Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 11 (1984). Thus, at best, given the development of more accurate and reliable assessment techniques, psychotherapists may be able to successfully predict violence only one out of every two times. Given these odds, there is little justification for holding therapists liable for failing to predict accurately their patients' dangerousness.

B. A Rule Imposing A Duty To Assess Dangerousness And Take Preventive Measures Will Have Adverse, Not Beneficial, Effects.

In view of therapists' fundamental inability to predict dangerous conduct, there is no valid argument for a new form of third-party liability for therapists for the violent acts of their patients. An effort to improve public safety by imposing a duty on professionals who lack the ability to predict or prevent violence will lead either to failure or to other adverse social consequences that outweigh any benefits.

1. Therapists Will Overpredict Violence.

The first problem with any rule imposing liability on therapists for their patients' conduct is that the response of the mental health professionals will necessarily affect a large number of patients—far more than the number who actually commit violent acts. Therapists cannot identify which of their many patients with potential violent "tendencies" will actually resort to violence. The only ration

response to this lack of knowledge, in the face of a threat of liability, is to assume that every patient who expresses violent emotions will act on those emotions. As a result, therapists will vastly "overpredict" violence, and will begin making decisions on that basis.

The majority below, although aware of these predictive problems,²¹ rejected the notion that therapists would "over-react" in this way to a risk of liability. The majority apparently believed that a liability rule based on the prevailing "professional standard of care" would not have any real impact on the large majority of therapists who are attempting to do their jobs in good faith. But this belief is untenable, in view of the absence of a professional consensus about what facts may properly lead to a prediction of violence. Because there is no acknowledged professional approach to predicting violence, therapists treating potentially violent patients will necessarily be preoccupied with other ways of minimizing their legal exposure.

There are several rational responses for these therapists faced with a "duty" that they feel unable to fulfill. First, they can seek to avoid altogether the patients that cause the problem. A rule of third-party liability is certain to discourage many mental health professionals from treating any patients whose history or behavior suggests that future violence is a possibility. Even without such a rule, many therapists already tend to avoid these kinds of patients because they are notoriously difficult to communicate with and treat.²² If these therapists are now told that they may be held responsible for their patients' violent conduct—despite their acknowledged inability to predict that violent conduct—they will be even more reluctant to begin treatment. This, in turn, could lead to

²¹ 124 Mich. App. 291, 301; 335 N.W.2d 481, 487 ("Medical doctors cannot predict with perfect accuracy whether or not an individual will do violence to himself or to someone else.").

²² See Stone, *supra* note 7, at 371-372.

less effective care for the very patients about whom the majority below was most concerned.

Among those therapists who remain willing to treat potentially dangerous patients, there will be another, equally predictable response. They will increase dramatically the number of occasions on which they anticipate violence and act on that prediction. They will know that, in the event of a lawsuit, the "dangerousness" of a particular patient who has committed a serious violent act will seem obvious. A court or jury, with the benefit of hindsight, is not likely to be moved by abstract protestations about the difficulties of behavioral predictions. Nor will it do much good to describe the many other patients with comparable violent "tendencies" who have been stabilized and integrated successfully into society. Once a homicide or other crime has been committed, there will be an almost irresistible temptation, on the part of the legal system, to determine that the therapist should have done something more to prevent it.²³

Faced with this prospect, therapists are bound to recognize an additional fact: the potential costs of inaction far outweigh any costs, for them personally, of taking action. In any individual case, if they guess that a patient is not really violent and take no preventive steps, they face potentially huge liabilities in the event they are wrong. If, on the other hand, they assume that this same patient is violent, and take "appropriate" action, the impact on them is minimal. Depending on what the facts and law seem to require in a given case, they can avoid the risk of liability simply by making a warning phone call, or by adjusting their own decisionmaking about a given clinical issue like a hospital discharge.

²³ See *Tarasoff v. Regents of the University of California*, 51 P.2d at 361 (Clark, J., dissenting) (since "the decision not to warn or commit must always be made at the psychiatrist's civil peril one can expect most doubts will be resolved in favor of the psychiatrist protecting himself"); Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 188 (1978) [hereafter *Stanford Note*].

Thus, the major impact of routine overpredictions of violence will not be on the therapist but on the patients themselves. It is they, after all, who will have their confidences spread to family members, friends, and business associates through warnings. Or it is they who will be kept in psychiatric hospitals despite a therapist's clinical judgment that a discharge would be desirable.

For all of these reasons, the Court would be wise not to minimize the likely effects of a liability rule on the behavior of psychotherapists. Regardless of whatever cautionary language the Court might use to lower the standard of care, the potential for liability for patient violence will predictably lead therapists to act differently in a large number of cases, whenever they have any suspicion whatever that they are dealing with a potentially violent person.²⁴

2. The Costs of Such a Rule Will Outweigh the Benefits.

Whether such a broad-ranging change in clinical behavior is desirable, of course, depends on exactly what decisions and actions are being encouraged by the tort system. The ultimate issue is whether society will be better off if it moves from the present system to one where therapists are forced to consider warnings and/or hospitalization whenever patients utter violent thoughts. We analyze the utility of each of these two available types of responses in turn.

a. The efficacy of warnings.

The most commonly discussed preventive measure when patients are suspected of future violence is to warn the potential victim, if identifiable. The lack of a warning in the present case, for example, was central to the ruling

²⁴ This effect has been demonstrated empirically. See Givelber, *et al.*, *supra* note 20, at 477 ("The most dramatic effect of *Tarasoff* can be seen exactly where one would expect it: in increased willingness to notify potential victims, public authorities, and police.") (citations omitted).

of the court below that the evidence supported a finding of negligence.²⁵ And *Tarasoff* itself is often labelled, or somewhat inaccurately, as a "duty to warn" case. So can safely be assumed that one of the responses of mental health professionals in Michigan, if faced with a rule of third-party liability for patient violence, would be to make a great many more warnings. The question is whether this would accomplish anything.

The most central concern about forcing therapists to make warnings to victims is the fact that they constitute a breach of the confidential treatment relationship between therapist and patient. Effective psychotherapy requires that patients be able to reveal their innermost thoughts and feelings, secure in the knowledge that their thoughts and feelings will be kept confidential. As the Sixth Circuit has noted, a therapist's "capacity to help his patients is completely dependent upon their willingness and ability to talk freely." *In re Zuniga*, 714 F.2d 638 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983) (quoting Prop. Fed. R. Evid. 504 note, 56 F.R.D. at 2 (1976)).²⁶ This fact, in turn, "makes it difficult if impossible for him to function without being able to assure his patients of confidentiality. . . . A threat of secrecy blocks successful treatment." *Id.* In sum, a warning, like any other breach of confidence, is far from

²⁵ 124 Mich. App. 291, 308-09; 335 N.W.2d 481, 491.

²⁶ See *Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955); *In re Lifschutz*, 2 Cal.3d 415, 431, 85 Cal. Rptr. 829, 467 P.2d 100 (1970). See also MCL §§ 333.18237, 600.2157 (creating psychologist and physician-patient testimonial privileges). For clinical discussion of these issues, see, e.g., Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCIENCES & LAW 273, 277 (1984) [hereinafter *Beigler*] ("[A]ny evidence of breach of confidentiality will undermine the patient's trust of the therapist, deter the patient from taking advantage of treatment, and deprive the patient and society of the beneficial effects of psychiatric interventions."); Schuchman, Roth & Lidz, *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMM. PSYCHIATRY 353 (1983) (empirical study confirming importance of confidentiality to patients).

cost-free. It necessarily represents a threat to the treatment process itself.

To be sure, we do not suggest that this confidential relationship should be inviolate in every conceivable situation. State law, for example, generally requires a report to the authorities whenever a therapist learns about ongoing child abuse.²⁷ And most therapists would acknowledge moral responsibility to take some discretionary action if they are convinced that a patient is about to commit a violent crime. But the question here is whether the law should force a large increase in the number of warnings being made—i.e., whether it is desirable to enact a rule that will lead, predictably, to warnings that are motivated, not by the clinical and moral judgment of therapists, but by their fear of being second-guessed in a later tort suit.²⁸

Such a development would erode significantly the ability of psychotherapists to treat the very persons who are causing the problem—those who may have some urge to violence. As we have discussed, the number of patients likely to be affected by this rule is quite large. These patients will know that if they reveal these impulses, even in a confidential therapy session, the therapist is likely to describe these feelings to the very family member, friend, or business associate who is directly involved. This breach of secrecy, in turn, not only will be painful for patients but almost certainly will have collateral consequences, e.g., loss of employment, estrangement from family, and the like. Faced with this prospect, the natural response of patients will be to avoid treatment, or to avoid the very statements during treatment that may be most essen-

²⁷ See, e.g., MCL § 25.248.

²⁸ See *Stanford Note*, *supra* note 23, at 190 (distinguishing the effects of "discretionary" disclosures from the effects of a legal duty to warn).

tial to their recovery.²⁹ Such reticence, in turn, may end up *increasing* the likelihood that patients will actually carry out their secret violent impulses.³⁰

This danger is more than mere speculation. In a survey of California psychotherapists conducted by the *Stanford Law Review* after the *Tarasoff* decision, a majority of those surveyed "thought that patients will withhold information important to treatment if they believe the therapist may breach confidentiality."³¹ And fully one-fourth of the respondents "reported actually observing their patients' reluctance to discuss their violent tendencies when informed of the possibility of an exception to absolute confidentiality."³²

This risk might be worth taking if there were reason to believe that the warnings themselves are an effective means of preventing violence. But that is hardly clear in

²⁹ See *Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting) (majority's rule will deter persons from seeking treatment, prevent full disclosure of patients' thoughts, and interfere with the development of a trusting relationship between therapist and patient); *Stone*, *supra* note 7, at 370 ("Anyone who has worked in a therapeutic program serving drug addicts, prisoners, parolees, probationers, or juvenile delinquents can attest that the duty to breach the patient's privacy as required by *Tarasoff II* would eviscerate whatever possibility of treatment exists with these difficult patients.").

It is noteworthy that the patient in *Tarasoff* never returned for further treatment to his psychotherapist after the therapist disclosed his patient's threat to third parties. It would be two months before the patient's eventual victim returned, yet the therapist had no opportunity to treat his patient or further assess his capacity for violence during this time.

³⁰ See *Stone*, *supra* note 7, at 373 (duty to warn "will reduce rather than increase public safety because it will diminish the ability and motivation of therapists to treat effectively mentally disturbed and potentially dangerous people"); Gurevitz, *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289 (1977) [hereafter *Gurevitz*].

³¹ *Stanford Note*, *supra* note 23, at 183.

³² *Id.*

itself. First, there is the problem of what a potential victim can do to forestall a violent act even after receiving a warning. The options are certainly few.³³ Indeed, in many circumstances, a warning may precipitate a confrontation and thus "may in fact increase the likelihood of violence."³⁴ In such a case, other options are obviously far preferable. "Most patients will tolerate a variety of other protective forms of crisis intervention by the therapist with much less damage to the therapeutic alliance and with much less rage towards both the therapist and the potential victims because their psychological implications are much less sinister to the patient."³⁵ In sum, a warning is not a very effective way to prevent patient violence.³⁶

For all of these reasons, *amici* believe it is a serious mistake to create a tort rule that encourages therapists to make a warning whenever there is a possibility of patient violence. A decision about how to respond to a patient's threats of violence is often complex and difficult. Under the present system, therapists can decide, on a case-by-case basis, whether a given threat is serious enough to outweigh the need for confidentiality and whether, in the particular circumstances involved, a warning will improve matters or simply make them worse. Under the ruling below, by contrast, the likely result will

³³ S. HALLECK, LAW IN THE PRACTICE OF PSYCHIATRY 81-82 (1980).

³⁴ Stone, *supra* note 7, at 370. Accord Roth, *supra* note 13, at 58 ("warnings may increase rather than decrease the likelihood of subsequent violence."); Beigler, *supra* note 26, at 283; Gurevitz, *supra* note 30, at 290.

³⁵ Stone, *supra* note 7, at 370-71.

³⁶ Dr. Lhim could have selected the alternative of contacting the police, but until an overt violent act occurs, there is virtually nothing that the police can do to protect a potential victim. In *Tarasoff*, for example, the campus police were notified and they temporarily detained the patient. That did not prevent the victim's homicide.

be a large number of warnings motivated primarily by the risks of tort liability—a development that, more likely than not, will be counterproductive.

b. *The efficacy of hospitalization.*

A warning to third parties is not the only type of action, that, under the majority rule below, a therapist may be required to take in order to avoid liability for patient violence. Therapists may also be held liable if a court subsequently determines that their clinical decisions failed adequately to take into account the risk of violent actions by their patients. In particular, the court below expressed a willingness to second-guess a decision that a particular patient is ready to be discharged from a hospital setting.³⁷

This kind of rule might, in theory, reduce the number of violent acts by mentally ill persons, but it would do so only by drastically increasing the number and duration of psychiatric hospitalizations. This solution thus raises once again the problem that those persons who will actually commit violent acts cannot be systematically identified. If their actions are to be prevented through isolation in a hospital, it will require "preventive detention" of the far *larger* group of people who exhibit some *potential* for violence.³⁸

³⁷ In analogous cases, the trend toward a broader "duty to protect" third parties has gone even further. In two recent cases involving physicians' liability to third parties for automobile accidents allegedly caused by their patients' epileptic condition, *Duvall v. Goldin*, 139 Mich. App. 342, 362 N.W.2d 275 (1984), and medication, *Welke v. Kuzilla*, 144 Mich. App. 245, 375 N.W.2d 403 (1985), the courts have relinquished any requirement that the third-party victim be "identifiable" in advance. The *Welke* court went so far as to suggest that third-party liability is desirable here because doctors typically are covered by malpractice insurance. *Id.*

³⁸ There is evidence that third-party liability rules do promote more hospitalizations of potentially dangerous patients. In the Stanford survey of the effects of the *Tarasoff* decision, several responding psychiatrists volunteered that the decision had made them more likely to commit patients who made threats of violence. *Stan-*

It follows that a decision to deal with patient violence by second-guessing treatment decisions would be effective only if it had a major impact on the existing balance struck in our society between two competing values: the value of preventing violence against third parties, and the value of allowing many mentally disabled persons to receive appropriate treatment in a non-restrictive outpatient setting. This is not an easy balance to strike. Any enthusiasm for use of physical isolation as a means to control violence by the mentally disabled has to be tempered by due recognition of the costs of such an approach.

One fundamental concern is the significant reduction in patients' liberty. "Because of the virtual impossibility of predicting dangerousness, such an approach would necessarily lead to prolonged incarceration for many patients who could become useful members of society." *Johnson v. United States*, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978). This sizeable group of people would experience significant restrictions on their freedom, *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), solely to protect the rest of society from the violent acts that a *very few* of their number would otherwise commit.

This isolation, in turn, would become a major impediment to further treatment for these many patients. In most cases, effective treatment of mental disability cannot be fully carried out unless, at some point, the therapist allows the patient to leave a controlled hospital environment. This decision will often be a "calculated risk," but it is a risk that must be taken "if there is any reasonable possibility that the patient will ever again be able to mix with society and become a useful citizen." *Eanes v. United States*, 407 F.2d 823, 824 (4th Cir. 1969).

ford Note, *supra* note 23, at 189, n.24. And a later survey found that therapists are, in fact, more likely to seek involuntary hospitalizations if they feel they are bound by the *Tarasoff* rule. *Givelber, et al.*, *supra* note 20, at 478.

By restricting involuntary commitment of the mentally disabled to cases in which there is "clear and convincing" evidence of dangerousness, *see* MCL § 330.1465; *Matter of Wagstaff*, 93 Mich. App. 755, 287 N.W.2d 339 (1979), the Michigan Legislature has drawn a balance between these social risks and benefits that strongly favors de-institutionalization of the mentally disabled in cases of doubt. The rule adopted by the majority below is completely inconsistent with this legislative judgment, because it effectively means that mental health professionals who discharge the mentally disabled do so at their peril. After all, in the context of individual court cases, the appropriateness of a patient's discharge will always be assessed after a patient has in fact proved to be dangerous and an innocent person has been seriously injured. In these circumstances, it will always seem unreasonable for a mental health professional to have "risked" a violent occurrence by failing to isolate a given patient.

Facing this possibility (and unable to protect themselves by complying with "standards" in the profession that simply do not exist), mental health professionals will be forced to "indulge every presumption in favor of further restraint, out of fear of being sued." *Sherrill v. Wilson*, 653 S.W.2d 661, 664 (Mo. 1983).³⁹ The inevitable result will be pressure in only one direction—toward hospitalizing patients who show any sign of violence, even though the vast majority could be successfully treated in the community.

³⁹ In *Sherrill*, the court explained that "[t]he plaintiff could undoubtedly find qualified psychiatrists who would testify that the treating physicians exercised negligent judgment, especially when they are fortified by hindsight. The effect would be fairly predictable. The treating physician would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest." 653 S.W.2d at 664. *See also Cairl v. Minnesota*, 323 N.W.2d 20, 23 note 3 (Minn. 1982) (same); *supra* note 23.

Amici strongly believe that if the prevailing social balance is to be fundamentally altered in this way, the decision should be made by the Legislature, not the courts. For all of these reasons, we strongly urge the Court to reject the legal duty established by the lower court.

II. EVEN ASSUMING THAT THERAPISTS MAY SOMETIMES BE LIABLE FOR THE PATIENTS' ACTIONS, THERE IS NO JUSTIFICATION FOR IMPOSING LIABILITY ON THE PRESENT FACTS.

Even if the Court determines that mental health professionals can sometimes be held liable for failing to predict patient violence and warning third parties, the concerns raised in Part I should demonstrate vividly the need for careful delineation and application of such a liability rule. The decision of the court of appeals illustrates vividly the dangers of failing to specify the exact circumstances in which a therapist has a duty to take some preventive action. If liability can be imposed on the present facts, then the persons treating the mentally disabled in Michigan will effectively become strictly liable for *any* act of patient violence. This degree of legal exposure, in turn, will lead to even more over-prediction of patient violence, and thus to a greater number of unnecessary warnings and ill-advised hospitalizations.

The majority's opinion unreasonably broadens the extent to which therapists may be subjected to liability for failing to protect those who are subsequently harmed by their patients. In this case, Dr. Lhim was held to have a duty to protect the decedent even though the evidence establishing Patterson's dangerousness was sketchy at best. The only real evidence of Patterson's dangerousness to his mother (or anyone else) was an entry in the emergency room record two years prior to his mother's death, which was based on an unverified oral report submitted by Patterson's aunt that Patterson "paces the floor and acts strangely and keeps threatening his

mother" *Davis v. Lhim*, 335 N.W.2d at 490. The only indication that Patterson's mother was a potential victim was this two-year-old incident, during which Patterson had allegedly threatened his mother because he needed money. There is no evidence that Patterson had a long history of violence, had threatened to kill his mother, had ever acted upon or repeated his threat two years earlier, or had exhibited any violent behavior or aggressive emotions to Dr. Lhim. Nevertheless, the majority inferred that appellant should have taken some preventive action because Patterson would need money again once he left the hospital and that his mother was one possible source of money.

This set of facts contrasts sharply with the facts in *Tarasoff* and its progeny, where the patients conveyed *specific* and *express* threats to their psychotherapists that they were going to harm readily identifiable victims. See, e.g., *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983); *Merchants National Bank & Trust Co. of Fargo v. United States*, 272 F. Supp. 409 (D.N.D. 1967) (patient threatened to kill his wife, and wife indicated to his therapists that she feared for her safety); *Hedlund v. Superior Court*, 34 Cal. 3d 695, 669 P.2d 41 (Cal. 1983) (patient told therapist of his intent to commit serious bodily injury upon victim); *McIntosh v. Milano*, 403 A.2d 500 (N.J. Super. 1979) (patient fired a gun at the car of the victim or her boyfriend, exhibited knife to the defendant psychiatrist, and expressed jealousy and desire for revenge because victim dated other men).⁴⁰ Moreover, in many of these cases the patients' dangerousness was obvious to the treating professionals and the violence was clearly imminent. See *Tarasoff*, 551 P.2d at 345 (psychologist "did in fact predict that [the patient]

⁴⁰ See also *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 735, 167 Cal. Rptr. 70 (1980), where the duty to warn arises only when the patient "poses a *predictable* threat of harm. . . ." *Id.* at 738. (Emphasis added.)

would kill . . .").⁴¹ See generally *Cairl v. Minnesota*, 323 N.W.2d 20, 26 (Minn. 1982) (" . . . if a duty to warn exists, it does so only when *specific* threats are made against specific victims) (emphasis added).

In addition, the alleged "threat" in this case was made *to the victim and not to the therapist*. Thus, to the extent the two-year-old "threat" signified Patterson's violent impulses toward his mother, she was fully aware of whatever threat her son presented her. The fact that the "threat" was not made in the presence of the therapist made it even more difficult for the therapist to assess its significance. Indeed, Patterson's mother, unlike Dr. Lhim, was a witness to the patient's alleged efforts to force her to give him money, and was therefore in a much better position than Dr. Lhim to anticipate any future similar conduct. In this situation, as at least two courts have held, it is simply indefensible to hold a mental health professional liable for failing to warn the victim. *In re Estate of Votteler*, 327 N.W.2d 759 (Iowa 1982); *Cairl v. Minnesota*, 323 N.W.2d 20 (Minn. 1982) (no duty to warn one who already knows of the danger).

To be sure, the court below did seek to limit its holding in one way, by stating that lawsuits may only be brought by victims who were "readily identifiable" in

⁴¹ Similarly, in *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983), the patient's medical records indicated that he had a "homicidal ideation towards his wife," that he had tried to kill her on numerous occasions, and that "the possibility of future violent behavior was a distinct probability . . ." *Id.* at 393. Moreover, approximately ten days before murdering his girlfriend, the patient had threatened the victim's mother with a knife and apparently had attempted to rape her; the victim twice indicated to hospital personnel her fear of the patient; the psychiatrists believed that the patient was dangerous; the patient admitted that "he had had frequent problems all his life with violent reactions . . ."; and there were indications that his violence was likely to be directed against women, like the victim, who were very close to him. See *id.* at 393, 394, 398.

advance. But this limitation is essentially meaningless, for two reasons. First, the court did not require that the patient make a specific threat of violence toward this "identifiable" victim during therapy. Instead, it suggested that the therapist must comb the patient's history and determine if there are any persons who, for any reason, are likely victims of potential violence. Moreover, the evidence they are required to consider apparently can be as slender as a two-year-old, unverified oral description of alleged efforts to coerce a mother to turn over some money. Obviously, under this approach, it will be only the rare case in which therapists will be able to feel confident that they have identified, and dealt with, every potential victim who might later be deemed "identifiable."

Second, even if these potential plaintiffs could be identified with precision, the court did not suggest that a therapist can safely avoid liability in every case through a warning. Instead, by authorizing a claim of "negligent discharge," the court suggested the possibility of a claim that the therapist had a broader duty, in lieu of, or in addition to, a duty to warn—*i.e.*, a duty to prevent violence itself. This broader duty presumably would be carried out by initiating or continuing an involuntary commitment to a mental hospital, if, with the benefit of hindsight, a jury determines that that was the most "reasonable" course of action.

Taken together, these features of the court's approach—the extraordinarily low threshold for a later finding of dangerousness, the indeterminacy of the potential plaintiffs, and the indeterminacy of the conduct required to forestall liability—mean that the ruling, in effect, is no different from the broadest possible rule of third-party liability. Therapists seeking to avoid liability under the court's test have no real choice but to do everything in their power to prevent any violence by any patient against any person.

Although *amici* do not believe that any rule of third-party liability for patient violence is justified, should the Court disagree, there is a way to frame the rule that would be far preferable to the version espoused by the court below. Under this rule, liability could only arise if, in the therapist's presence,⁴² a patient makes a specific threat of imminent violence toward a specific individual. A therapist would not be required to sift through a patient's entire history—much of which may not even be available to the therapist—and seek to identify his/her most likely victims at every turn. In addition, the therapist must actually believe that the patient poses a serious risk of imminent violence to the threatened individual.⁴³ Third, the threatened individual must be unaware of the threat. Finally, the rule should make clear that therapists who warn the intended victims thereby satisfy their legal duties. There should then be no further legal duty to "control" the patient through hospitalization or some other means, although the therapist would remain free to determine that some such alternate approach is clinically more desirable than a warning.

Under this rule, mental health professionals could be reasonably confident of knowing the circumstances in which they are required to act, would not be required to take action where the victim is already aware of the risk, and could be quite confident about the type of action required for them to satisfy their legal obligations. Such a rule, while imperfect and probably ineffectual as a measure to protect the public, would be far preferable to the much broader and ill-defined liability rule enunciated

⁴² Cf. *Brady v. Hopper*, 570 F. Supp. 1333 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984); *Shaw v. Glickman*, 45 Md. App. 718, 415 A.2d 625 (1980); *Cairl v. Minnesota*, 323 N.W.2d 20 (Minn. 1982).

⁴³ The tort system certainly should not require a warning in every case where a patient makes an idle threatening comment, absent some genuine and supportable reason to believe that the comment should be taken seriously. See *supra* note 14.

here by the court of appeals. However, *amici* would re-emphasize our fundamental view that the Court should hold that there is *no* legal duty to warn or otherwise protect allegedly suspected victims.

III. THE DEFENDANT'S DECISIONS ARE IMMUNE FROM TORT LIABILITY.

In *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984), this Court held that lower-level government employees are immune from tort liability for "discretionary" decisions (as contrasted with "ministerial" acts) unless those decisions are *ultra vires* or made in bad faith. When the instant case was remanded for reconsideration in light of *Ross*, a majority for the court of appeals ruled that the immunity recognized in *Ross* did not protect Dr. Lhim's decisions. The court reasoned that Dr. Lhim's discretion was constrained by the "relevant standard of care." Because the jury found that Dr. Lhim violated this standard, the majority concluded that Dr. Lhim's decision was ministerial. *Davis v. Lhim*, 382 N.W.2d 195, 198 (Mich. App. 1985). The dissent objected to this view because "[w]hether John Patterson should have been discharged from the state mental hospital or whether there was a need to warn plaintiff's decedent, involved complex medical discretionary decision-making." 382 N.W.2d at 200 (Cynar, J., dissenting).

The majority's ruling cannot be reconciled with *Ross*. *Ross* expressly protects public employees from the risk of tort liability when they are required to exercise significant decisionmaking in the performance of their duties. As this Court recognized in *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985) (By Order), and many other Michigan cases have held, mental health decisions such as those made by Dr. Lhim are discretionary and hence immune from tort liability. By characterizing these decisions as ministerial whenever the "relevant standard of care" is violated, the majority below would eliminate the immunity afforded public employees

in negligence actions. *Amici* urge the Court to reject this view and hold that Dr. Lhim's decisions are precisely the kind that *Ross* immunizes from tort liability.

A. Acts By Public Employees That Require Significant Decisionmaking Are Immune From Tort Liability.

In *Ross*, this Court addressed the unsettled law in Michigan concerning the immunity of State employees from tort liability. The Court explained that immunity for public servants was required "to ensure that a decision maker is free to devise the best overall solution to a particular problem, undeterred by the fear that those few people who are injured by the decision will bring suit." 363 N.W.2d at 666. Consequently, the Court held that lower level government officials, employees and agents are immune from tort liability when they are:

- 1) acting during the course of their employment and acting, or reasonably believe they are acting, within the scope of their authority;
- 2) acting in good faith; and
- 3) performing discretionary, as opposed to ministerial acts.

363 N.W.2d at 667-68.

Because the third prong of this test had sometimes been difficult to apply, the Court carefully explained the distinction between discretionary and ministerial acts. Discretionary acts were not limited to those involving "quasi-judicial or policymaking authority." 363 N.W.2d at 668. Instead, this Court cited with approval Professor Prosser's definition of "discretionary acts" as those which "require personal deliberation, decision and judgment." *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984). Hence, "[a]n individual who decides whether to engage in a particular activity and how best to carry it out engages in discretionary activity." *Id.* The Court

characterized the protected conduct as "'discretionary-decisional' acts." *Id.*

Discretionary-decisional acts were contrasted with conduct in which the actor had little or no choice or was merely executing a prior decision. Characterizing the latter conduct as "ministerial-operational," the Court ruled that such conduct is not immune from tort liability. The Court concluded that the "distinction between 'discretionary' and 'ministerial' acts is that the former involves significant decision-making, while the latter involves the execution of a decision and might entail some minor decision-making." *Id.*

Although in some cases the line between acts involving significant decisionmaking and those involving execution of a decision and minor decisionmaking may blur, this is not such a case. The decisions made by Dr. Lhim clearly required the exercise of substantial discretion, and a straightforward application of the principles articulated in *Ross* indicates that those decisions are immune from tort liability.

B. Dr. Lhim's Acts Were "Discretionary-Decisional" And Are Immune From Tort Liability.

The plaintiff's claim against Dr. Lhim included two distinct acts of negligence: the decision not to seek involuntary hospitalization for Patterson after he requested release, and the decision not to warn Mollie Barnes that Patterson presented a danger to her. Each of these decisions by Dr. Lhim required significant decisionmaking and hence is protected from tort liability.

1. The Decision Not to Apply for Involuntary Hospitalization of Patterson.

Because Patterson had been voluntarily admitted to the hospital, he had a statutory right to be released within three days after requesting release, unless the commitment procedures provided in § 330.1420 of Michigan's Mental Health Code were initiated. MCL § 330.1419(1).

That section provides that after a patient requests release, an application for involuntary hospitalization shall be filed in court if it is determined that the patient is "a person requiring treatment as defined in [the statute] and should remain in the hospital." MCL § 330.1420 (emphasis added). The relevant language in § 330.1401 defines a "person requiring treatment" as, *inter alia*:

[a] person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

MCL § 330.1401. Before a court will approve the involuntary hospitalization of a patient, the State must prove by clear and convincing evidence that the patient is a person requiring treatment within the meaning of the statute. *Matter of Wagstaff*, 93 Mich. App. 755, 287 N.W.2d 339 (1979).

Following Patterson's request for release, Dr. Lhim determined that Patterson could not reasonably be expected within the near future to intentionally or unintentionally cause significant physical harm to himself or another person. Testimony of Dr. Lhim, Vol. 7, at 103. Consequently, Dr. Lhim did not apply for Patterson's continued hospitalization, and Patterson was instead released and referred to the South-West Mental Health Clinic for outpatient treatment. Two months later, a second psychiatrist also determined that Patterson was not a "person requiring treatment" and refused to admit Patterson to a mental hospital on an involuntary basis. Testimony of Ruby Davis, Vol. 4, at 73.

In deciding whether an application to involuntarily hospitalize Patterson was appropriate, Dr. Lhim was required to exercise significant discretion. The criteria specified in § 330.1401 of the Mental Health Code neces-

sitate several very difficult judgments, including: (1) whether the person has a "substantial disorder of thought or mood which significantly impairs judgment, behavior capacity to recognize reality, or ability to cope with the ordinary demands of life," MCL § 330.1400a (defining "mental illness"); (2) whether the person can reasonably be expected within the near future to seriously physically injure himself or another person, MCL § 330.1401(a); and (3) whether the persons' acts or threats are "substantially supportive" of this expectation. *Id.*

These criteria require the mental health professional to diagnose mental disorders, assess the degree of the disorder and its effects, and attempt to predict the probability of violent behavior in the future. In describing the criteria in very general language, the Legislature has correctly recognized that their application requires the exercise of considerable judgment, based on a careful (and necessarily uncertain) balancing of many factors. Which factors should be taken into account, and the relative weight they should be given, is a matter of substantial disagreement. As the United States Supreme Court has recently observed:

Psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness.

Ake v. Oklahoma, 105 S. Ct. 1087, 1096 (1985). Perhaps the one conclusion that can definitively be reached about the mental health professional's role in resolving such questions is that it requires "personal deliberation, decision and judgment." *Ross*, 363 N.W.2d at 668.

It should also be emphasized that in deciding whether to apply for involuntary hospitalization under § 330.1420, the criteria specified in § 330.1401 are not the only considerations. This section provides that involuntary hos-

pitalization should only be sought if these criteria are satisfied *and* a determination is made that the patient "should remain in the hospital." Nothing in the statute constrains the determination of whether a voluntary admittee who satisfies the § 330.1401 criteria "should remain in the hospital." In making this determination, the mental health professional will consider factors such as the therapeutic consequences of refusing a voluntary admittee's request for release, the feasibility of satisfactory outpatient treatment and the advantages of integrating the patient back into the community. See *Cairl v. Minnesota*, 323 N.W.2d 20, 23 (Minn. 1982) (indicating that the assessment and balancing of factors such as these in deciding whether to release mentally retarded patient requires "precisely the type of governmental decision that discretionary immunity was designed to protect from tort litigation by after-the-fact review.").⁴⁴

In *Teasel v. Department of Mental Health*, 419 Mich. 390, 355 N.W.2d 75 (1984), this Court recognized the discretion that such decisions entail. Discussing the decision to discharge a patient, the Court indicated that:

Manifestly, the decision whether a hospitalized patient is "clinically suitable for discharge" or "no longer meets the criteria of a person requiring treatment" is a matter of professional judgment. The nature of psychiatric care and treatment to be provided to a hospitalized patient and the decision whether treatment is any longer necessary are matters calling for the exercise of informed medical judgment....

⁴⁴ Section 330.1476 of the Mental Health Code also provides that a mental health professional may decide that a "person requiring treatment" should be discharged from a mental hospital. While § 330.1476(2) requires a discharge if the criteria are *not satisfied*, even if they are met, § 330.1476(1) provides that a patient may be discharged "at any time" if deemed "clinically suitable for discharge." MCL § 330.1476(1).

... [I]t is clear to us that the decision to release a judicially hospitalized patient is discretionary with health care professionals.

355 N.W.2d at 83.⁴⁵

It is equally clear in this case that Dr. Lhim's determination that an application for involuntary commitment was unwarranted involved "significant decisionmaking." As *Ross* expressly protects acts requiring "significant decisionmaking," 363 N.W.2d at 668, Dr. Lhim's conduct is immune from tort liability.⁴⁶

Without questioning the fact that a decision concerning commitment involves substantial discretion, the majority below stated that Dr. Lhim's judgment was constrained by the "relevant standard of care"—"the conduct of a reasonable psychiatrist practicing medicine in the light of present-day scientific knowledge." 382 N.W.2d at 198. According to the majority, if the relevant standard of care is violated, *i.e.*, there is negligence, a public employee's decision is transformed into a ministerial one. In so holding, *the majority opinion effectively eliminates the doctrine of individual immunity in all negligence actions, for if the elements of the negligence*

⁴⁵ See also *id.* at 86 ("the nature of decisions concerning psychiatric care, treatment, and discharge from hospitalization involves the application of specialized knowledge, experience, and professional judgment."). Although stating that this decision was judgmental and discretionary, the Court also held that an official deciding to release a judicially hospitalized patient must make an informed decision "according to the criteria for discharge established by the Legislature." *Id.* at 83. In this case, Dr. Lhim's decision was in fact based on the statutory criteria; the appellee's argument is simply that Dr. Lhim wrongly decided that the statutory criteria were not satisfied. This is exactly the type of judgment that the Court found to be clearly discretionary in *Teasel*.

⁴⁶ It should be noted that "[t]here is no suggestion" in this case "that defendant was not acting within . . . the scope of his authority or that defendant was not acting in good faith." 382 N.W.2d at 196

claim are established the defense of immunity is forfeited.⁴⁷

Nothing in *Ross* remotely hints at this drastic limitation on the scope of individual immunity. To the contrary, in protecting significant decisionmaking by public employees from tort liability, *Ross* intended "to ensure" that the decisionmaking process is not encumbered by the fear of litigation.

By restricting this assurance to decisions that fall within the "relevant standard of care," the majority opinion completely undermines this objective. No matter what decision is made, if an injury results this will pose a significant risk of litigation, with its attendant burdens, embarrassment and potential for liability. If a plaintiff properly alleges negligence, a public employee (and the State if indemnification is provided) will be subjected to the costs of discovery and other pretrial proceedings. If the plaintiff's proof even raises a question of fact as to negligence, the employee will face the burdens and risks of a jury trial.

The implications are particularly disturbing in a case such as this, where the "relevant standard of care" governing predictions of dangerousness is at best both unclear and subject to widespread disagreement, and at worst a fiction.⁴⁸ If the majority's view is adopted, men-

⁴⁷ The fact that the majority found that the standard of care included the statutory criteria in § 330.1401 does not limit the scope of the majority's ruling. As its holding on the failure to warn issue indicates, the majority would reach the same result even absent statutory "constraints."

Moreover, as explained *supra*, the statutory scheme requires the exercise of significant discretion and there is no suggestion that Dr. Lhim stepped outside the boundaries of the statute by considering impermissible factors. See *supra* note 45. For reasons developed in the text, Dr. Lhim's highly discretionary decision that the statutory criteria were not satisfied should not be deemed "ministerial" simply because it was later determined that he decided incorrectly.

⁴⁸ See *supra* note 7.

tal health professionals will know that if they decide that a patient is not dangerous, and the patient later injures someone, the reasonableness of their judgment will be second-guessed by a jury with the knowledge that they were in fact wrong. Because the majority's rule effectively eliminates the protection afforded such decisions by *Ross*, it provides a strong incentive to choose the course of action entailing the least risk of litigation and liability.

This is exactly what *Ross* was intended to prevent. *Amici* urge the Court to adopt Judge Cynar's view and hold that Dr. Lhim's decision that involuntary hospitalization was unwarranted involved "complex . . . discretionary-decision making" and is immune from tort liability.⁴⁹

2. The Decision Not to Warn the Eventual Victim.

Like the decision not to seek involuntary hospitalization of a patient, the decision to warn a third party about a patient's threats is not ministerial. To the contrary, the courts and commentators have uniformly recognized that there are many possible responses to such threats. In choosing between those alternatives, the men-

⁴⁹ It is also important to note that characterization of such decisions as ministerial has implications far beyond the context in which this case arises. Increasingly, mental health professionals are being asked to make extraordinarily difficult predictions of dangerousness—judgments they are ill-equipped to make, but are demanded by society's needs to make. On these judgments, decisions affecting freedom or institutionalization, and even life or death, may turn. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880 (1983) (mental health testimony is admissible to aid jury's determination of whether defendant presented a future threat to society, for purposes of imposing death penalty); *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (limiting State's authority to civilly commit *nondangerous* individuals).

Although the necessity for these judgments is easily understood, their consequences make it critical to dispel any notions of scientific objectivity. These are not ministerial tasks. They are decisions involving significant discretion, and if they are to be given appropriate (rather than dispositive) weight, they must be recognized as such.

tal health professional must exercise "personal deliberation, judgment and decision." The choice reached in each case clearly is a "discretionary-decisional" act and hence is immune from tort liability.

The first determination that must be made by the mental health professional confronted with this choice, is the probability that a threat will be acted upon. As demonstrated in Part I, this judgment is both extremely difficult and necessarily uncertain.⁵⁰ It involves an assessment and balancing of many factors, such as the clinical diagnosis of the patient, the context in which the threat is uttered, the way in which the threat is expressed, the patient's opportunity to act on the threat, the patient's past history of violence or suicide attempts, the factors that provoked the threat (e.g., stress, a specific act, etc.) and whether they are likely to continue, the patient's response to treatment, the patient's resources outside the hospital (e.g., a supportive family), the patient's relationship with the specified "victim," and the ability of that person to protect him/herself.⁵¹

Assuming that the mental health professional concludes that the threat presents a serious risk, the possible responses must be assessed. These alternatives include:

- (1) Intensifying the therapy by increasing the frequency of treatment, (2) requesting the patient to turn over his planned weapon to the temporary custody of the therapist, (3) starting the patient on tranquilizing medication, (4) increasing the dosage

⁵⁰ See, e.g., Roth & Weisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508, 509 (1977) ("[T]he bulk of expert opinion and research data indicates that neither psychiatrists nor anyone else can reliably predict the likelihood of a mentally ill patient's future violence. The clinician willing to make such judgments is necessarily uncertain as to the accuracy of his predictions, save for the certainty that he will overpredict that which he fears to be possible.") [hereafter *Roth & Weisel*].

⁵¹ See, e.g., MacDonald, *Homicidal Threats*, 124 AM. J. PSYCH. 475, 479-80 (1967).

of a patient already on medication, (5) convincing the patient to submit to a brief voluntary hospitalization, (6) urging the patient to return for his regularly scheduled visit, and to call the therapist if the patient in the interim fears a loss of control.⁵²

In some cases, it may be deemed necessary to warn the police, the patient's family, a person who will have custody of the patient or the specified victim. Involuntary hospitalization may also be considered.

In deciding what is the most appropriate response to a given situation, judgments must be made about the seriousness of the threat, "the impact of the proposed intervention on future therapy" and the likelihood that the intervention will prove successful in preventing violence.⁵³ Needless to say, this decision is not ministerial—it requires significant discretionary decisionmaking by the mental health professional.

Those courts that have followed the *Tarasoff* rule have uniformly recognized the importance of preserving this discretion. In fact, in *Tarasoff* the court stated that there was a "broad range of reasonable practice and treatment" and the proper manner to discharge the duty

⁵² Leonard, *A Therapist's Duty to Potential Victims*, 1 LAW & HUM. BEH. 309, 313-14 (1977). See also, Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 CURRENT PSYCHIATRIC THERAPIES 55, 57-58 (1978) (indicating that instead of issuing warnings, therapists alternatively may decide that "other persons, even the threatened person . . . [should] be brought into the therapy, the patient's environment may be restructured (ridding the patient of weapons), or increased frequency of psychotherapeutic contacts may be recommended. Some patients, given knowledge of the therapist's dilemma and their legitimate concern for the welfare of others, may themselves be willing to warn others of a potential danger or else may give permission for the therapist to warn others."); Roth & Weisel, *supra* note 50, at 510 (indicating that "even when danger seems likely[,] several alternatives are often available that permit continuing management of the violent or potentially violent patient without compromising treatment").

⁵³ Roth & Weisel, *supra* note 50, at 511.

of care would "necessarily vary with the facts of each case" *Tarasoff v. Regents of University of California*, 131 Cal. Rptr. 14, 551 P.2d 334, 345 (1976).⁵⁴ The court further stated that patients' threats are infrequently executed and "[c]ertainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened." 551 P.2d at 347.

The dispute now before the court provokes a stark illustration of the discretion involved in such decisions. In this case the patient had no history of violence, the only specific threat was made outside the presence of Dr. Lhim, the threat was made two years earlier and had not been acted upon, and the threat was made directly to the victim. In these circumstances, Dr. Lhim had a wide range of options to choose from (including taking no specific action in response to such an attenuated threat), and the appropriateness of warning the victim was, to say the least, highly questionable.

In holding that Dr. Lhim's failure to warn Mollie Barnes was a ministerial act, the majority below did not question the difficulty of determining the appropriate response to a patient's threat. Instead, it ruled that such decisions become "ministerial" whenever they are made negligently, *i.e.*, they violate the standard of care. This diminution of the protection that *Ross* affords public

⁵⁴ See also, *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 193 (D. Neb. 1980) ("This duty requires that the therapist initiate whatever precautions are reasonably necessary to protect potential victims of this patient."); *Mathes v. Ireland*, 419 N.E.2d 782, 785 (Ind. 1981) (duty is "to exercise reasonable care under the circumstances"); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500, 511-12 (1979) ("duty to take whatever steps are reasonably necessary"); Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597, 598 (1984) ("The common thread that runs through the cases is the duty to use reasonable care under the circumstances. The discharge of that duty depends on the circumstances of each case.").

employees should be rejected. Dr. Lhim's decision was highly discretionary and falls squarely within the individual immunity recognized in *Ross*.

C. Michigan Case Law Clearly Establishes That Mental Health Decisions By State Employees Are Discretionary And Are Immune From Tort Liability.

Issues very similar to those raised here have previously been considered by this Court and by the Michigan Court of Appeals on numerous occasions. These cases overwhelmingly establish that Judge Cynar correctly found that mental health decisions involve "complex . . . discretionary-decision making" and that public employees making these decisions are immune from tort liability.

Most importantly, in *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985) (By Order), this Court held that a trial court had properly granted summary judgment in favor of individual state defendants who were being sued for negligent hospitalization and detention of the plaintiff in a state mental institution. The court of appeals had reversed the trial court and held that the defendant psychiatrists had not been engaged in discretionary acts. After holding the appeal of that decision in abeyance pending a decision in *Ross*, this Court summarily ordered reinstatement of summary judgment in favor of the individual defendants. We urge the Court to adhere to its decision in *Fisher* here and hold that Dr. Lhim's decisions were discretionary and immune from tort liability.

With the exception of the majority below, all other Michigan cases support this result. In a case much like this, *Fuhrmann v. Hattaway*, 109 Mich. App. 429, 311 N.W.2d 379 (1981), *lv den.*, 414 Mich. 858 (1982), the court of appeals affirmed the trial court's decision granting summary judgment in favor of the defendant psychiatrists. In *Fuhrmann*, the two defendants had certified that a patient was mentally ill but was not dangerous to

himself or to other persons. The patient was then released from the Center for Forensic Psychiatry, and four months later shot the plaintiff. Although the plaintiff alleged that the defendants acted negligently, the court of appeals ruled that their actions were discretionary and, hence, immune. It reasoned:

Plainly, the activities of the defendant psychiatrists are anything but ministerial. The decisions required of these persons are perhaps the ultimate in discretion. To determine the state of a person's psyche is in itself a task requiring great discretion and when this task is conjoined with the even more imposing job of resolving another's liberty, the consequent decision cannot be said to be "ministerial" in any sense of that word.

311 N.W.2d at 382.

Similarly, in *Hamilton v. Reynolds*, 129 Mich. App. 375, 341 N.W. 152 (1983), *lv den.*, 422 Mich. 890 (1985), a suit was brought after a patient at a state-operated psychiatric hospital left the hospital grounds and killed the plaintiff's decedent. The plaintiff alleged that one of the defendants, the patient's treating physician, had negligently given the patient a grounds pass. The trial court ruled that as a public employee, the defendant was immune as a matter of law. The court of appeals had little difficulty affirming this conclusion and observed "[t]hat the exercise of considerable discretion is required of those charged with the responsibility of determining whether psychiatric hospital patients shall be confined to the hospital building cannot be gainsaid." 341 N.W.2d at 154-55. See also *Pomilee v. City of Detroit*, 121 Mich. App. 121, 328 N.W.2d 595, 596 (1982), *lv den.*, 422 Mich. 890 (1985) (affirming grant of summary judgment in favor of doctor and clinical psychologist who were responsible for care, treatment and attention of patients in mental hospital. Explaining that this result was required by either the discretionary/ministerial or "scope of employ-

ment" test of immunity, court indicated that "very little" of what a psychologist does is ministerial).⁵⁵

Subsequent to *Ross*, in *Canon v. Bernstein*, 144 Mich. App. 604, 375 N.W.2d 773 (1985), the court of appeals reviewed a trial court's decision that employees at a public mental health facility were immune from suit for negligence in counseling and treating a mental patient. The Court of Appeals affirmed the lower court's ruling, holding that as a matter of law the alleged conduct involved "discretionary acts." 375 N.W.2d at 775.

Finally, in *Tobias v. Phelps*, 144 Mich. App. 272, 375 N.W.2d 365 (1985), the court considered an action brought by the estate of a patient who died at a state medical facility. The estate alleged that the physicians

⁵⁵ Accord *Knapp v. Moreno*, 137 Mich. App. 768, 359 N.W.2d 560, 563 (1984) (where plaintiff claimed that staff psychiatrist had been negligent in diagnosis and treatment of patient, trial court's grant of summary judgment based on psychiatrist's immunity was affirmed; court of appeals stated that this result was dictated by either the "scope of employment" or "discretionary/ministerial" test for immunity); *Estate of Adams v. Northville State Hospital*, 131 Mich. App. 583, 345 N.W.2d 207, 208 (1983) (holding that diagnosis and treatment of patient at state mental hospital was a discretionary activity); *Mason v. Rosen*, 124 Mich. App. 204, 333 N.W.2d 513, *vacated and remanded*, 422 Mich. 897, 368 N.W.2d 243 (1985) (holding that various allegations of negligence relating to the care and treatment of mentally ill person concerned discretionary acts and hence public employee was immune from liability); cf. *McGhee v. Bhama*, 140 Mich. App. 49, 363 N.W.2d 293, *remanded*, 422 Mich. 940, 369 N.W.2d 854 (1985) (noting the "reluctance of other panels" to follow *Davis*, and holding that psychiatrist at state facility was immune from liability based on the "scope of employment" test).

It should be noted that while *Mason* and *McGhee*, along with many other Michigan Court of Appeals cases, were remanded for reconsideration in light of *Ross*, this Court did not indicate how that issue was to be resolved on remand. Cf. *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985).

The same conclusion has been reached in other jurisdictions. See *Papenhausen v. Schoen*, 268 N.W.2d 565 (Minn. 1978); *Sherrill v. Wilson*, 653 S.W.2d 661, 664-67 (Mo. 1983); *Jarrett v. Wills*, 383 P.2d 995, 997-98 (Or. 1963).

involved had been negligent in treating and monitoring the patient and providing instructions to the staff. After observing that numerous cases prior to *Ross* had ruled that such conduct was "inherently discretionary," 375 N.W.2d at 369, the court recognized a less absolute—but nevertheless very broad—immunity for such conduct. The court stated that

[t]he decisions whether to wean decedent from the medication and whether or how often to monitor her condition during the weaning process involved medical judgments. These are discretionary determinations. However, if defendants in fact decided that monitoring was necessary to guard against deterioration of the decedent's condition, negligent execution of that decision would fall outside the scope of their individual immunity. . . . In addition, if defendants decided that monitoring was necessary, a failure to inform or properly inform the staff of the decedent's condition was a ministerial act.

Id.

If this test is applied to Dr. Lhim's decisions, those decisions clearly are protected from tort liability. Like decisions about the appropriateness of treatment and monitoring, deciding whether a patient is dangerous, whether involuntary hospitalization is warranted and whether a warning is appropriate is highly discretionary. There is no allegation in this case that after making these decisions, Dr. Lhim was negligent in executing them.

Finally, two points should be made about the decisions in *Fuhrmann*, *Hamilton*, *Pomilee*, *Knapp*, *Adams*, *Mason*, *Canon* and *Tobias*. First, all of these cases implicitly reject the view of the majority below that a decision is ministerial simply because it is made negligently. Second, these cases uniformly hold that decisions very similar to those at issue here involve significant discretion and are immune from tort liability. We believe that these cases were correctly decided in both respects and we urge the Court to adopt the same position.

CONCLUSION

For the reasons stated above, the judgment of the court of appeals should be reversed and judgment should be entered in favor of the defendant.

Respectfully submitted,

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