A Psychotherapist's Duty to Control: *Estates of Morgan*

INTRODUCTION

Although cited by the mental health profession as the imposition of an onerous duty,[1] the decision of the Ohio Supreme Court in ***Estates of Morgan v. Fairfield Family Counseling Center*** (1997), 77 Ohio St.3d 284,[2] merely assures quality medical care to those unfortunate persons who suffer from a mental illness. The decision, at its essence, extends the legal duty to control imposed traditionally upon mental health practitioners treating *inpatients* to those treating *outpatients* as well. The Morgan court recognized that the mentally ill who are amenable to successful outpatient treatment should be protected from negligent mental health practitioners.

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THE MORGANS' STORY

On July 25, 1991, Matt Morgan was playing a game of cards at home with his parents, Jerry and Marlene Morgan, and his sister, Marla. During the game, Matt developed a severe headache. A "voice" told him that his headache would go away if he killed his parents. Matt excused himself and went to a bedroom to obtain a handgun. He returned to the kitchen and proceeded to shoot and kill his parents and seriously wound Marla. This tragic incident was a manifestation of Matt Morgan's paranoid schizophrenia and of negligent outpatient psychotherapy which failed to control the illness.

Matt's mental illness probably began during his senior year of high school as his attendance and grades declined. He became unable to maintain employment due to his increasingly abusive and disrespectful attitude. Finally, in January of 1990, Matt was forcefully removed from his home because of his increased propensity for violent outbursts and threats towards his family.

After wandering through the southeast, Matt ultimately presented himself to Thomas Jefferson University Hospital in Philadelphia, Pennsylvania, in a frantic condition.[3] He was subsequently transferred to C.A.T.C.H. Respite, a residential mental health facility, and diagnosed with a schizophreniform disorder.[4] Miles C. Landenheim, M.D., a resident physician in psychiatry, confirmed this diagnosis and Matt responded to treatment which included drug therapy. His condition improved.

After several months, Matt returned to his family. Dr. Ladenheim, at the time of Matt's discharge, advised his parents the medication "would be for a lifetime." Matt began outpatient treatment at Fairfield Family Counseling Center (FFCC). Harold T. Brown, M.D., a consultant contract psychiatrist with FFCC, oversaw Matt's treatment. However, apparently as the result of budget and time restraints, Dr. Brown's treatment consisted only of three visits: July 19, 1990; August 16, 1990; and October 11, 1990. This "treatment" totaled one hour.[5] Dr. Brown never read Matt's chart from C.A.T.C.H. Respite, never contacted Dr. Landenheim, repeatedly reduced Matt's dosage of Navane, and eventually diagnosed Matt with "atypical psychosis." Dr. Brown's diagnosis and treatment were based on his belief that Matt was a malingerer merely seeking disability benefits. After October 11, 1990, Dr. Brown terminated Matt's prescription for Navane, referred him back to FFCC for vocational training and other psychotherapy, and never again saw him.[6]

Once Matt's medication ran out, his condition deteriorated.[7] Matt began to exhibit many of the same aggressive and bizarre traits he manifested prior to hospitalization.[8] Without Navane, Matt

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attended and participated in psychotherapy erratically. The center then terminated his therapy, leaving his psychiatric care to a vocational counselor. Matt's condition further deteriorated. He refused to comply with treatment, became weak, refused to eat, repeatedly threatened others, frequently hallucinated, and demonstrated paranoia.

Matt's parents repeatedly contacted FFCC to inquire whether Matt could be involuntarily hospitalized to receive treatment. FFCC refused to seek the civil commitment of Matt. FFCC maintained an unwritten policy on civil commitment: it would not initiate involuntary hospitalization proceedings.[9] Jerry and Marlene Morgan unknowingly found themselves in a situation that resulted in their deaths: the probate court would not initiate involuntary commitment proceedings without the participation of FFCC, and FFCC would not initiate such proceedings, but would only participate in the proceedings after the family had initiated them.

Five days prior to their deaths, Jerry and Marlene Morgan sent a letter to FFCC requesting assistance.[10] However, the employees of FFCC again refused to assist the Morgans in involuntarily committing Matt. The last entry made in Matt's chart at FFCC was made on July 25, 1991, the day he shot his parents and sister: "it is apparent that Matt is . . . decompensating. FFCC is unable to assist since he refuses medication or psychiatric care."[11]

The Estates of Jerry and Marlene Morgan and Marla Morgan, individually, brought an action against Dr. Brown, FFCC, and its employees, alleging their negligence caused the deaths of Jerry and Marlene and resulted in Marla's personal injuries. The trial court entered summary judgment in favor of all defendants.[12] The court of appeals reversed judgment with respect to Dr. Brown, but affirmed judgment for FFCC and its employees.[13] The Ohio Supreme Court granted a discretionary appeal as both plaintiffs and Dr. Brown appealed the decision.[14] The Ohio Supreme Court reversed the decision of the court of appeals with respect to FFCC and its employees, and affirmed the reversal of summary judgment for Dr. Brown, remanding the entire case for trial.[15]

THE DUTY TO CONTROL IN THE OUTPATIENT SETTING

Estates of Morgan addressed the issue explicitly left open by the Court in *Littleton v. Good Samaritan Hosp. & Health Ctr*, (1998), 39 Ohio St. 3d 86. Do psychotherapists treating outpatients have a duty to control dangerous patients?[16] The extension of *Littleton* to the outpatient setting is neither illogical nor impractical.

The Court utilized a two-step process to arrive at its decision. Writing for the four-member majority, Justice Alice Robie Resnick applied traditional tort principles in finding defendants owed plaintiffs a duty under Restatement (Second) of Torts, Section 315, as recognized previously in *Gelbman v. Second Natl. Bank of Warren*.[17] The majority then strictly interpreted existing Ohio law in addressing the relationship and privileges of psychotherapists and their patients.

A. RESTATEMENT (SECOND) OF TORTS: TRADITIONAL TORT ANALYSIS

Estates of Morgan applied the duty announced in *Littleton* and derived from Section 319 of the Restatement (Second) Torts, to the outpatient setting by operation of Section 315 of the Restatement. A discussion of *Tarasoff v. Regents of the University of California*[18] was the Court's starting point for the analysis of the duty imposed upon professionals rendering outpatient psychiatric care. However, as noted, the California Supreme Court "did not engage in a traditional Restatement analysis" in concluding a defendant therapist owed a duty beyond his or her patient.[19] While *Tarasoff* represented a bold expansion of the psychotherapist's duty to third parties, it "does not enjoy universal acceptance."[20] Most importantly, the holding of *Tarasoff* centered on the duty to warn and not the duty to control asserted by plaintiff's in *Estates of Morgan*.[21]

One's duty to control another is outlined in Sections 315 *et seq.* of the Restatement. In *Tarasoff*, the California Supreme Court did not strictly follow relevant sections of the Restatement. It looked to them as "reflective of an overall principle that affirmative duties to control should be imposed whenever the nature of the relationship warrants social recognition as a special relation."[22] To arrive at its decision, the California Supreme Court first analogized the situation to cases in which a health care provider is liable for the failure to diagnose and warn of a patient's contagious disease. Under such circumstances, the physician's duty runs to the patient and any third person who is known to be threatened by the medical condition.[23] In addition, the court found the public's interest in safety outweighed the interests that safeguard the confidential nature of psychotherapist-patient communications and the difficulty in predicting dangerousness.[24]

The Ohio Supreme Court noted that in spite of theoretical problems with *Tarasoff*, a majority of courts have found the psychotherapist-outpatient relationship constitutes a special relationship giving rise to a duty to control.[25] The existence of a duty requires situational analysis of the specific facts presented in each case. This approach does not produce a universal checklist for controlling a patient.

The Ohio Supreme Court's assessment of the amount of control necessary to give rise to a duty was fundamental as sufficient elements of control exist in the outpatient setting.[26] The lesser degree of control present in the outpatient relationship, as compared to the *Littleton* inpatient relationship, does not preclude the finding of duty.[27] The psychotherapist's ability to control is the important issue in the outpatient setting. Indicia of control include prescription of medicine, creation of an appropriate treatment program, actions necessary to control or limit the patient's access to weapons, persuasion of the patient to voluntarily enter a hospital, the notification of appropriate law enforcement officials of a threat and even the initiation of involuntary commitment proceedings.[28] The ability or need to exercise such measures "embod[y] sufficient elements of control to warrant a corresponding duty to control."[29] The elements of control are thus intertwined with the elements of appropriate care under the circumstances. "[I]t is within the contemplation of the Restatement that there will be diverse levels of control which give rise to corresponding degrees of responsibility."[30]

The Court also looked to public policy to address the imposition of duty. The Court balanced a psychotherapist's ability to control the patient's illness, the public interest of safety, the difficulty in assessing a patient's propensity for violence, the desirability of obtaining optimum treatment for a patient and

society's interest in maintaining the confidentiality of patient-therapist communications.[31] The scope of this analysis is not what the psychotherapist did but what the psychotherapist could have done under the circumstances.

The Court specifically rejected the claim that no duty could be imposed because psychotherapists cannot accurately predict dangerousness.[32] Although predicting a patient's potential dangerousness may be difficult, that difficulty does not preclude liability; *Littleton* required a psychotherapist to make an informed assessment of the patient's propensity for violence.[33] The *Morgan* opinion noted that Ohio's civil commitment procedure would be meaningless if a patient's propensity for violence could not be assessed.[34]

Finally, the Court addressed the inherent conflict between society's interest in security and the patient's right to avoid unnecessary confinement. The Court rejected the claim that imposition of a duty to control would result in the unnecessary and defensive commitment of nonviolent psychiatric patients. Finding no empirical data in support of this argument, the Court noted *Tarasoff* "has not discouraged therapists from treating dangerous patients, nor has it led to an increased use of involuntary commitment of patients perceived as dangerous."[35]

B. *STARE DECISIS* AND STRICT APPLICATION OF R.C. §5122.34

Estates of Morgan logically extends *Littleton* to the outpatient mental health setting and strictly construes Ohio Revised Code §5122.34[36] which governs the immunity provided to individuals involved in the civil commitment process.

1. *Littleton*

In *Littleton*, the Court applied the "professional judgment standard" to inpatient treatment. *Estates of Morgan* addressed the question left open by footnote 3 of the *Littleton* decision.[37] Under *Estates of Morgan*, psychotherapists who treat outpatients are held to the same standard of care as those who treat inpatients. A psychotherapist, regardless of the setting for their practice, must consider all viable treatment alternatives.[38] The evaluation of treatment alternatives must be thorough.

The subjective knowledge and actions of the psychotherapist must be considered in applying the professional judgment rule. Clearly, a treatment decision has not been made in good faith if the practitioner subjectively knew the chosen course of treatment would be ineffective. The professional judgment rule, however, does not punish a practitioner acting in good faith who makes a treatment decision after evaluating all treatment options; even though the decision proves subsequently to be wrong.

The elements of the professional judgment rule are clearly stated in the syllabus to *Littleton*:

> A psychiatrist will not be held liable for the violent acts of a voluntarily hospitalized mental patient subsequent to the patient's discharge if (1) the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge, or (2) a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant factors, and a good faith decision was made by the psychiatrist that the patient had no violent propensities, or (3) the patient was diagnosed as having violent propensities, and after a thorough evaluation of the severity of the propensities and a balancing of the patient's interests and the interests of potential victims, a treatment plan was formulated in good faith which included discharge of the patient.[39]

As applied to psychotherapists, the professional judgment rule analyzes liability in terms of the "'good faith, independence and thoroughness' of a psychotherapist's decision not to commit a patient."[40] *Morgan* reaffirmed *Littleton* in extending it to outpatient treatment:

> the professional judgment rule... seeks to strike an appropriate balance by not allowing the psychotherapist to act in careless disregard of the harm presented to others by violently inclined patients, yet preserving the confidence, autonomy, and flexibility necessary to the psychotherapeutic relationship. There is nothing in the analysis itself that would suggest a different result in the outpatient setting.[41]

2. R.C. §5122.34

The Ohio Supreme Court also rejected the claim of immunity asserted by FFCC and its employees under R.C. §5122.34 which provides immunity to those engaged in the civil commitment process. Immunity under the statute is available only if an individual protected by it acted in good faith. Good faith cannot be determined as a matter of law. It is for the finder of fact to assess the credibility of the individual who is asserting immunity.

Although it could have applied this analysis to reverse the trial court's grant of summary judgment, the Court went farther. It looked to the plain language of the statute and found it inapplicable to FFCC and its employees. The Court rejected the argument presented by FFCC and echoed in the works of some commentators on the subject.[42] The Court held the statute only applies if an individual participates in the civil commitment process.[43] FFCC and its employees neither initiated nor participated in civil commitment proceedings of Matt Morgan; therefore immunity was not available to them.

The Court held immunity only exists if the party asserting it has "procedurally or physically assist[ed]" in confinement proceedings under Chapter 5122. This interpretation relied on the plain meaning of the terms used by the General Assembly. Had the General Assembly intended the meaning FFCC ascribed, it would not have limited immunity to those who "procedurally or physically assist" in the decision to hospitalize, discharge, or make a change in the patient's placement. It would have immunized everyone.

THE IMPORTANCE OF *ESTATES OF MORGAN*

The Ohio Supreme Court's decision in *Estates of Morgan* is judicially sound. Using *Tarasoff* as a starting point rather than a destination, Justice Resnick avoided many of the dangers other courts have encountered in addressing psychotherapy negligence. While *Tarasoff* is instructive and informative, the law and facts of that case are somewhat problematic. Although plaintiffs in *Tarasoff* alleged defendants failed to detain a dangerous patient, failed to warn the victim of the patient's dangerousness, abandoned a dangerous patient, and breached a duty to the patient and the public, the only cause of action recognized was the duty to warn.[44]

Estates of Morgan does not address the duty to warn; thus, the "specific victim-specific threat" and "readily identifiable victim" standards played no role in the Court's decision.[45] While many of the issues that arise in a duty to warn case are similar to those found in psychiatric negligence actions, the "specific victim-specific threat" or readily identifiable victim standards have no application outside the duty to warn case.[46]

Traditional foreseeability analysis is more appropriate to the psychiatric negligence and failure to commit situations.[47] The patient's dangerous propensities are sufficient to merit commitment without the identification of a specific victim.[48] Matt Morgan's aggressive, paranoid, and violent behavior imposed upon defendants the duty to control his behavior regardless of a specific threat. Application of a "specific victim-specific threat" standard to the duty to commit would illogically preclude liability for the negligent treatment of an individual who exhibited antisocial and violent propensities toward society as a whole.[49]

The traditional use of foreseeability in assessing the existence of a duty gives practitioners more guidance in making the commitment decision. If an outpatient is a candidate for involuntary commitment due to violent or antisocial behavior, then logically, imposition of a duty to control provides more protection to society and the individual than waiting for a specific threat against a specific victim. The "specific victim-specific threat" standard provides minimal protection to society and the mentally ill under most circumstances. In addition, the view is ill-conceived as it provides immunity to the negligent psychotherapist who fails to make appropriate inquiries of the patient. Under this view, one who fails to illicit imperative information concerning the patient's dangerous propensities is not liable for the subsequent harm. The *Morgan* duty to control, however, is consistent with traditional tort law: "It is not necessary that the defendant should have anticipated the particular injury. It is sufficient that his act is likely to result in an injury to someone."[50]

The Ohio Supreme Court followed a legally sound course when it used *Tarasoff* to frame its discussion. However, it proceeded to address the case in terms of traditional Ohio tort principles.[51] The Court in *Littleton* had explicitly left the issue of a duty to control in the outpatient setting open for future consideration. Although the outpatient and inpatient settings for treatment of mental illness present different levels of control, imposition of a

duty based upon the specific facts of each case is appropriate in light of the social goals of treating mental patients in the least restrictive environment.[52] The need for a uniform standard in both settings was further mandated by the reality of modern mental health treatment: many patients who were formerly institutionalized are now being treated on an outpatient basis.

[1] *See Morgan Family Wins Wrongful Death Suit*, NEWS BRIEFS (Alliance for the Mentally Ill of Ohio), Vol. 16, No. 2, at 5 (citing an internal Ohio Psychological Association memorandum) and Letter from Debra M. Belinky, Ohio Department of Mental Health, to Executive Committee et al. (Mar. 20, 1997)(on file with the *Cleveland State Law Review*).

[2] The syllabus of the Court states:

> 1. Generally, a defendant has no duty to control the violent conduct of a third person as to prevent that person from causing physical harm to another unless a "special relation" exists between the defendant and the third person or between the defendant and the other. In order for a special relation to exist between the defendant and the third person, the defendant must have the ability to control the third person's conduct
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> 2. R.C. 5122.34 does not preclude the finding that a special relation exists between the psychotherapist and the outpatient which imposes a common law duty on the therapist to take affirmative steps to control the patient's violent conduct.
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> 3. The relationship between the psychotherapist and the patient in the outpatient setting constitutes a special relation justifying the imposition of a duty upon the psychotherapist to protect against and/or control the patient's violent propensities.
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> 4. When a psychologist knows or should know that his or her outpatient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her best professional judgment to prevent such harm from occurring.

[3] *Estates of Morgan v. Fairfield Family Counseling Center*(1997), 77 Ohio St. 3d 284, 285.

[4] *Id.*, at 286.

[5] *Id.*, at 287-88.

[6] *Id.*, at 288.

[7] *Id.*, at 288-89.

[8] *Id.*, at 289.

[9] *Id.*, at 289-90.

[10] *Id.*, at 290.

[11] *Id.*

[12] *Id.*, at 292.

[13] *Id.*

[14] *Id. Estates of Morgan v. Fairfield Family Counseling Center*, No. 94CA11, 1994 Ohio App. LEXIS 6053 (Ohio Ct. App. Dec. 8, 1994). The court unanimously reversed the trial court's grant of summary judgment to Dr. Brown. The court determined the trial court improperly applied the standard announced in *Littleton v. Good Samaritan Hospital & Health Center* (1988), 39 Ohio St. 3d 86, when it determined as a matter of law it was "most evident Dr. Brown has no liability here." *Estates of Morgan*, 1994 Ohio App. LEXIS 6053 at *18. The court of appeals affirmed judgment for FFCC and its employees, holding there was no evidence they had not acted with good faith and were thus immune under R.C. §5122.34. Judge William B. Hoffman, in a dissenting opinion as to the liability of FFCC and its employees, astutely noted even if it was eventually determined that the statute applied to the case, the issue of good faith was an issue for the finder of fact and could not be determined as a question of law.

[15] *Id.*, at 317.

[16] (1988), 39 Ohio St. 3d 86, 92 n.3 ("We are not deciding whether a psychiatrist's duty to protect a person from the violent propensities of the psychiatrist's patient extends to the outpatient setting.")(citing *Tarasoff v. Regents of the University of California* (1976), 551 P.2d 334.

[17] (1984), 9 Ohio St. 3d 77, 79.

[18] (1976), 551 P.2d 334.

[19] *Estates of Morgan, supra*, at 295.

[20] *Id.*, at 297.

[21] *Tarasoff*, 551 P.2d at 341-42. The court held the first and fourth causes of action, failure to detain and abandonment of a dangerous patient, were barred by governmental immunity and the third cause of action failed as a matter of law because exemplary damages were unavailable in a wrongful death action. *Id.*

[22] *Id.*, at 295, citing *Tarasoff*, 551 P.2d at 343.

[23] *Estates of Morgan, supra*, at 295, citing *Tarasoff*, 551 P.2d at 344

[24] *Estates of Morgan, supra*, at 295, citing *Tarasoff*, 551 P.2d at 344-48.

[25] *Estates of Morgan, supra*, at 295-96.

[26] *Id.*, at 305.

[27] *Id.*, at 296.

[28] *Id.*

[29] *Id.*, at 299.

[30] *Id.*, at 298.

[31] *Id.*, at 297.

[32] *Estates of Morgan*, supra at 301.

[33] *Id.*, at 301-02.

[34] *Id.*, at 302.

[35] *Id.*, at 303 (citing Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 486).

[36] OHIO REV. CODE ANN. § 5122.34 states:

> Persons, including, but not limited to, boards of alcohol, drug addiction, and mental health services and community mental health agencies, acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge, determination of appropriate placement, or in judicial proceedings of a person under this chapter, do not come within any criminal provisions, and are free from any liability to the person hospitalized or to any other person. No person shall be liable for any harm that results to any other person as a result of failing to disclose any confidential information about a mental health client, or failing to otherwise attempt to protect such other person from harm by any such client. This section applies to expert witnesses who testify at hearings under this chapter.

[37] 39 Ohio St. 3d at 96 n.3.

[38] *Id.*, at 307 n.7.

[39] *Littleton, supra*, at Syllabus.

[40] *Littleton*, 39 Ohio St. 3d at 96 (quoting Currie v. United States, 644 F. Supp. 1074, 1083 (M.D.N.C. 1986).

[41] *Estates of Morgan*, supra at 307.

[42] *Id.*, citing Eagle & Kirkman, BALDWIN'S OHIO MENTAL HEALTH LAW 127-29 (2d ed. 1990) and Hulteng, *The Duty to warn or Hospitalize: The New Scope of Tarasoff Liability in Michigan*, 67 U. OF DET. L. REV. 1, 11.

[43] *Id.*, at 304-05.

[44] *Tarasoff*, 551 P.2d at 341-42.

[45] Although the case is instructive on the issue of duty, *Tarasoff* is inapplicable due to California's governmental immunity baring the duty to commit claim. *Tarasoff*, 551 P. 2d at 340.

[46] *Estates of Morgan, supra*, at 310.

[47] The Ohio Supreme Court approvingly cited *Currie v. United States* (1986), 644 F. Supp. 1074, 1080, (aff'd other grounds 836 F.2d 209 (4th Cir. 1987), which noted that:

> The court does not believe that it is wise to limit any duty to commit according to the victim. Arguably the patient who will kill wildly (rather than specifically identifiable victims) is the one most in need of confinement. In negligent release cases, a defendant's duty generally has not been limited to readily identifiable victims, and the court believes a similar rule is appropriate here. Citizens outside of the "readily identifiable" sphere but still within the "foreseeable zone of danger" are potential victims a therapist should consider if he has a duty to them and a means of adequately protecting them.

[48] *Curie*, 644 F. Supp. at 1079. ("[T]he therapist in a duty to commit case need only know that the patient is dangerous generally in order to adequately commit him. As a practical matter, the victim's identity is irrelevant to whether the doctor can adequately act -- by committing the patient the therapist is able to protect all possible victims.").

[49] The inapplicability of this standard to the negligent failure to commit case is readily apparent. Matt Morgan's manifestation of antisocial and violent behavior contrasted with his marked improvement when treated with medication and his compliance in receiving treatment during his stay at C.A.T.C.H. Respite, demonstrate the fact it was foreseeable if his schizophrenia were not treated he would react violently and could injure others. *Estates of Morgan. supra*, at 285-90.

[50] *Di Gildo v. Caponi* (1969), 18 Ohio St. 2d 125, 130.

[51] *Gelbman v. Second Natl. Bank of Warren* (1984), 9 Ohio St. 3d 77, 79 (1984)(explicitly following Section 315).

[52] *Estates of Morgan, supra*, at 297. OT