Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality

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For psychotherapy to be successful, a trusting relationship must be established between the psychotherapist and his patient so that the patient will talk freely with the therapist about his problems.[1] The therapeutic community has acknowledged that the confidentiality of a patient's communications during therapy is basic to the formation of a trusting relationship.[2] It is important, therefore, that a therapist not violate confidentiality and forsake that trust. An absence of confidentiality[3] may cause considerable psychological harm to the patient. For

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1. *See, e.g.*, Allred v. State, 554 P.2d 411, 417-18 (Alas. 1976); ALASKA STAT. § 08.86.200 (1973) (granting a psychological privilege); Heller, *Some Comments to Lawyers on the Practice of Psychiatry*, 30 TEMP. L.Q. 401, 405 (1957); Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 184-88 (1960).

2. *See In re* Lifschutz, 2 Cal. 3d 415, 421-22, 467 P.2d 557, 560, 85 Cal. Rptr. 829, 832 (1970). In this case, the California Supreme Court stated: "From the affidavits and correspondence included in the record we note that a large segment of the psychiatric profession concurs in Dr. Lifschutz's strongly held belief that an absolute privilege of confidentiality is essential to the effective practice of psychotherapy." *Id.* at 421, 467 P.2d at 560, 85 Cal. Rptr. at 832. *See also* Dubey, *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 AM. J. PSYCH. 1093 (1974); Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CALIF. L. REV. 1050, 1052-53 (1973). Two propositions are advanced to justify confidentiality:

> [F]irst, that it is in the interests of society that persons in need of professional help for the solution of mental problems which render them unable to lead normal lives should not be deterred from seeking this help, and, once having sought it, from reaping its benefits: second, that the nature of the therapeutic relationship is such that unless an evidentiary privilege is extended to it, many persons who are in great need of help *will be* deterred from seeking it and then reaping its benefits.

Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 618 (1964) (emphasis in original). An evidentiary privilege for such communication does not indicate that the need for confidentiality is limited to judicial proceedings, but rather indicates that confidentiality must be preserved for all purposes. *See* Goldstein & Katz, *Psychiatric-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175, 178 (1962); Slovenko, *supra* note 1; Zenoff, *Confidential and Privileged Communications*, 182 J.A.M.A. 656 (1962).

3. Violations of confidentiality can occur in a variety of ways. Discussions of patients' cases may be overheard in the hallways of hospitals, at cocktail parties, or in the therapist's home. R. SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION 54 (1966). Psychiatric evaluations have been disclosed by mail upon the request of a stranger, Berry v. Moench, 8 Utah 2d 191, 331 P.2d 814 (1958),

example, a patient may leave therapy[4] or cease to benefit from it.[5] Additionally, an absence of confidentiality may deter individuals who require therapy from seeking help.[6]

There are varying modes of therapy as well as different types of mental health professionals classifiable as psychotherapists,[7] all of whom require confidentiality for successful treatment of a client. Psychiatrists, who are qualified physicians with additional training in the treatment of mental disorders,[8] may be termed psychotherapists. The extent of their training is established by the American Board of Psy-

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and upon the request of a spouse, Hammer v. Polsky, 36 Misc. 2d 482, 233 N.Y.S.2d 110 (Sup. Ct. 1962); Furniss v. Fitchett, [1958] 77 N.Z.L.R. 396.

The possibility of breaches of confidentiality by divulgence of a patient's records is also of concern in the field of mental health. *See* MENTAL HEALTH LAW PROJECT, PROPOSED MENTAL HEALTH LEGISLATIVE GUIDE § 2 (Tent. Draft No. 1 1975); Hofmann, *Confidentiality and the Health Care Records of Children and Youth*, PSYCHIATRIC OPINION, Jan., 1975, at 20. The problem is especially acute with regard to computerization of records. MENTAL HEALTH LAW PROJECT, *supra* § 1, at 11-20.

4. Goldstein & Katz, *supra* note 2, at 179. *See generally* Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

5. *See* Goldstein & Katz, *supra* note 2, at 179.

6. *See* Fisher, *supra* note 2.

7. The term "psychotherapy" will be used throughout this Note to indicate a one-to-one relationship between patient and therapist. Technically, psychotherapy is a term applied to a few distinct methodologies that treat nervous diseases and maladjustments by using the techniques of psychoanalysis, suggestion, or reeducation. L. LOWREY, PSYCHIATRY FOR SOCIAL WORKERS 345-46 (2d ed. 1958). However, the terms "psychotherapy" and "counseling" are sometimes used synonymously. *See* T. ALEXANDER, PSYCHOTHERAPY IN OUR SOCIETY 6 (1963). Where a distinction is drawn, psychotherapy denotes a method of dealing with an individual with severe and deep-seated problems, while counseling refers to short term psychological aid for social-psychological adjustment problems. *See* L. BRAMMER & E. SHOSTRON, THERAPEUTIC PSYCHOLOGY 3-21 (1968); Note, *Regulation of Psychological Counseling and Psychotherapy*, 51 COLUM. L. REV. 474 (1951). Even where a distinction is drawn, it is conceded that the same techniques are often used in both methodologies. L. BRAMMER & E. SHOSTRON, *supra*, at 6. The relationship that is fostered between patient and therapist is what is important to a study of confidentiality, so, for the sake of convenience, the term psychotherapy will be used to describe those types of therapy or counseling where such a relationship exists.

The term "profession" will be used to denote a type of employment requiring special training as a prerequisite for admission to practice; such training often being prescribed by the state. *See* Semler v. Oregon State Bd. of Dental Examiners, 294 U.S. 608, 611 (1935); Pitts v. State Bd. of Examiners of Psychologists, 222 Md. 224, 226, 160 A.2d 200, 201 (1960). Additionally, a profession usually has an organization for the advancement of the profession, and a commitment to public service is required from all members. Wade, *Public Responsibilities of the Learned Profession*, 21 LA. L. REV. 130, 131 (1960). *See also* Goode, *Encroachment, Charlatanism and the Emerging Profession: Psychology, Sociology, and Medicine*, 25 AM. J. SOC. 902, 903 (1960). Under this definition, disciplines other than medicine and law may qualify as professions if their members are required to receive special training, join an organization devoted to the furtherance of the discipline, and make a commitment to public service. *See generally* II PRACTICING LAW INSTITUTE, PROFESSIONAL MALPRACTICE (Schreiber ed. 1967). Thus, architects, engineers, insurance agents or brokers, and corporate executives are all held to the standards of professionals. *See generally id.*

8. "Psychiatrist" means a licensed physician who has completed 3 years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association. *See* ARIZ. REV. STAT. ANN. § 36-501(25) (1974); MO. ANN. STAT. § 202.472(3) (Vernon 1972); 2 AM. SPECIALTY BOARDS, DIRECTORY OF AM. SPECIALISTS 2173-74 (17th ed. 1975); Note, *Confidential Communications to a Psychotherapist: A New Testimonial Privilege*, 47 NW. U.L. REV. 384, 387 n.20 (1952).

chiatry and Neurology, which requires 3 years of postgraduate specialized training in psychiatry, plus 2 years of experience in a qualified ward.[9] Because psychiatrists are medical doctors, they are subject to the American Medical Association's [AMA] Principles of Medical Ethics.[10] Clinical psychologists are therapists who have not received a license to practice medicine, but they do possess a doctoral degree in the field of psychology.[11] Although psychologists often work on teams with psychiatrists and social workers,[12] many go into private practice as psychotherapists.[13] Psychologists adhere to the American Psychological Association's [APA] Ethical Standards of Psychologists.[14] Fi-

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9. 2 AM. SPECIALTY BOARDS, *supra* note 8. The experience is taken concurrently with the last 2 years of training. *Id.*

10. R. SLOVENKO, *supra* note 3, at 26. The ethical obligation of a physician is expressed in A.M.A., PRINCIPLES OF MEDICAL ETHICS (1971), where it is stated:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Id. at § 9. *See generally* Copple, *Physician-Patient Privilege: A Need to Revise the Arizona Law*, 6 ARIZ. L. REV. 292, 292-97 (1965).

11. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 32-2061(2), -2071(c), -2085 (1976); CAL. BUS. & PROF. CODE § 2914 (West 1974); CONN. GEN. STAT. ANN. § 20-188 (West Supp. 1976). *See also* F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, THE MENTAL HEALTH PROCESS 24 (1976); Louisell, *The Psychologist in Today's Legal World: Part II*, 41 MINN. L. REV. 731, 733 (1957).

12. *See* T. ALEXANDER, *supra* note 7; L. LOWREY, *supra* note 7, at vii.

13. Ellis, *The Roots of Psychology and Psychiatry*, in PSYCHOLOGY, PSYCHIATRY, AND THE PUBLIC INTEREST 190 (M. Krout ed. 1956).

14. AM. PSYCHOLOGICAL ASS'N, ETHICAL STANDARDS OF PSYCHOLOGISTS (1972) Principle 5 provides:

> *Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless certain important conditions are met.*
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> a. Information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities.
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> b. Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others are discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports should present only data germane to the purposes of the evaluation and every effort should be made to avoid undue invasion of privacy.
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> c. Clinical and other materials are used in classroom teaching and writing only when the identity of the persons involved is adequately disguised.
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> d. The confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express permission is a confidential professional communication shown to the individual concerned. The psychologist is responsible for informing the client of the limits of the confidentiality.
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> e. Only after explicit permission has been granted is the identity of research subjects published. When data have been published without permission for identification, the psychologist assumes responsibility for adequately disguising their sources.
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> f. The psychologist makes provisions for the maintenance of confidentiality in the preservation and ultimate disposition of confidential records.

Id., quoted in AM. PSYCHOLOGICAL ASS'N, BIOGRAPHICAL DIRECTORY 28-29 (1975) (emphasis in original). All but Principle 5 of the code has been revised, see Am. Psychological Association Monitor, Mar., 1977, at 22, col. 1.

nally, psychiatric social workers are therapists who have received advanced training in the behavioral sciences. A master's degree in social work from an accredited college is usually required.[15] Social workers belong to the National Association of Social Workers, and adhere to a code of ethics promulgated by the Association.[16] Although social workers usually work on teams with psychiatrists and psychologists, the work they do is often identical to that of psychiatrists and psychologists.[17] Moreover, they are responsible for their own decisions about the therapy they conduct.[18] Thus, each of these therapists sees patients who are troubled mentally or emotionally, and attempts to help them cope with their problems and lead more productive lives.[19]

A patient who has been harmed by a breakdown in confidentiality receives no remedial assistance from procedures invoked against the therapist to revoke his license or censure him.[20] Further, a license revocation action is rarely successful when based on breaches of confidentiality.[21] For these reasons the patient is in need of a compensatory remedy for harm done to his reputation and to his personal and occupational relationships. In addition, the recognition of a legal remedy could work to compensate the patient for expenditures for any treatment rendered ineffective because of the disclosure. Moreover, a remedy with a deterrent effect is needed to prevent further indiscretions. Several theories of recovery can be advanced. These include breach of contract, breach of a fiduciary duty, invasion of the

15. *See* Comment, *supra* note 2, at 1051 n.8. Since social work has emerged as a profession a bachelor's degree in social work has become available and is accepted as a lower level social work degree. E. FERGUSON, SOCIAL WORK 18-24 (3d. ed. 1975). *See generally* F. MILLER, R. DAWSON, G. DIX, & R. PARNAS, *supra* note 11.

16. NAT'L ASS'N OF SOCIAL WORKERS, CODE OF ETHICS (1967), *reprinted in* 2 NAT'L ASS'N OF SOCIAL WORKERS, ENCYCLOPEDIA OF SOCIAL WORK 958 (1971): "I respect the privacy of the people I serve. I use in a responsible manner [information] gained in professional relationships."

17. *See* Comment, *supra* note 2, at 1052.

18. *See* L. LOWREY, *supra* note 7, at viii, 344-45.

19. *See* CIBA FOUNDATION, THE ROLE OF LEARNING IN PSYCHOTHERAPY 190-91 (R. Porter ed. 1969). Although therapeutic techniques may differ between therapists, *see* L. BRAMMER & E. SHOSTROM, *supra* note 7; Note, *supra* note 7, at 474 n.3, the dynamics of the relationship are the same: A one-to-one relationship between patient and therapist is established, wherein the patient can express his innermost feelings to the therapist. *See* Fisher, *supra* note 2.

20. A license revocation involves no compensation for the patient. *See, e.g.*, ALASKA STAT. § 08.64.330(b) (1973); ARIZ. REV. STAT. ANN. § 32-2081 (1976); CAL. BUS. & PROF. CODE §§ 2960-2961 (West 1974). *See also* ALASKA STAT. §§ 08.86.180, .210 (1973) (psychologist may be found guilty of a misdemeanor for unprofessional conduct).

21. *See* McPheeters v. Board of Medical Examiners, 103 Cal. App. 297, 284 P. 938 (Ct. App. 1930), where the court failed to find a physician liable who was charged with unprofessional conduct in violation of the state's Medical Practice Act by "the willful betraying of a professional secret." *Id.* at 298, 284 P. at 938. This definition of unprofessional conduct no longer appears in the California statutes. *See* ch. 354, § 14, 1913 Cal. Stats. 722 (amended by ch. 1458, § 2, 1965 Cal. Stats. 3414) (current version at CAL. BUS. & PROF. CODE § 2361 (West Supp. 1977)). *But see* ARIZ. REV. STAT. ANN. §§ 32-1401(10)(b), -1451(A) (1976), which lists breach of confidentiality as a reason for the refusal or revocation of a license.

right to privacy, and breach of a duty in tort sounding in malpractice. These theories of recovery are received by the courts with varying degrees of success.

This Note will discuss each of these proposed theories, focusing on their availability, likelihood of success, and beneficial consequences. It will conclude that a breach of contract action, although viable, will suffer practical problems of proof in terms of damages. The breach of fiduciary duty action will be shown to be a weak theory of recovery, while invasion of privacy is found to be a viable theory despite arguable limitations. Finally, the strength of the traditional malpractice or negligence action will be demonstrated. The last section of this Note will explore the outer tolerances of liability for disclosure by contrasting the liability incurred by a psychotherapist who fails to disclose a communication made by a dangerous patient.

BREACH OF CONTRACT

While the relationship between the psychotherapist and his patient is essentially a medical one, it can also be characterized as contractual. The contract arises when the psychotherapist agrees to treat the patient in return for a fee.[22] If, in the agreement for services, the patient explicitly expresses a desire for confidentiality of communications, and the therapist agrees, this becomes a valid provision of the contract and clearly is binding upon the therapist.[23] Such express contracts, in-

22. *See, e.g.*, Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 710, 287 So. 2d 824, 831 (1973); Rainer v. Grossman, 31 Cal. App. 3d 539, 543, 107 Cal. Rptr. 469, 471 (1973). *See generally* Schwitzgebel, *A Contractual Model for the Protection of the Rights of Institutionalized Mental Patients*, 30 AM. PSYCHOLOGIST 815 (1975).

Of course, a contract need not be written to be valid, unless there is a particular statutory requirement of a writing. *See, e.g.*, Joy Enterprises, Inc. v. Reppel, 112 Ariz. 42, 46, 537 P.2d 591, 595 (1975) (contract partly oral); Youngman v. Nevada Irrigation Dist., 70 Cal. 2d 240, 246, 449 P.2d 462, 466, 74 Cal. Rptr. 398, 402 (1969) (implied contract); Empire Skel Bldg. Co. v. Harvey Mach. Co., 122 Cal. App. 2d 411, 415, 265 P.2d 32, 34 (Ct. App. 1954) (oral contract); Smith v. Recrion Corp., 91 Nev. 666, —, 541 P.2d 663, 664 (1975) (implied contract); Hankins v. American Pac. Sales Corp., 7 Wash. App. 316, 318, 499 P.2d 214, 215 (1972) (oral contract). A contract with written or oral terms is an express contract; and a contract created from a set of circumstances is an implied contract. Youngman v. Nevada Irrigation Dist., 70 Cal. 2d at 246, 449 P.2d at 466, 74 Cal. Rptr. at 402; Smith v. Recrion Corp., 91 Nev. at —, 541 P.2d at 664. Where a patient is treated in return for a fee, the five requirements for a valid contract are met. These generally recognized requirements for a contract are mutual assent, Gifford v. Makus, 112 Ariz. 232, 236, 540 P.2d 704, 708 (1975), two or more contracting parties, Moore v. Smotkin, 79 Ariz. 77, 283 P.2d 1029, 1031 (1962), consideration, McPheters v. Hapke, 94 Idaho 744, 746, 497 P.2d 1045, 1047 (1972), a legal purpose, Apperson v. Security State Bank, 215 Kan. 724, 734, 528 P.2d 1211, 1219 (1974), and parties having legal capacity to contract. Fewel & Dawes, Inc. v. Pratt, 17 Cal. 2d 85, 90, 109 P.2d 650, 653 (1941). *See generally* J. MURRAY, MURRAY ON CONTRACTS § 17, at 28 (2d rev. ed. 1974).

23. *See* Simrin v. Simrin, 233 Cal. App. 2d 90, 43 Cal. Rptr. 376 (Ct. App. 1965) (a written agreement for confidentiality between a rabbi social worker and a

cluding a confidentiality provision, are often made by therapists to alleviate anxieties a patient may have about therapy and to set the goals of treatment.[24] A provision for confidentiality may be binding upon a therapist even as to testimony before a court.[25] Thus, a therapist may contractually establish a privilege even in the absence of a statute. However, if there is no provision regarding confidentiality in the agreement, or if no express contract is made, the existence of a contractual duty to safeguard confidentiality will depend upon whether it may be inferred from the contract for treatment.[26] To determine whether such a provision may be inferred, an analogy may be drawn from related areas in the law of medicine.

The most common type of contract between physician and patient is implied.[27] Such a contract consists, in part, of an agreement by the physician to give treatment in accordance with the standards of his profession.[28] Due to the public's tendency to rely on the commonly known ethical obligation of physicians to remain silent with regard to information received from or about the patient,[29] it has been held that the physician impliedly agrees that any confidential information gained through the physician-patient relationship will not be released without

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couple he was counseling sufficient to prevent judge from compelling the rabbi to testify).

24. *See* Alexander & Szasz, *From Contract to Status Via Psychiatry*, 13 SANTA CLARA LAW. 537, 555 (1973). *See generally* Maluccio & Marlowe, *The Case for the Contract*, 19 SOC. WORK. 28 (1974); Seabury, *The Contract: Uses, Abuses and Limitations*, 21 SOC. WORK 16 (1976).

25. *Cf.* Simrin v. Simrin, 233 Cal. App. 2d 90, 43 Cal. Rptr. 376 (Ct. App. 1965). In *Simrin* such a contract was upheld, but the circumstances were unusual, as the social worker was also a rabbi. *Id.* at 94, 43 Cal. Rptr. at 379. In addition, the court upheld the contract in part because it was designed to protect the parties' marriage, *id.* at 95, 43 Cal. Rptr. at 379, which was found to be of greater interest to the state than the testimony sought to be compelled.

26. When parties act in a way that indicates they have reached a mutual agreement, an implied contract will be found. Martens v. Metzgar, 524 P.2d 666, 672 (Alas. 1974); Alexander v. O'Neil, 77 Ariz. 91, 98, 267 P.2d 730, 734 (1954). *See* 1 A. CORBIN, CORBIN ON CONTRACTS § 18 (1963).

27. Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965). A physician who treats a nonconsenting patient may be liable for the tort of battery. *See, e.g.*, Hundley v. St. Francis Hosp., 161 Cal. App. 2d 800, 802, 327 P.2d 131, 133 (Ct. App. 1958); Rogers v. Lumberman's Mut. Cas. Co., 119 So. 2d 649, 650 (La. Ct. App. 1960); Alexander & Szasz, *supra* note 24, at 548. An exception to this is the situation of a critical, unforeseen emergency, where treatment is essential and consent unobtainable because of the patient's condition. Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Jackovach v. Yocum, 212 Iowa 914, 237 N.W. 444 (1931); King v. Carney, 85 Okla. 62, 204 P. 270 (1922). *See generally* Note, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84 (1974).

28. McNamara v. Emmons, 36 Cal. App. 2d 199, 205, 97 P.2d 503, 507 (Ct. App. 1939).

29. Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 711, 287 So. 2d 824, 832 (1973). For further discussion of the physician's obligation to keep his patient's confidences, see Simonsen v. Swenson, 104 Neb. 224, 227-29, 177 N.W. 831, 832 (1920); Berry v. Moench, 8 Utah 2d 191, 196, 331 P.2d 814, 817 (1958); Smith v. Driscoll, 94 Wash. 441, 442, 162 P. 572, 572 (1917).

the patient's permission.[30] Reliance springs either from the expression of the obligation of confidentiality in the Hippocratic Oath,[31] the AMA's Principles of Ethics,[32] medical licensing requirements,[33] or common customs and practices.[34]

The reasoning applied to find an implied contractual relationship between patient and physician also can be applied to the relationship of patient and psychotherapist. Psychiatrists, psychologists, and social workers all must adhere to an ethical code requiring confidentiality.[35] The need for confidentiality in psychotherapy, and reliance by patients on the confidential nature of the relationship, are well known.[36] In-

30. Horne v. Patton, 291 Ala. 701, 710, 287 So. 2d 824, 831 (1973); *see* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965). In *Horne*, the patient accused his physician of divulging information about him to his employer, thus causing him to be dismissed from his job. 291 Ala. at 704-05, 287 So. 2d at 825-26. The Alabama Supreme Court held that such an action could be brought on the theory of breach of implied contract. *Id.* at 711, 287 So. 2d at 832. The court also held the action a proper one for breach of a fiduciary duty, *id.* at 708-09, 287 So. 2d at 829-30, and invasion of privacy. *Id.* at 709, 287 So. 2d at 830.

The *Hammonds* case involved the divulgence of a patient's confidential information by a physician to his malpractice insurer. 243 F. Supp. at 795. The district court held that such an action could lie in tort for breach of a duty to keep silent, *id.* at 799, in contract, *id.* at 801, and for breach of a fiduciary duty. *Id.* at 802-03.

31. "Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." *Quoted in* Horne v. Patton, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1974).

32. *See* discussion note 10 *supra.*

33. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 32-1401(10)(b), 1423(6) (1976); CAL. BUS. & PROF. CODE §§ 2361, 2379 (West 1977); COLO. REV. STAT. §§ 12-36-107 to -118 (1976).

34. Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 711, 287 So. 2d 824, 832 (1973). An objection to an implied contractual obligation of confidentiality has been made in states where there is no evidentiary privilege for physician witnesses, on the grounds that since no legal obligation of confidentiality exists, it cannot be implied in a contract for medical services. *Id.* at 712-13, 287 So. 2d at 833-34 (McCall, J., dissenting). This objection seems to be based on the premise that the provisions of an implied contract must be supported by legal obligations or they are not valid. However, an implied contract can be forged from the intent of the parties. See text & note 26 *supra.* Thus, when a contract exists between physician and patient for services, and a common understanding exists as to the confidential nature of those services, that understanding is part of the contract regardless of the existence of a legal duty. The dissent in *Horne* relied on Quarles v. Sutherland, 215 Tenn. 651, 655, 389 S.W.2d 249, 251 (1963), *noted in* 79 HARV. L. REV. 1723 (1966), for the contention that the absence of a legal duty is fatal to an implied contract. 291 Ala. at 713, 287 So. 2d at 834. Although the *Quarles* court held that the absence of a legal duty to safeguard confidentiality was fatal to an action in tort, it noted that an action would be possible in contract providing there existed the proper physician-patient relationship. 215 Tenn. at 657, 389 S.W.2d at 252.

One writer has argued that requiring a physician-patient relationship should be recognized regardless of whether a physician receives compensation from his patient. Note, *Medical Confidence—Civil Liability for Breach*, 24 N. IR. L.Q. 19, 22 (1973). *See also* 79 HARV. L. REV. 1723, 1724-25 (1966) (asserts that an implied contract can arise even where the technical requirements are not met, if the patient justifiably believes there is an agreement and relies on it).

35. *See* text & notes 10, 14, 16 *supra.*

36. *See* text & note 1 *supra.* *See also* Proposed Fed. R. Evid. 504 note, *reprinted in* 11 MOORE'S FEDERAL PRACTICE § 504, app. I, at 46-48 (2d ed. 1976). In *Moore's* it is stated that there is a greater need for confidentiality in a psychotherapist-patient

deed, it may be greater than the need for confidentiality in general medicine.[37] Therefore the imposition of an obligation of confidentiality upon physicians may provide an a fortiori case for psychotherapeutic confidentiality. Further, the extent to which a patient must divulge his feelings in therapy justifies an expectation of the preservation of confidentiality.[38] In that both the psychotherapist and the patient have a common understanding as to confidentiality, it should be considered an implied provision of the contract between them.[39] If the requirements of a valid contract are met, and an action for breach of contract can be brought successfully, the problem of obtaining adequate recovery remains.

In general, remedies for breach of contract are for damages, res-

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relationship than in a physician-patient relationship. The Federal Rules Advisory Committee stated the parameters of the proposed privilege as follows:

> (a) Definitions.
> (1) A "patient" is a person who consults or is examined or interviewed by a psychotherapist.
> (2) A "psychotherapist" is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.
> (3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

Proposed Fed. R. Evid. 504 note. Although this rule was not enacted at the federal level, see FED. R. EVID. 501, the policy arguments for the proposed rule may encourage states to adopt it via the common law or through legislation.

37. *See* discussion note 2; *see also* Proposed Fed. R. of Evid. 504 note, *supra* note 36.

38. *See* Slovenko, *supra* note 1, at 184-85, 189; Comment, *supra* note 2, at 1057. Secrecy is usually maintained even as to the fact that the patient is in therapy. Slovenko, *supra* at 184-85.

39. The legal requirement of privity of contract may limit the availability of a contract theory of recovery for breach of confidentiality. "Privity of contract" is a connection or relation between the contracting parties which grows out of the contract. Howarth v. Pfeifer, 443 P.2d 39, 42 (Alas. 1968). Generally, privity exists where consideration has passed from one party to another. 1 A. CORBIN, *supra* note 26, § 124, at 533. Thus, privity is lacking where the claimant is a third-party beneficiary to the contract. The party paying the physician's fee and the physician may make a contract to benefit the patient (third-party beneficiary). *See* 4 A. CORBIN, *supra* §§ 774-776, at 7-24. *Cf.* United States v. Ogden Technology Laboratories, Inc., 406 F. Supp. 1090, 1092 (E.D.N.Y. 1973) (United States found to be third-party beneficiary of contract between defendant and subcontractor so that the government could sue for breach of contract, even though defendant was not a party to contract with the government); Professional Realty Corp. v. Bender, 216 Va. 737, 739, 222 S.E.2d 810, 812 (1976). This type of arrangement may be involved where the patient is an incompetent and the therapist would prefer not to contract with him directly. *See* Alexander & Szasz, *supra* note 24. Such reluctance to contract might be present because a contract with a mental incompetent is voidable by that person, while the mentally competent party may not void the contract. Krasner v. Berk, 366 Mass. 464, 468, 319 N.E.2d 897, 900 (1974); Ortelere v. Teachers' Retirement Bd., 25 N.Y.2d 196, 202, 250 N.E.2d 460, 464, 303 N.Y.S.2d 362, 367 (1969) (contract voidable but not void). *See also* Alexander & Szasz, *supra*.

Where the patient is a third-party beneficiary, the question is not whether the patient has the right to enforce the contract, but whether his right to confidentiality

titution, or specific performance.[40] The purpose behind these remedies generally is to put the nonbreaching party in a position comparable to what he would have been in if the contract had been fully performed.[41] These remedies for breach of contract, with the exception of specific performance,[42] generally involve an affront to pecuniary interests.[43] A breach of confidentiality, however, will have a primarily

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may be exercised when the disclosure is made to the paying party. Arguably, in such a situation, the party providing the consideration would be contracting for the therapist to provide skill and care in accordance with the standards of his profession, and therefore secrecy should be preserved. *Cf.* ABA CODE OF PROFESSIONAL RESPONSIBILITY EC 5-23, DR 5-107(B) (1975) (prohibiting attorney from allowing a third-party who is paying for a client's legal services to interfere in the exercise of his independent judgment). The weight of modern authority seems to support the view that a third-party beneficiary to a contract may avail himself of a promise made in the contract for his benefit. *See* Keith v. Schiefen-Stockham Ins. Agency, Inc., 209 Kan. 537, 544-45, 498 P.2d 265, 273 (1972); Olson v. Iacometti, 91 Nev. 241, —, 533 P.2d 1360, 1364 (1975). *See also* Furniss v. Fitchett, [1958] 77 N.Z.L.R. 396, stating:

> The duty in contract is only owed to the parties to the contract but it would seem that there is in most cases a contract between patient and medical practitioner, even if the patient himself is not liable for payment of the service rendered, such payment being made by someone else.

Id. at 399.

40. Beefy Trails, Inc. v. Beefy King Int'l, Inc., 267 So. 2d 853, 856 (Fla. Dist. Ct. App. 1972); Sykes v. Perry, 162 Kan. 365, 374, 176 P.2d 579, 585-86 (1947); Mohr v. Lear, 239 Ore. 41, 48, 395 P.2d 117, 120 (1964); Chambliss, Bahner & Crawford v. Luther, 531 S.W.2d 108, 110 (Tenn. App. 1975).

41. Chambliss, Bahner & Crawford v. Luther, 531 S.W.2d 108 (Tenn. App. 1975).

> The purpose of the remedy of damages is to put the party in as good a position as he would have been had the contract been completed . . . .
>
> The remedy of specific performance requires the party to perform that which he had promised to do . . . .
>
> . . . The remedy of restitution restores the injured party to the position he occupied prior to the contract being made. . . . One who has been wrongfully denied or otherwise prevented from fully performing . . . may regard the contract as terminated and seek judgment for the reasonable value of all the defendant received in the performance of the contract . . . .

Id. at 110; *see* Beefy Trails, Inc. v. Beefy King Int'l, Inc., 267 So. 2d 853 (Fla. Dist. Ct. App. 1972) (damages and restitution); Hochard v. Deiter, 219 Kan. 738, 549 P.2d 970 (1976) (specific performance).

The commentators have found three categories of interests for the remedies for breach of contract: expectation, reliance, and restitution. D. DOBBS, REMEDIES § 12.1, at 786-88 (1973); J. MURRAY, *supra* note 22, § 219; Farnsworth, *Legal Remedies for Breach of Contract*, 70 COLUM. L. REV. 1145, 1147-49 (1970). The expectancy interest operates to preserve for the nonbreaching party the pecuniary result of the contract; that is, he receives the benefit of his bargain. Runyan v. Pacific Air Indus., Inc., 2 Cal. 3d 304, 316 n.15, 466 P.2d 682, 691 n.15, 85 Cal. Rptr. 138, 147 n.15 (1970); *See* D. DOBBS, *supra* at 786. Technically, under the rubric of the reliance interest a party may be compensated for expenditures made in order to perform the contract, while to satisfy the restitution interest any gain made by the breaching party must be disgorged. *Id.* at 788. However, since both interests operate to protect a party who has relied to his detriment upon performance of the contract, this technical distinction is often ignored by the courts. *See* Runyan v. Pacific Air Indus., Inc., 2 Cal. 3d 304, 311, 466 P.2d 682, 687, 85 Cal. Rptr. 138, 143 (1972) ("restitution of benefits . . . and any consequential damages"); Allen v. Allen Title Co., 77 N.M. 796, 798, 427 P.2d 673, 675 (1967) ("restoration to the injured of what he has lost by the breach"); D. DOBBS, *supra* at 787. *See generally* Childress & Garamella, *The Law of Restitution and the Reliance Interest in Contract*, 64 NW. U.L. REV. 433 (1969).

42. Specific performance is an equitable remedy, Loose v. Brubacher, 219 Kan. 727, 735, 549 P.2d 991, 998 (1976), whereby the court requires the contract to be performed. Gindhart v. Skourtes, 271 Ore. 115, 120, 530 P.2d 827, 829 (1975).

43. Talbot v. Waterbury Hosp. Corp., 22 Conn. Supp. 149, 152, 164 A.2d 162, 164 (1960); Moffet v. Kansas City Fire & Marine Ins. Co., 173 Kan. 52, 57, 244 P.2d 228, 233 (1952).

psychological effect on the patient.[44] If such psychological harm does not also involve pecuniary loss, there will generally be no applicable measure of damages under the traditional contract remedies.[45] Thus, traditional contract remedies are inadequate to compensate a patient for a breach of confidentiality. Damages for mental or emotional distress, as well as punitive damages, are generally not available in contract.[46] This limitation stems largely from the rules of *Hadley v. Baxendale*[47] governing general and special damages.[48] Under *Hadley*,

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44. *See* text & notes 3-6 *supra*.

45. Asher v. Reliance Ins. Co., 308 F. Supp. 847, 852 (N.D. Cal. 1970). *But see* Farmers Ins. Exch. v. Henderson, 82 Ariz. 335, 343, 313 P.2d 404, 409 (1957). Where the breach is considered tortious in nature and results from wanton or reckless conduct recovery may be granted for emotional distress and pain and suffering. *See* Uyemura v. Wick, 57 Haw. 102, —, 551 P.2d 171, 177-78 (1976) (recovery denied because breach did not entail wanton or reckless conduct).

46. *See, e.g.*, Continental Nat'l Bank v. Evans, 107 Ariz. 378, 382, 489 P.2d 15, 19 (1971); Hedworth v. Chapman, 135 Ind. App. 129, 133, 192 N.E.2d 649, 651 (1963); Burton v. Juzwik, 524 P.2d 16 (Okla. 1974). *See also* D. DOBBS, *supra* note 41, § 12.4, at 818-19. *But* see Crisci v. Security Ins. Co., 66 Cal. 2d 435, 426 P.2d 173, 58 Cal. Rptr. 13 (1967). For a discussion of mental distress as an element of damages in breach of contract actions, see Comment, *Recovery for Mental Anguish from Breach of Contract: The Need for an Enabling Statute*, 5 CAL. W.L. REV. 88 (1968).

47. 9 Exch. 341, 156 Eng. Rep. 145 (1845). In *Hadley*, a miller whose mill had broken down sent the broken shaft to a nearby town by carrier to get a replacement. The carrier did not get the shaft back within the agreed upon time and the mill was out of operation for several days. *Id.* at 341-42, 156 Eng. Rep. at 146. The Court of Exchequer did not allow recovery for loss of profits during this period because the carrier had not known what problems the delay would cause, and therefore would not be held liable for damages not "within the contemplation of the parties" at the time of contracting. *Id.* at 356, 156 Eng. Rep. at 151-52. The pertinent language of *Hadley* is:

> Where two parties have made a contract which one of them has broken, the damages which the other party ought to receive in respect of such breach of contract should be such as may fairly and reasonably be considered either arising naturally, i.e., according to the usual course of things, from such breach of contract itself, or such as may reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract, as the probable result of the breach of it. Now, if the special circumstances under which the contract was actually made were communicated by the plaintiffs to the defendants, and thus known to both parties, the damages resulting from the amount of injury which would ordinarily follow from a breach of contract under these special circumstances so known and communicated. But, on the other hand, if these special circumstances were wholly unknown to the party breaking the contract, he, at the most, could only be supposed to have had in his contemplation the amount of injury which would arise generally, and in the great multitude of cases not affected by any special circumstances, from such a breach of contract. For, had the special circumstances been known, the parties might have specially provided for the breach of contract by special terms as to the damages in that case; and of this advantage it would be very unjust to deprive them.

Id. at 354-55, 156 Eng. Rep. at 151.

48. 9 Exch. at 354-55, 156 Eng. Rep. at 151; *see* note 47 *supra*. *See also* Continental Plants Corp. v. Measured Marketing Serv. Inc., 274 Ore. 621, 625, 547 P.2d 1368, 1371 (1976); D. DOBBS, *supra* note 41, § 3.2, at 138-39.

General damages are damages commonly caused by the breach of the sort of agreement involved and are said to flow naturally from such a breach. Prince v. Peterson, 538 P.2d 1325, 1328 (Utah 1975). Special damages also flow from the breach, but differ from general damages in that they are particular to the instant plaintiff and breach, and are not common to actions on similar breaches. Cohn v. J.C. Penney Co., 537 P.2d 306, 307 (Utah 1975).

general damages are not recoverable unless they can reasonably be considered to arise and flow generally from the breach of contract,[49] and special damages are not recoverable unless they were "within the contemplation of the parties" at the time of the contract.[50]

Arguably, mental distress can be characterized as general damages because such distress might be considered common to all breaches of confidentiality by psychotherapists.[51] It can be presumed reasonably that mental distress and psychological damage will naturally flow from a breach of a patient's expectation of confidentiality. Mental distress may also come under special damages. Because a patient and psychotherapist form a therapeutic relationship for the purpose of dealing with mental distress, and because of the great concern of patients for confidentiality, it is not unreasonable to find that mental distress caused by a breach of confidentiality was within the contemplation of the parties at the time of the agreement.[52] Thus, the showing of an implied contractual provision for confidentiality could be considered prima facie proof of contemplation of damages for mental distress.

Even if damages for mental distress may be awarded in a contract action for breach of confidentiality, however, the lack of availability of punitive damages remains a problem. Punitive damages are aimed at punishment and deterrence.[53] For this reason, they have been traditionally awarded by the courts only where the defendant has engaged in willful, malicious, or reckless conduct.[54] As a general rule, however, punitive damages are not awarded in contract.[55] Without an award of

49. 9 Exch. at 354, 156 Eng. Rep. at 151; *see* Jacob v. Miner, 67 Ariz. 109, 116, 191 P.2d 734, 738 (1948); Apperson v. Security State Bank, 215 Kan. 724, 735-36, 528 P.2d 1211, 1220 (1974).

50. 9 Exch. at 354-55, 156 Eng. Rep. at 151. The phrase "contemplation of the parties" has been construed to mean foreseeability; the damage must have been reasonably foreseeable to the parties at the time of the formation of the contract. *See* La Villa Fair v. Lewis Carpet Mills, Inc., 219 Kan. 395, 406, 548 P.2d 825, 834 (1976); Continental Plants Corp. v. Measured Marketing Serv. Inc., 274 Ore. 621, 625-26, 547 P.2d 1368, 1371 (1976). *See also* J. MURRAY, *supra* note 22, § 12.3, at 804, where the author states that the use of the word "foreseeable" in the context of contract law is misleading.

51. *See generally* text & notes 1-6 *supra.*

52. The contract need not be express in order to bring the "contemplation of the parties" rule into play. *See* Stewart v. Rudner, 349 Mich. 459, 471-72, 84 N.W.2d 816, 823 (1957) (damages for the wrongful death of a child at birth). Damages for mental distress have been upheld as impliedly contemplated in situations where the contract was not associated with business, *id.* at 472-73, 84 N.W.2d at 825, or where the contract had a nonpecuniary purpose. *See* D. DOBBS, *supra* note 41, § 12.4, at 819-21.

53. Ahmed v. Collins, 23 Ariz. App. 55, 58, 530 P.2d 900, 904 (1975); Midwest Supply Inc. v. Waters, 89 Nev. 210, 213, 510 P.2d 876, 878 (1973). *See* D. DOBBS, *supra* note 41, § 319, at 204-05. *Cf.* Farmer's Ins. Exch. v. Henderson, 82 Ariz. 335, 343, 313 P.2d 404, 409 (1957) (damages for pain and suffering awarded only where contract breach causes mental suffering for reasons other than the pecuniary loss).

54. Salt River Valley Water Users' Ass'n v. Giglio, 113 Ariz. 190, 202, 549 P.2d 162, 174 (1976); Ford v. Guarantee Abstract & Title Co., 220 Kan. 244, —, 553 P.2d 254, 269 (1976); Kesler v. Rogers, 542 P.2d 354, 359 (Utah 1975).

55. Gonzales v. Allstate Ins. Co., 217 Kan. 262, 265, 535 P.2d 919, 922 (1975);

such damages a psychotherapist who breaches the confidentiality of a patient, through gossip or other reckless behavior,[56] but causes only nominal damages, will face a financially inconsequential penalty. To the extent that such damages are unavailable, the utility of the contract cause of action is reduced.

This problem is ameliorated somewhat by recent decisions which permit punitive damages where the breach is in reckless or wanton disregard of a party's rights,[57] or the breach results in tortious injury.[58] The problem also may be vitiated if the action for breach of confidentiality is treated as a hybrid, combining features of tort and contract,[59] with the tort growing out of the breach of a duty established by the contractual relationship. This hybrid theory has been upheld in an action for damages for breach of a contract imposing a duty to give notice of an act,[60] in actions for breach of promise to marry,[61] and in malpractice actions.[62] Allowing the use of such a hybrid notion in actions by patients against psychotherapists for breach of confidentiality would impart a degree of flexibility to award punitive damages if warranted by the circumstances, and would allow recovery for mental distress where necessary to compensate the plaintiff.[63]

Z.D. Howard Co. v. Cartwright, 537 P.2d 345, 347 (Okla. 1975); *see* Furniss v. Fitchett, [1958] 77 N.Z.L.R. 396, 400-01. The New Zealand Supreme Court stated that punitive damages are not available in contract, such as in an action by a patient against a physician for breach of confidentiality. *Id.* *See also* D. DOBBS, *supra* note 41, § 12.4, at 818.

56. *See* discussion note 3 *supra*.

57. State Farm Gen. Ins. Co. v. Clifton, 86 N.M. 757, 759, 527 P.2d 798, 800 (1974); Sierra Blanca Sales Co. v. Newco Indus., Inc., 88 N.M. 472, 475, 542 P.2d 52, 55 (Ct. App. 1975).

58. Dold v. Outrigger Hotel, 54 Hawaii 18, 22, 501 P.2d 368, 372 (1972) (where contract is breached in a wanton or reckless manner the aggrieved may recover in tort).

59. *See* Rainer v. Grossman, 31 Cal. App. 3d 539, 543, 107 Cal. Rptr. 469, 471 (1973) ("In the usual case of medical malpractice the duty of care springs from the physician-patient relationship which is basically one of contract."); Giambozi v. Peters, 127 Conn. 380, 385, 16 A.2d 833, 835 (1940) (An action for malpractice presents a claim of a hybrid nature. In one aspect, it may be viewed as based upon negligence; in another aspect as based upon breach of contract."); Dowell v. Mossberg, 226 Ore. 173, 190, 359 P.2d 541, 543 (1961) ("[T]he unspoken contractual relationship between a physician and patient is a matter of inducement in a malpractice action, . . . Failure to exercise due care in the treatment of a patient is a breach of a legal duty which arises, not out of contract, but out of the relationship of physician and patient.").

60. Iowa Power & Light Co. v. Abild Constr. Co., 259 Iowa 314, 337, 144 N.W.2d 303, 316-17 (1966): "It is not a suit for breach of contract, but an action for damages alleged to have been sustained by [plaintiff] because [defendant] failed to perform the duties assumed by it under the claimed agreement. . . . [I]t is an action sounding in tort."

61. American courts have stated that while an action for breach of promise to marry lies in contract, damages are awarded as in tort actions. Syfort v. Solomon, 95 Cal. App. 228, 237, 272 P. 811, 814 (Ct. App. 1928); *see* Note, *supra* note 34, at 35-36.

62. Rainer v. Grossman, 31 Cal. App. 3d 539, 543, 107 Cal. Rptr. 469, 471 (1973); Giambozi v. Peters, 127 Conn. 380, 385, 16 A.2d 833, 835 (1940); Dowell v. Mossberg, 226 Ore. 173, 190, 359 P.2d 541, 543 (1961). *But cf.* ARIZ. REV. STAT. ANN. § 12-562 (c) (1976) (no malpractice action may be based upon breach of contract unless the contract is in writing).

63. Even if punitive damages are permitted, the weight of authority indicates that

It is clear that an action may be brought in contract by a patient against his therapist for breach of confidentiality, since a contract and its terms may be implied from the nature of the relationship and the conduct of the parties. Although under traditional legal theory, damages for mental distress and punitive damages are not available in contract, modern theory will permit damages for mental distress, and an alternative pleading in tort may permit punitive damages. This form of action has the advantage of not requiring proof of negligence;[64] a mere showing of a contract and a breach will suffice. However, while contract provides an effective cause of action, other causes of action may be pleaded alternatively—each with certain advantages and disadvantages.

BREACH OF FIDUCIARY DUTY

Less restrictive in terms of technical requirements for the establishment of a legal relationship, but still problematic in the area of damages, is a cause of action based on a breach of fiduciary duty owed by the psychotherapist to his patient. The terms "fiduciary relation" and "confidential relation" are both used to denote a relationship wherein one party places his trust in another party with the understanding that the latter will act with regard to the former's interest.[65] Essentially, where such a relationship exists, a duty of loyalty is created. The fiduciary duty of loyalty was originally imposed on the trustee of a trust, for three reasons: The trust relationship is easily exploited; a trustee

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they will be awarded only where there are actual compensatory damages. *See* Continental Nat'l Bank v. Evans, 107 Ariz. 378, 381, 489 P.2d 15, 18 (1971); Contractor's Safety Ass'n v. California Compensation Ins. Co., 48 Cal. 2d 71, 77, 307 P.2d 626, 629 (1957). However, where the action is in equity rather than at law, punitive damages have been awarded although no compensatory damages could be recovered. *See* Starkovich v. Noye, 111 Ariz. 347, 529 P.2d 698 (1975) (action for reformation of contract where defendant acted fraudulently), *noted in* "Punitive Damages Awarded in Equity Without Compensatory Damages," 17 ARIZ. L. REV. 639, 873 (1975).

64. For a discussion of negligence and the malpractice standard, see text & notes 113-16 *infra*.

65. *See, e.g.*, Mattingly v. Sisler, 198 Okla. 107, 110, 175 P.2d 796, 799 (1946) (buyer-seller relationship in real property transfer termed confidential relationship); Lockett v. Goodill, 71 Wash. 2d 654, 656, 430 P.2d 589, 591 (1967) (physician-patient relationship termed fiduciary relationship); Hunter v. Brown, 4 Wash. App. 899, 905-06, 484 P.2d 1162, 1166 (1971) (physician-patient relationship termed fiduciary relationship), *aff'd*, 81 Wash. 2d 465, 502 P.2d 1194 (1972). *See also* G. BOGERT, TRUSTS AND TRUSTEES § 482 (2d ed. 1960); Bogert, *Confidential Relations and Unenforceable Express Trusts*, 13 CORNELL L.Q. 237, 248 (1928).

Courts often use the term "confidential relationship" rather than "fiduciary relationship" where no formal trust is involved, but an element of trust and dependence is present. *See, e.g.*, Ostertag v. Donovan, 65 N.M. 6, 13, 331 P.2d 355, 356 (1958) (using both terms); Penn v. Barret, 273 Ore. 471, 474-75, 541 P.2d 1282, 1285 (1975); Jardine v. Archibald, 3 Utah 2d 88, 92, 279 P.2d 454, 456 (1955) (using both terms). Regardless of whether the term fiduciary or confidential is used, or whether the court chooses simply to describe the relationship the responsibility of the physician is the same. *Accord*, Laubner v. Altick, 9 Ariz. App. 510, 511, 454 P.2d 180, 181 (1969) ("relationship between physician and client is that of confidence and trust"). In this Note, the terms will be treated as having the same meaning.

with a conflict of interest might be tempted to exploit the trust;[66] and the opportunity to discover such exploitation is remote.[67] The fiduciary duty also has been imposed in other situations susceptible of easy secret exploitation, even where there is no formal trust.[68] The law will recognize a fiduciary relationship where there is great intimacy between the parties and where one person has reposed his trust and confidence in the other because of the other's superior position.[69]

A psychotherapist-patient relationship is one where the patient places his trust and confidence in his therapist. Because a psychotherapist usually does not become involved with his patient's finances, there is usually no opportunity for him to exploit the relationship in a pecuniary way; however, the relationship has been described as a fiduciary one.[70] The particular professional status of the psychiatrist, psychologist, or social worker has little to do with the need for a trusting rela-

66. *See, e.g.*, Dowdy v. Jordan, 128 Ga. App. 200, 196 S.E.2d 160 (1973) (guardian found to have a conflict of interest with his ward due to his position as joint tenant with right of survivorship with respect to certain funds and therefore he was held accountable for the funds); Hawaiian Int'l Fins., Inc. v. Pablo, 53 Hawaii 149, 488 P.2d 1172 (1971) (breach of fiduciary duty found where corporate officer and director, who was also a real estate broker acting as a purchaser of property for the corporation, retained commissions received from the brokers representing the sellers without disclosure to, or an agreement with, the corporation); *In re* Estate of La Grove, 31 App. Div. 2d 928, 299 N.Y.S.2d 80 (1969) (counsel for life interest beneficiary of testamentary trust found to have a conflict of interest when he joined with the trustee's attorney in accounting and other matters, and thus was denied compensation for his duties), *aff'd*, 30 N.Y.2d 624, 282 N.E.2d 329, 331 N.Y.S.2d 439 (1972).

67. G. BOGERT, *supra* note 65, § 543, at 475-82; Hoover, *Basic Principles Underlying Duty of Loyalty*, 5 CLEV.-MAR. L. REV. 7, 10 (1956).

68. *See, e.g.*, Edwardsen v. Morton, 369 F. Supp. 1359 (D.D.C. 1973) (federal government has a fiduciary duty to Alaskan natives); Ostertag v. Donovan, 65 N.M. 6, 331 P.2d 355 (1958) (confidential relationship between physicians and sick, aged patient); Hewett v. Bullard, 258 N.C. 347, 128 S.E.2d 411 (1962) (physician in a confidential relationship with patient he had been treating for 2 years). *See also* G. BOGERT, *supra* note 65, at 136.

69. In Hewett v. Bullard, 258 N.C. 347, 128 S.E.2d 411, 413 (1962), the heirs to the decedent's estate brought an action against the decedent's physician who had accepted a deed to real property in the estate. The Supreme Court of North Carolina upheld the trial court's judgment that the deed was void and stated that "[w]here a physician regularly treats a chronically ill person over a period of two years, a confidential relationship is established, raising a presumption that financial dealings between them are fraudulent." *Id.* at 349, 128 S.E.2d at 413. Similarly, in Ostertag v. Donovan, 65 N.M. 6, 331 P.2d 355 (1958) a physician who treated a woman for several years received stock certificates from her, in appreciation of his service, before she died. The estate's administrator sued the physician, and the court found that the presumption of undue influence was present because the confidential relationship between physician and patient was not overcome by the evidence. *Id.* at 14, 331 P.2d at 359-60. Finally, see Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 802 (N.D. Ohio 1965) where the court stated:

> [T]he patient necessarily reposes a great deal of trust not only in the skill of the physician but in his discretion as well. The introduction into the relationship of this aura of trust, and the expectation of confidentiality which results therefrom, imposes the fiduciary obligations upon the doctor. As a consequence, all reported cases dealing with this point hold that the relationship of physician and patient is a fiduciary one.

Id.

70. D. DAWIDOFF, THE MALPRACTICE OF PSYCHIATRISTS 44 (1973); Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025, 1050 (1975).

tionship. Rather, the one-to-one structure of therapy requires a similar role and similar responsibilities for all psychotherapists.[71] To determine whether the psychotherapist's fiduciary duty includes the duty of confidentiality, an analogy to the general law of medicine is again appropriate.

It has long been asserted by both courts and legal writers that due to the patient's placing his trust in the physician, a fiduciary relationship exists between physician and patient.[72] In order to allow the physician-fiduciary to become completely apprised of the patient's condition, the physician-patient relationship imposes a duty of confidentiality upon physicians.[73] Because the patient of a psychotherapist often must communicate much more sensitive material than that which is entrusted to physicians,[74] this rationale has even greater strength when applied to the psychotherapist-patient relationship. Thus, if a physician-patient relationship imposes a fiduciary duty upon physicians, it is imposed a fortiori upon psychotherapists. Even if a fiduciary duty is imposed, however, the problem arises as to what remedies are available.

Since a breach of the duty of confidentiality will constitute a breach of a fiduciary relationship, the breach may constitute a tort.[75]

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71. *See* text & notes 7-19 *supra*.

72. Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 796-97 (N.D. Ohio 1965); Ostertag v. Donovan, 65 N.M. 6, 13, 331 P.2d 355, 359 (1958); Hewett v. Bullard, 258 N.C. 347, 349, 128 S.E.2d 411, 413 (1962); Alexander v. Knight, 25 Pa. D. & C. 2d 649, 655, 177 A.2d 142, 146 (Sup. Ct. 1962); *see* D. DAWIDOFF, *supra* note 61, at 43-44; Note, *Confidential Relationships: Does the Law Require Silence Outside the Courtroom?*, 6 UTAH L. REV. 380, 385 (1959); 34 HARV. L. REV. 312, 313 (1921).

73. Emmett v. Eastern Dispensary & Cas. Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967) ("The responsibilities of physicians and hospitals to protect their patients' medical facts from extrajudicial exposure spring from the confidential nature of the relationship."); Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801, 803 (N.D. Ohio 1965) ("[T]he doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission."); Cannell v. Medical & Surgical Clinic, 21 Ill. App. 3d 383, 385, 315 N.E.2d 278, 280 (1974) ("It is our opinion that the 'fiducial qualities of the physician-patient relationship' . . . require the disclosure of medical data to patient or his agent on request."). *See* R. MORRIS & A. MORITZ, DOCTOR AND PATIENT AND THE LAW 138-41 (1971).

74. *See* M. GUTTMACHER, PSYCHIATRY AND THE LAW 272 (1952); Slovenko, *supra* note 1. *Cf.* Allred v. State, 554 P.2d 411, 417 (Alas. 1976) ("Patients often make statements in psychotherapy which they would not make to even the closest members of their families."); *In re* Lifschutz, 2 Cal. 3d 415, 425, 467 P.2d 557, 563, 85 Cal. Rptr. 829, 833 (1970) ("because of the peculiar nature of psychotherapy, the debilitating effect of disclosure is particularly acute").

75. RESTATEMENT OF TORTS § 874 (1934). *See* Stacy v. Pantano, 177 Neb. 694, 697, 131 N.W.2d 163, 165 (1964); Hunter v. Brown, 81 Wash. 2d 465, 502 P.2d 1194 (1972); Lockett v. Goodill, 71 Wash. 2d 654, 430 P.2d 589 (1967). *See also* D. DAWIDOFF, *supra* note 70, at 48; Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 702-03, where it is argued that the relationship imposes upon a psychiatrist the duty to conduct himself with a high degree of skill and care, and if he does not, the failure to do so will be a breach of his fiduciary duty, forming the basis of a malpractice action. *But see* Demers v. Gerety, 85 N.M. 641, 515 P.2d 645 (Ct. App. 1973), *rev'd on other grounds*, 86 N.M. 141, 520 P.2d 869, *on remand*, 87 N.M. 52, 529 P.2d 278 (Ct. App. 1974). In *Demers*, which involved the question of informed consent to an operation, the court of appeals originally stated that a physician has a fiduciary duty to the patient, and that a breach of that duty would void a contract with the patient as against public policy. 85 N.M. at 645, 515 P.2d at 649. However,

Accordingly, a tort measure of damages may be applied.[76] However, restitution, the traditional remedy for breach of a fiduciary relationship,[77] is inapplicable to breaches of confidentiality by psychotherapists. Under the restitutionary remedy, which has been employed against physicians who breach their fiduciary duty to patients,[78] the fiduciary is prevented from unjustly profiting from his position of trust and all profits gained from that position must be given up.[79] This remedy has served well in instances where physicians have breached fiduciary duties to their patients, since such breaches often result in pecuniary gain to the wrongdoer.[80] However, because a breach of confidentiality by the psychotherapist is more likely to cause mental distress to the patient than pecuniary enrichment to the psychotherapist, a remedy designed to compensate the patient will be necessary, rather than one designed to disgorge the defendant's gains. Thus, the action for breach of fiduciary duty which is a creature of the equity courts[81] does not seem to benefit the psychotherapy patient whose therapist discloses confidential information, even where he can prove damages caused by the breach.[82]

It may be possible, however, to recover punitive damages for breach of a fiduciary duty where the action of the fiduciary is particularly offensive. Punitive damages have traditionally been denied in

on remand the court said that it did not intend to apply the whole law of fiduciaries to medical malpractice such that the burden of proof shifted from the plaintiff, where it rests in malpractice, to the defendant physician, where it would rest for breach of fiduciary duty. 87 N.M. at 54, 529 P.2d at 280. The situation is analogous to that where a tort action is found and tort damages imposed for breach of a duty established by contract. *See* text & note 60 *supra*.

76. RESTATEMENT OF TORTS § 874, Comment b (1934).

77. RESTATEMENT OF RESTITUTION § 200 (1937); *see, e.g.*, Broomfield v. Kosow, 349 Mass. 749, 212 N.E.2d 556 (1965); Peoples First Nat'l Bank & Trust Co. v. Ratajski, 399 Pa. 419, 160 A.2d 451 (1960); Holloway v. International Bankers Life Ins. Co., 354 S.W.2d 198 (Tex. Civ. App. 1962). *See also* D. DOBBS, *supra* note 41, § 10.4, at 684. For the standard remedies for breach of fiduciary duty by a trustee, see RESTATEMENT (SECOND) OF TRUSTS § 205 (1959), which states:

> If the trustee commits a breach of trust, he is chargeable with
>
> (a) any loss or depreciation in value of the trust estate resulting from the breach of trust; or
>
> (b) any profit made by him through the breach of trust; or
>
> (c) any profit which would have accrued to the trust estate if there had been no breach of trust.

78. *See* Ostertag v. Donovan, 65 N.M. 6, 331 P.2d 355 (1958) (stock transaction whereby physician of deceased patient received stock certificates voided in action by administrator); Hewett v. Bullard, 258 N.C. 347, 128 S.E.2d 411 (1962) (deed giving estate to physician of decedent-patient set aside in action by heirs). *See also* text & notes 40-41 *supra*.

79. *See* cases cited note 78 *supra*. *Cf.* Broomfield v. Kosow, 349 Mass. 749, 755, 212 N.E.2d 556, 560 (1965) ("Equity will, in sum, weigh whether unjust enrichment results from the relationship.").

80. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793 (N.D. Ohio 1965) (plaintiff's chances for recovery in a different suit lessened); Clark v. Geraci, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960) (plaintiff dismissed from job).

81. Rader v. Boyd, 252 F.2d 585, 587 (10th Cir. 1957); Garnver v. Boyd, 330 F. Supp. 22, 26 (N.D. Tex. 1970); Cook County v. Barrett, 36 Ill. App. 3d 623, 632, 344 N.E.2d 540, 549 (1975).

82. *See* D. DOBBS, *supra* note 41, § 10.1, at 653.

equity,[83] but modern cases are indicative of a contrary rule.[84] In fact, several cases have permitted exemplary damages for violation of a fiduciary duty.[85] These cases reflect the lessening importance of the distinction between law and equity courts, and seem to treat the fiduciary duty cases under a tort approach. Arguably, the same reasoning could be used to justify recovery of compensatory damages for breaches of psychotherapist confidentiality. Absent this breakthrough, however, another cause of action will provide more protection for a patient so damaged.

INVASION OF THE RIGHT OF PRIVACY

A breach of confidentiality on the part of a psychotherapist is not only a breach of trust, but an infringement of the privacy of the patient.[86] An action in tort, then, for invasion of the right of privacy, is possible. Although there are four subcategories of the tort,[87] only one is applicable to breaches of confidentiality: "public disclosure of

83. *See, e.g.*, Dekle v. Vann, 284 Ala. 142, 144, 223 So. 2d 30, 31 (1969); Carl v. Craft, 258 So. 2d 237, 241 (Miss. 1972); Pedah Co. v. Hunt, 265 Ore. 433, 434-36, 509 P.2d 1197, 1198 (1973). *See also* D. DOBBS, *supra* note 41, § 3.9, at 211-12.

84. *See, e.g.*, Security-First Nat'l Bank v. Lutz, 297 F.2d 159, 165 (9th Cir. 1961); Martin v. Swenson, 335 F. Supp. 765, 768 (W.D. Mo. 1971); Starkovich v. Noye, 111 Ariz. 347, 352, 529 P.2d 698, 703 (1975), *noted in* "Punitive Damages Awarded in Equity Without Compensatory Damages," 17 ARIZ. L. REV. 639, 873 (1975).

85. *See, e.g.*, Rivero v. Thomas, 86 Cal. App. 2d 225, 194 P.2d 533 (Ct. App. 1948); Fowler v. Benton, 245 Md. 540, 552-53, 226 A.2d 556, 564, *cert. denied*, 389 U.S. 851 (1967); Russell v. Stoops, 106 Md. 138, 143-44, 66 A. 698, 700 (1907).

86. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793 (N.D. Ohio 1965), in which the court declared:

> When a patient seeks out a doctor and retains him, he must admit him to the most private part of the material domain of man. Nothing material is more important or more intimate to man than the health of his mind and body. Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultations with his doctor—even that which is embarrassing, disgraceful or incriminating. To promote full disclosure, the medical profession extends the promise of secrecy referred to above. The candor which this promise elicits is necessary to the effective pursuit of health; there can be no reticence, no reservation, no reluctance when patients discuss their problems with the doctors. But the disclosure is certainly intended to be private. If a doctor should reveal any of these confidences, he surely effects an invasion of the privacy of his patient. We are of the opinion that the preservation of the patient's privacy is no mere ethical duty upon the part of the doctor; there is a legal duty as well. The unauthorized revelation of medical secrets, or *any* confidential communication given in the course of treatment, is tortious conduct which may be the basis for an action in damages.

Id. at 801-02 (emphasis in original).

87. Prosser, *Privacy*, 48 CALIF. L. REV. 383, 389 (1960). The right to privacy tort has been divided into four categories allowing recovery for the different types of invasion: intrusion, appropriation, publicity which places the plaintiff in a false light in the public eye, and public disclosure of private facts. W. PROSSER, LAW OF TORTS § 117, at 804 (4th ed. 1971); RESTATEMENT (SECOND) OF TORTS §§ 652A-652D, at 88-90 (Tent. Draft No. 21, 1975). *But see* Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U.L. REV. 962 (1964), where the author disagrees with Prosser's division of the right to privacy into four areas, with no single value or interest protected. *Id.* at 971-72. Instead, the author espouses the idea that

private facts."[88] Three elements traditionally have been set forth as necessary to establish an actionable invasion of privacy for public disclosure of private facts: The facts must be private;[89] the disclosure must be made to more than a small group of persons;[90] and the disclosure must be one which would be offensive to a reasonable person of ordinary sensibilities.[91]

The cause of action is not dependent upon the existence of any special relationship between the plaintiff and defendant. Accordingly, it may be applied not only to physicians, but also to all types of psychotherapists. Indeed, as matters revealed to physicians or psychotherapists are likely to be regarded as private, disclosure presumably fulfills the private facts requirement. Since the physician-patient and psychotherapist-patient relationships are analogous, the manner in which the courts have dealt with invasion of privacy actions against physicians may provide insight into the parameters of the action against psychotherapists who breach confidentiality.[92]

While most cases dealing with an invasion of privacy claim against a physician have involved the publication of photographs or films of a patient,[93] the cause of action for publication of private facts is of course not limited to those situations. The facts may be problems expressed verbally to a physician during treatment.[94] Further, the re-

invasion of privacy is a single tort underpinned by the principle that an individual has a right to be free from affronts to human dignity. *Id.* at 1000-07.

88. W. PROSSER, *supra* note 87, at 807; RESTATEMENT (SECOND) OF TORTS § 652B, at 89 (Tent. Draft No. 21, 1975).

89. *See* Blount v. TD Publishing Corp., 77 N.M. 384, 389, 423 P.2d 421, 424 (1966); Hubbard v. Journal Publishing Co., 69 N.M. 473, 474-75, 368 P.2d 147, 148 (1962).

90. Santiesteban v. Goodyear Tire & Rubber Co., 306 F.2d 9, 11 (5th Cir. 1962); Harrison v. Humble Oil & Ref. Co., 264 F. Supp. 89, 92 (D.S.C. 1967). *See* W. PROSSER, *supra* note 87, at 809. Prosser states that the publication must be to more than a small group of people or the action will not lie "unless there is some breach of contract, trust or confidential relation which will afford an independent basis for relief." *Id.* at 810. *But see* Bloustein, *supra* note 87, at 981. This statement by Prosser has been interpreted to mean that where breach of contract and breach of fiduciary duty claims are also raised, and provide independent bases for relief, an action for invasion of privacy may also be brought. 26 ALA. L. REV. 485, 490 n.28 (1974). Another possible interpretation may be simply that independent causes of action may be brought even though a cause of action for invasion of privacy fails.

91. Reed v. Real Detective Publishing Co., 63 Ariz. 294, 305, 162 P.2d 133, 139 (1945); Meetze v. Associated Press, 230 S.C. 330, 336, 95 S.E.2d 606, 610 (1956).

92. Psychiatrists are physicians, so the cases involving breach of confidentiality by physicians are directly applicable to them. *See* discussion note 8 *supra*. When a psychiatrist is conducting psychotherapy, however, his relationship with his patient is more similar to the patient-therapist relationships maintained by nonphysician psychotherapists than the relationship maintained by medical physicians with their patients. See text & notes 1, 7-19 *supra*. Since the patient's need for confidentiality for successful therapy remains the same regardless of the status of the psychotherapist, the invasion of privacy action should be applicable against psychologists and social workers.

93. *See, e.g.*, Bazemore v. Savannah Hosp., 171 Ga. 257, 155 S.E. 194 (1930); Lambert v. Dow Chem. Co., 215 So. 2d 673 (La. App. 1968); Griffin v. Medical Soc'y, 7 Misc. 2d 549, 11 N.Y.S.2d 109 (Sup. Ct. 1939); Note, *Medical Practice and the Right to Privacy*, 43 MINN. L. REV. 943, 947 (1959).

94. *See* Horne v. Patton, 291 Ala. 701, 287 So. 2d 824 (1973); Alexander v. Knight, 25 Pa. D. & C. 2d 649, 655, 177 A.2d 142, 146 (1962).

quirement that a large number of people be involved in the disclosure has been broadly construed. Indeed, at least one court was so liberal in applying the invasion of privacy action against a physician that divulgence of a patient's problem to one other person was sufficient publication.[95] Thus, the significant factor was the act of disclosure and its subsequent effect rather than the number of people to whom the disclosure is made.

The third element of the cause of action for invasion of privacy, that the information disclosed be offensive to a person of ordinary sensibilities, is not so liberally construed as the other two and must still be met. The problem thus arises that while the disclosure may be objectionable and upsetting to the person undergoing therapy, it may not be offensive to a person of ordinary sensibilities.[96] Because the meaning of "person of ordinary sensibilities" has not been clearly explained in any decision,[97] the phrase may not include the special sensibilities of a patient in therapy.[98]

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95. *See* Horne v. Patton, 291 Ala. 701, 709-10, 287 So. 2d 824, 830-31 (1973). *But see* Beaumont v. Brown, 65 Mich. App. 455, 237 N.W.2d 501 (1975), where disclosure to more than one person did not constitute invasion of privacy because a "large number of persons" were not involved, even though the information "leaked" from person to person through supportive personnel of the sender and receiver of a letter to a "few" people. *Id.* at 464, 237 N.W.2d at 506.

96. *See* Cameron, *Paranoid Conditions and Paranoia,* in III AMERICAN HANDBOOK OF PSYCHIATRY 676, 680-91 (2d ed. S. Arietei & E. Brody eds. 1974); Cameron, *Psychotic Disorders,* in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 665, 668-72 (A. Freedman ed. 1967); Linn, *Clinical Manifestations of Psychiatric Disorders,* in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* at 546, 555-56.

97. In Virgil v. Time, Inc., 527 F.2d 1122 (9th Cir. 1975), *cert. denied,* 425 U.S. 998 (1976), the court expressly left open as a question of fact whether the particular invasion of privacy in the case was highly offensive to a reasonable person of ordinary sensibilities. *Id.* at 1131. In Motschenbacher v. R.J. Reynolds Tobacco Co., 498 F.2d 821 (9th Cir. 1974), the court merely pointed out that

> [t]he gist of the cause of action in a privacy case is not injury to the character or reputation, but a direct wrong of a personal character resulting in injury to the feelings without regard to any effect which the publication may have on the property, business, pecuniary interest, or the standing of the individual in the community.

Id. at 824 (quoting Fairfield v. American Photocopy Equip. Co., 138 Cal. App. 2d 82, 86, 291 P.2d 194, 197 (1955)). Some courts, such as the Kansas Supreme Court in Atchison, T. & S.F. Ry. v. Lopez, 216 Kan. 108, 124, 531 P.2d 455, 469 (1975), cite the standard given in the RESTATEMENT (SECOND) OF TORTS § 652D (Tent. Draft. No. 13, 1975), that the invasion must be "highly offensive to a reasonable man." In Bitsie v. Walston, 85 N.M. 655, 515 P.2d 659 (Ct. App. 1973), the court did elaborate slightly: "The right of privacy is to be applied to the individual of ordinary sensibilities, not the super-sensitive." *Id.* at 658, 515 P.2d at 662 (quoting Blount v. TD Publishing Corp., 77 N.M. 384, 388, 423 P.2d 421, 424 (1966)).

If the New Mexico rule is applied, the "super-sensitivity" of a patient in therapy would not be compensable unless an exception to the rule is made where the sensitivity is known to the tortfeasor. The facts of *Bitsie,* however, indicate that even if such special conditions are known, the applicable standard does not change. In *Bitsie,* the special attitude of the Navajo people toward the type of privacy invasion that occurred was viewed by the plaintiff as important to show that sensibilities had been offended. 85 N.M. at 658, 515 P.2d at 662. The court however, refused to take these traditional beliefs into account, and instead looked at the standards of the New Mexico community.

98. The special sensitivities of a patient in therapy cannot be determined by use of the "reasonable man test" applied in tort law, W. PROSSER, *supra* note 87, § 32,

Because invasion of privacy itself is the actionable tort and injury from it is essentially mental and subjective, damages for mental distress

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because the test of "a reasonable man who goes to a psychiatrist" would either be too broad to constitute a standard or too narrow to encompass those who would be most upset by disclosure. See discussion in note 86 *supra*. However, if the therapist willfully or recklessly discloses the information, with knowledge that this patient will hear about the disclosure and become upset as a result, the patient may have a remedy for the tort of intentional infliction of mental distress. RESTATEMENT (SECOND) OF TORTS § 46, at 71-72 (1965). This tort is established where it is shown that a person acted in such a way that an average member of the community would consider the conduct outrageous, and damage is caused by this conduct. Linsenmeyer v. Hancock, 23 Ariz. App. 444, 447, 533 P.2d 1181, 1184 (1975); Dawson v. Associates Financial Serv. Co., 215 Kan. 814, 822, 529 P.2d 104, 109-10 (1974); *see* RESTATEMENT (SECOND) OF TORTS § 46, comment d, at 72-73 (1965). Everyday insults and indignities are not deemed actionable. *See* Hess v. Frank, 47 App. Div. 2d 889, 367 N.Y.S.2d 30 (1975), where a psychiatrist was held not liable for verbal abuse he gave his patient for failing to pay his bill. *Id.* at 890, 367 N.Y.S.2d at 31. The standard of conduct is what is reasonable under the circumstances. Leigh v. Lundquist, 540 P.2d 492, 494 (Alas. 1975); Morris v. Ortiz, 103 Ariz. 119, 121, 437 P.2d 652, 654 (1968). However, the circumstances to be considered may include the psychotherapist's knowledge of a patient's sensitivity. *Cf.* Carrigan v. Henderson, 192 Okla. 254, 135 P.2d 330, 332 (1943) (repossession case where court found that a cause of action for mental distress from verbal abuse would lie if defendant could be found to have had knowledge of plaintiff's condition, but that there existed no such knowledge in this case); W. PROSSER, *supra* note 87, § 12, at 58 (where plaintiff is especially susceptible and vulnerable, and defendant has knowledge of this condition, a cause of action will lie if the defendant causes the plaintiff mental anguish). Thus, the degree to which such conduct will be considered outrageous may be affected by the relationship between the plaintiff and defendant, so that a fiduciary may inflict mental distress where it might otherwise not be inflicted. *See* text & notes 65-69 *supra*.

There must be foreseeable mental distress flowing from the invasion. Gallela v. Onassis, 353 F. Supp. 196, 230 (S.D.N.Y. 1972); Mitran v. Williamson, 21 Misc. 2d 106, 109, 197 N.Y.S.2d 689, 692 (Sup. Ct. 1960). Further, there need not be personal malice or ill will if the defendant's conduct is wanton or reckless. Gallela v. Onassis, 353 F. Supp. 196, 230 (S.D.N.Y. 1972). Even so, the use of this tort against psychotherapists is difficult, because a psychotherapist's extrajudicial disclosure even if made carelessly, may still not reach the level of recklessness or have the requisite intent. In Steiner & Munach v. Williams, 334 So. 2d 39 (Fla. App. 1976), the defendant, a medical professional association, was sued by a patient for sending a bill to him that the patient's insurance company was supposed to take care of, causing the patient severe mental distress. Even though the conduct was in violation of a Florida statute prohibiting the collection of debts by using a communication resembling a legal complaint, the court concluded that the element of wanton and outrageous conduct was lacking because there was no showing that the anesthesiologist who sent the bill could know what effect his communication would have. *Id.* at 42. It appears that unless a disclosure is calculated to cause mental distress, or unless it is blatantly reckless, the tort of intentional infliction of mental distress will not be established.

The relatively new tort of negligent infliction of mental distress is even more difficult to establish. Courts are reluctant to award damages without accompanying physical harm. Chriss v. Manchester Ins. & Indem. Co., 308 So. 2d 803, 805 (La. App. 1975); Ledisco Financial Servs. v. Viracola, 533 S.W.2d 951, 957 (Tex. Civ. App. 1967); W. PROSSER, *supra* note 87, § 54. However, with the abolition, in some jurisdictions, of the "impact rule," Leong v. Takasaki, 55 Hawaii 398, 407, 520 P.2d 758, 762 (1974), and the "zone of danger" rule, Dillon v. Legg, 68 Cal. 2d 728, 747, 441 P.2d 912, 925, 69 Cal. Rptr. 72, 85 (1968), some courts have indicated a willingness to continue the trend and give compensation where there is no physical harm. *See* Jarchow v. Transamerica Title Ins. Co., 48 Cal. App. 3d 917, 122 Cal. Rptr. 470 (1975), where, although the court noted that the California Supreme Court had not yet permitted recovery for negligently inflicted emotional distress where the mental injury was the only damage caused by the defendant's wrongful conduct, *id.* at 937 n.11, 122 Cal. Rptr. at 484 n.11, it did say that "interference with one's legally protected interests is sufficient damage to satisfy the [substantial damage] test set forth in [Crisci v. Security Ins. Co., 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967)], and to guard against potentially fraudulent emotional distress claims." 48 Cal. App. 3d at 937, 122 Cal. Rptr. at 484. *See also* Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (Sup.

are permitted without any showing of physical injury.[99] The tort is characterized by the courts as willful;[100] a negligent invasion of privacy has been deemed not compensable,[101] although a showing of maliciousness is not required. Apparently because of the public policy favoring patient confidentiality and the fiduciary duty imposed upon a physician to his patient, a cause of action for invasion of privacy has been upheld against a physician who breached his duty of confidentiality.[102] Further, it appears that where a fiduciary duty of confidentiality exists, the courts may not strictly construe the willfulness standard, and a breach of confidentiality may constitute an actionable invasion of privacy.[103]

In evaluating whether a particular disclosure warrants imposition of liability for invasion of privacy, the court must balance against the right of privacy any public interests in disclosure.[104] Traditional application of invasion of privacy reasoning has upheld disclosures by a patient's medical doctor in his role as a creditor, and by the doctor to the patient's spouse.[105] Such reasoning cannot be automatically applied when the patient is asserting a breach of confidentiality by a psychotherapist, unless the public would otherwise be endangered.[106] Unlike the physician-patient relationship, the therapist-patient relationship relies on absolute trust and secrecy, perhaps even as to the fact

Ct. 1976), where the court allowed damages for mental distress in a malpractice action against a psychiatrist who had engaged in sexual intercourse with his patient. The court, in ruling on the trial court's dismissal of the cause of action after the plaintiff's opening statement, stated: "By alleging that his client's mental and emotional status was adversely affected by this deceptive and damaging treatment, plaintiff's counsel asserted a viable cause of action for malpractice in his opening statement." *Id.* at 893, 381 N.Y.S.2d at 588.

99. Fergerstrom v. Hawaiian Ocean View Estates, 50 Hawaii 374, 376-77, 441 P.2d 141, 143 (1968); McCormick v. Haley, 37 Ohio App. 2d 73, 78, 307 N.E.2d 34, 37 (1973); Billings v. Atkinson, 489 S.W.2d 858, 859 (Tex. Civ. App. 1973).

100. *See* Cluff v. Farmers Ins. Exch., 10 Ariz. App. 560, 564, 460 P.2d 666, 670 (1969); McCormick v. Haley, 37 Ohio App. 2d 73, 78, 307 N.E.2d 34, 38 (1973).

101. McCormick v. Haley, 37 Ohio App. 2d 73, 78, 307 N.E.2d 34, 38 (1973).

102. *See* Horne v. Patton, 291 Ala. 701, 709, 287 So. 2d 824, 830 (1973). *See also* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801-02 (N.D. Ohio 1965).

103. The courts have imposed a limitation on the action for invasion of privacy which may operate in the context of psychotherapist disclosure. Where competing public interests weigh in favor of disclosure, it has been held that the cause of action for invasion of privacy is not established. In Patton v. Jacobs, 118 Ind. App. 358, 78 N.E.2d 789 (1948), for example, the court held that a creditor-physician was justified in revealing his patient's debt to the patient's employer. The courts have given creditors a certain degree of latitude in collecting debts, and generally do not find an invasion of privacy unless the creditor has blatantly harassed the debtor or otherwise acted in bad faith. *See, e.g.*, Dawson v. Associates Financial Serv. Co., 215 Kan. 814, 822, 529 P.2d 104, 113 (1974); Vogel v. W.T. Grant Co., 458 Pa. 124, 130, 327 A.2d 133, 137-38 (1974); Lewis v. Physicians & Dentists Credit Bureau, 27 Wash. 2d 267, 273, 177 P.2d 896, 899 (1947).

A second instance where disclosure is found to be justified is where a physician reveals a patient's physical condition to the patient's spouse. *See* Tooley v. Provident Life & Accident Ins. Co., 154 So. 2d 617 (La. App. 1963); Curry v. Corn, 52 Misc. 2d 1035, 277 N.Y.S.2d 470 (Sup. Ct. 1966).

104. See discussion note 103 *supra.*

105. *See* discussion note 103 *supra.*

106. In California, the dangerous patient issue has been decided in favor of disclos-

of treatment.[107] Because of the general societal prejudice against persons with mental disorders,[108] disclosure of a debt by a therapist-creditor to the patient's employer might well be seriously damaging to the effectiveness of future therapy, trust in the therapeutic relationship, and possibly the patient's employment. Moreover, disclosure to a spouse could have even more severe consequences; both the patient and the viability of his marriage could be damaged if the patient's spouse were informed of his partner's mental condition.[109] Such disclosures should therefore be made only after a careful weighing of the facts.

In weighing the arguments for and against keeping confidentiality, the therapist should look at the nature and necessity of disclosure, the effect disclosure might have on the patient, and any other facts particular to the case.[110] The test for liability that is used in most creditor disclosure cases is the reasonableness of the invasion of privacy. Such a test could be applied in the psychotherapist-patient situation. Since a psychotherapist will be familar with the patient's condition and will therefore be able to anticipate the possible adverse effects of disclosure,[111] reasonableness in a psychotherapeutic context should include consideration of the patient's condition. A minimum standard for determining whether the breach was reasonable might be whether a reasonable person believes the breach was necessary. A higher standard would be to determine whether a reasonable psychotherapist believes the breach was necessary. Utilizing concepts of general tort law, as applied to professionals,[112] it would seem that a psychotherapist would be held to the higher standard of care.

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ure, on the basis that the public interest outweighs the policy interest in confidentiality. Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). See text & notes 151-67 *infra.*

107. See text & notes 1-6 *supra.*

108. Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations,* 70 J. ABNORMAL PSYCH. 47, 47 (1965). The problem is even more profound where the person has been hospitalized. *See* Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), where the court noted that "[i]n the job market, it is better to be an ex-felon than ex-patient." *Id.* at 1089 (quoting *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary,* 91st Cong., 1st & 2d Sess. 284 (1969-1970) (testimony of Bruce Ennis)).

109. Horne v. Patton, 291 Ala. 701, 287 So. 2d 824 (1974). *Cf.* Furniss v. Fitchett, [1958] 77 N.Z.L.R. 395, 397 (during a divorce action, the husband of the patient produced in court a written statement by his wife's physician that she was mentally disturbed, causing her to collapse from anxiety in the courtroom).

110. *See* Harrison v. Humble Oil & Ref. Co., 264 F. Supp. 89, 92 (D.S.C. 1967); Passman v. Commercial Credit Plan, Inc., 220 So. 2d 758, 762 (La. App. 1964).

111. This knowledge will put the therapist within the reach of the tort of "intentional infliction of mental distress." *See* W. PROSSER, *supra* note 87, § 12, at 58; RESTATEMENT (SECOND) OF TORTS § 46, at 71-72 (1965). A therapist's knowledge of a patient's special sensitivity may bring the disclosure under the category of extreme outrage. *See* discussion note 98 *supra.*

112. *See, e.g.,* Kronke v. Danielson, 108 Ariz. 400, 402-03, 499 P.2d 156, 158-59

Invasion of privacy, then, is an action in tort that may be used against psychotherapists who breach confidentiality, and therefore may be used to get damages for mental distress and, in a proper case, punitive damages. However, it is subject to certain restrictions. Where the disclosure is objectionable and upsetting to the person in therapy, but not offensive to a person of ordinary sensibilities, the action may not be permitted. Even more limiting is the possibility of privileges for disclosures to a spouse, or to a third person for the purpose of collecting a fee. Another alternative theory on which to sue a psychotherapist for a breach of confidentiality is professional negligence, or malpractice.

MALPRACTICE

Malpractice is an action for negligence involving "any professional misconduct or any unreasonable lack of skill *or fidelity in the performance of professional or fiduciary duties.*"[113] It differs, however, from ordinary negligence in that the defendant's conduct in a malpractice action is measured against the conduct of the average professional in the community, rather than against that of a reasonable and prudent person.[114] Thus, malpractice is simply a tort action involving a special standard of care.[115] The elements of the action consist of a duty owed by the professional to the consumer to conform to a particular standard of care and skill, a breach of that duty, and harm proximately caused by the breach.[116] Whether a breach of confidentiality is an act for which a malpractice action may be brought depends upon whether the elements of professional negligence can be demonstrated. The most difficult hurdles to overcome in establishing malpractice in this situation are whether the standard of care to which the psychotherapist is obliged to conform encompasses confidentiality, whether that duty is

(1972); Harris v. Campbell, 2 Ariz. App. 351, 355, 409 P.2d 67, 71 (1965); Landeros v. Flood, 17 Cal. 3d 399, 408, 551 P.2d 389, 392-93, 131 Cal. Rptr. 69, 72-73 (1976); Burrows v. Hawaiian Trust Co., 49 Hawaii 351, 360, 417 P.2d 816, 821 (1966).

113. Stacy v. Pantano, 177 Neb. 694, 697, 131 N.W.2d 163, 165 (1964) (emphasis in original). *See* Malone v. University of Kan. Medical Center, 220 Kan. 371, —, 552 P.2d 885, 888 (1976); Rogers v. Horvath, 65 Mich. App. 644, 646-47, 237 N.W.2d 595, 597 (1975); Hale v. State, 53 App. Div. 2d 1025, 1025, 386 N.Y.S.2d 151, 152 (Sup. Ct. 1976).

114. Samuels v. Doctors Hosp., Inc., 414 F. Supp. 1124, 1128 (W.D. La. 1976); Note, *Malpractice and the Healing Arts—Naturopathy, Osteopathy, Chiropractic,* 9 UTAH L. REV. 705, 717 (1965).

115. Holton v. Pfingst, 534 S.W.2d 786, 787 (Ky. App. 1975). *See generally* Comment, *Professional Negligence,* 121 U. PA. L. REV. 627 (1973).

116. Hale v. State, 53 App. Div. 2d 1025, 1025, 386 N.Y.S.2d 151, 152 (Sup. Ct. 1976); *see* Rothblatt & Leroy, *Avoiding Psychiatric Malpractice,* 9 CAL. W.L. REV. 260, 263 (1973); Note, *Medical Malpractice: The Liability of Psychiatrists,* 48 NOTRE DAME LAW. 693, 695-96 (1973). For a discussion of the relationship between contract and malpractice, see text & notes 59-63 *supra.*

breached by disclosure in the particular case, and whether recoverable damages are incurred.

To determine whether a duty of confidentiality exists within the physician-patient relationship, courts have looked to public policy.[117] Essentially three indicia have been used by the courts[118] in finding a public policy to support a duty of confidentiality: Physician-patient privilege statutes;[119] physician licensing statutes;[120] and codes of medical ethics.[121] Testimonial privilege statutes were heavily relied upon in the early breach of medical confidentiality cases as a criterion for determining the substance of public policy.[122] The courts reasoned that because there was no testimonial privilege at common law, unless one was statutorily enacted, the state had no policy favoring confidentiality.[123] In later cases, however, the courts began to look at other indicia of a public policy favoring confidentiality—licensing statutes and medical ethics codes.

Physician licensing statutes which denominate breaches of confidentiality as unprofessional conduct justifying license revocation[124]

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117. *See* Hague v. Williams, 37 N.J. 328, 336, 181 A.2d 345, 348-49 (1962); Clark v. Geraci, 29 Misc. 2d 791, 793, 208 N.Y.S.2d 564, 567 (Sup. Ct. 1960) (both courts found that a duty based upon public policy existed, but disclosure was allowable for other reasons). *See also* Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 441, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (1976), where the Supreme Court of California stated:

> [T]he therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.

118. *See, e.g.*, Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 796-800 (N.D. Ohio 1965) (privilege statute, licensing statute, and medical ethics); Horne v. Patton, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1974) (licensing statute and medical ethics); Schaffer v. Spicer, — S.D. —, —, 215 N.W.2d 134, 137 (1974) (privilege statute).

119. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-2235 (1976) (physician-patient privilege in civil actions); *id.* § 13-1802(4) (1973) (physician-patient privilege in criminal actions); CAL. EVID. CODE § 994 (West Supp. 1977) (provides for physician-patient privilege); *id.* § 998 (1966) (no privilege in a criminal proceeding); COLO. REV. STAT. § 13-90-107 (1976) (physician-patient privilege in civil and criminal actions); HAWAII REV. STAT. § 621-20.5 (Supp. 1975) (physician patient privilege in civil action).

120. *See* statutes cited note 33 *supra.*

121. *See* text & note 10 *supra.*

122. *See* Collins v. Howard, 156 F. Supp. 322, 324 (S.D. Ga. 1957); Quarles v. Sutherland, 215 Tenn. 651, 656-57, 389 S.W.2d 249, 251 (1965) (no cause of action was allowed in either case in part because there was no existing testimonial privilege). *See also* Note, *Extrajudicial Truthful Disclosure of Medical Confidences: A Physician's Civil Liability*, 44 DEN. L.J. 463, 471-73 (1967); Note, *Action for Breach of Medical Secrecy Outside the Courtroom*, 36 U. CIN. L. REV. 103, 112 (1967). *But see* Simonsen v. Swenson, 104 Neb. 224, 227, 177 N.W. 831, 832 (1920) (court stated in permitting disclosure that the testimonial privilege statute was not relevant to the issue of extrajudicial disclosure; it only applied to courtroom disclosures).

123. Collins v. Howard, 156 F. Supp. 322, 324 (S.D. Ga. 1957); Quarles v. Sutherland, 215 Tenn. 651, 657, 389 S.W.2d 249, 251-52 (1965).

124. *See* statutes cited note 33 *supra.* ARIZ. REV. STAT. ANN. §§ 32-1401(10)(b), 1423(b) (1976) provides that the willful betrayal of a secret is unprofessional conduct, and such conduct is a bar to receiving a license to practice medicine.

have been construed to indicate a public policy favoring confidentiality.[125] In an early case, such a provision was interpreted to require maliciousness on the part of the physician in breaching his duty of confidentiality before a license could be revoked,[126] but this interpretation has now been discounted.[127] Courts now reason that the licensing statutes, like the testimonial privilege statutes, establish a public policy favoring confidentiality sufficient to support imposition of liability for the disclosure of confidences.[128]

The third indicia of a public policy favoring confidentiality, lacking the geographical restrictions of the other two, is the existence of the medical profession's ethical standards, embodied in the AMA's Principles of Medical Ethics[129] and the Hippocratic Oath.[130] The principles of ethics and the oath demand that the physician keep his patient's communications confidential. The public's knowledge of these ethical codes and the right to rely on them have been given as reasons for using these ethical standards as criteria for the determination of public policy.[131] The ethical standards, however, are usually considered in conjunction with licensing statutes,[132] and therefore have not been themselves held dispositive of the existence of such a public policy. Even so, it is apparent from an examination of the various indicators of public policy that a physician has a duty of confidentiality to his patient, and that insofar as public policy is used as a standard for the imposition of a duty, the first element of malpractice is satisfied.[133]

Objections to this point of view have been raised, however, and it has been asserted that a physician's duty of secrecy does not involve questions of knowledge and care, the traditional negligence notions, be-

125. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 797-98 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1974).

126. McPheeters v. Board of Medical Examiners, 103 Cal. App. 297, 284 P. 938 (Ct. App. 1930).

127. Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 798 (N.D. Ohio 1965).

128. *Id.* at 801-02; Horne v. Patton, 281 Ala. 701, 707-08, 287 So. 2d 824, 828-29 (1974).

129. *See* discussion note 10 *supra.*

130. *See* provision set forth in note 31 *supra.*

131. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 702-03, 287 So. 2d 824, 825-26 (1974).

132. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 802 (N.D. Ohio 1965); Horne v. Patton, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1974).

133. An obligation to keep a patient's communications secret may also be viewed as a duty imposed upon a psychotherapist through his fiduciary duty to his patient. See text & notes 65-74 *supra.* In Clark v. Geraci, 29 Misc. 2d 791, 792-93, 208 N.Y.S.2d 564, 567 (Sup. Ct. 1960), the court held that an action would lie for breach of confidentiality, based upon the policies indicated by the physicians' code of ethics, an evidentiary rule prohibiting testimonial disclosure, and an unprofessional conduct statute. The court did not acknowledge that the action was one based on negligence, but the plaintiff brought his action in malpractice and the court was responsive to the claim. *Id.* at 792-95, 208 N.Y.S.2d at 566-67. However, a waiver of the right to confidentiality was found, and the judgment of the trial court denying recovery was therefore affirmed on appeal. *Id.* at 793-94, 208 N.Y.S.2d at 568.

cause the keeping of a patient's secret does not affect the way a physician exercises his medical knowledge during the treatment of a patient. Under such a view, malpractice is not an appropriate action for breach of confidentiality.[134] Implied in this view seems to be an assertion that the types of damages incurred due to a breach of confidentiality are not suited to an action in malpractice because malpractice actions generally involve some type of physical harm.[135]

This objection, while possibly relevant to physicians, is not compelling in regard to psychiatrists or other psychotherapists.[136] Alleviation of mental distress and elimination of emotional problems are the aims of psychotherapy. If the psychotherapist fails to attain those goals because he has disclosed a confidence where other psychotherapists would have kept silent, he has acted below the prescribed standard of care of his profession and has thereby breached a duty to his patient. Words and trust are the tools of the psychotherapist,[137] and they must be used with skill and care.

The duty to act according to the standards of one's profession is not limited to physicians, but rather has been applied generally to the learned professions.[138] Where a professional duty of confidentiality

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134. Note, *Extrajudicial Truthful Disclosure of Medical Confidences: A Physician's Civil Liability*, 44 DEN. L. REV. 463, 474 (1967). In Hammer v. Polsky, 36 Misc. 2d 482, 483-84, 233 N.Y.S.2d 110, 111 (Sup. Ct. 1962), the court stated that a cause of action for malpractice could neither be based upon a theory of unprofessional conduct nor on an evidentiary rule prohibiting disclosure. However, the court did not consider whether the unprofessional conduct or evidentiary statutes were indicative of a policy against extrajudicial disclosures upon which a malpractice action could be based, as the earlier New York court did in Clark v. Geraci, 29 Misc. 2d 792, 793, 208 N.Y.S.2d 564, 567 (Sup. Ct. 1960), but instead looked only to see whether the statutes directly supported the action. The *Hammer* court provided no authority or reasons for why a cause of action in malpractice could not be brought, using the policy of these statutes as an indicator of public policy.

135. *See, e.g.*, Martin v. Bralliar, 36 Colo. App. 254, 540 P.2d 1118 (1975) (question of informed consent for surgery); Druilhet v. Comeaux, 317 So. 2d 270 (La. App. 1975) (sponge left in body); Anderson v. Somberg, 67 N.J. 291, 338 A.2d 1 (1975) (patient injured during surgery).

136. *See* text & notes 138-45 *infra*. One commentator points out that damages for mental distress caused by psychiatric malpractice "evidence a situation where the harm caused is in the mode of the treatment itself or of the illness being treated and is thus like the breaking of or hindering of the curing of an elbow while it is being treated." D. DAWIDOFF, *supra* note 70, at 69. *See also* Ferrara v. Galluchio, 5 N.Y.2d 16, 21, 152 N.E.2d 249, 252, 176 N.Y.S.2d 996, 999 (1958), where it was stated:

> This case is somewhat novel, of course, in that it appears to be the first case in which a recovery has been allowed against the original wrongdoer for purely mental suffering arising from information the plaintiff received from a doctor to whom she went for treatment of the original injury.

A psychotherapist's breach of confidentiality may have as much impact on the healing process of his patient as the mistreatment of a broken arm would have on a physician's patient; the patient should similarly be compensated for the malpractice.

137. *See* text & notes 1-6 *supra*. *See also* D. DAWIDOFF, *supra* note 70, at 68-69.

138. Although malpractice is most commonly brought against members of the medical and legal professions, Richardson v. Doe, 176 Ohio 370, 372, 199 N.E.2d 878, 879 (1964), it has been extended to other professions as well. *See* RESTATEMENT (SECOND) OF TORTS § 299A, comment b (1965); Comment, *supra* note 115, at 630-33.

exists, breach of that duty is an element of malpractice. A duty of confidentiality exists for both psychologists and psychiatric social workers. Thus, the claim of malpractice may properly be applied to both psychologists and social workers.[139] Just as the existence of a public policy favoring confidentiality for physicians has been gleaned by the courts from principles of medical ethics, physician privilege statutes, and physician licensing statutes, a public policy favoring confidentiality for psychologists and social workers may be determined from the standards of conduct for psychologists and social workers[140] in the psychotherapist privilege statutes and psychologist licensing provisions.[141] The existence of these statutes does not by itself determine the policy; rather the policy is determined by looking at the reason behind the provisions.[142] It is in the public interest for patients to be able to speak freely to physicians so that they can be effectively treated.[143] This in-

See generally Vacca, *Teacher Malpractice*, 8 U. RICH. L. REV. 447 (1974); PRACTICING LAW INSTITUTE, 2 PROFESSIONAL MALPRACTICE (1967).

139. For a discussion of the similar functions performed by all practitioners of psychotherapy, see text & notes 7-11 *supra*. An analogy may be drawn between nonphysician psychotherapists and nurses, to further strengthen the assertion that a malpractice action may be applied to all psychotherapists. The analogy is imperfect because nurses are often subordinate to physicians, *see* E. SPRINGER, NURSING AND THE LAW 6-7 (1970), but many activities of a nurse are independent of physicians and malpractice actions can be brought against them if the standard of care of the nursing profession is not met. *See* Thompson v. United States, 368 F. Supp. 466 (W.D. La. 1973); Kambas v. St. Joseph's Mercy Hosp., 33 Mich. App. 127, 189 N.W.2d 879 (1971). Just as a nurse's educational background and training differ from that of a physician, a psychologist or social worker's background may differ from that of a psychiatrist, although they may perform the same therapeutic duties. A malpractice action, then, need not be dependent upon the educational status of the defendant, as long as there is an established professional standard of care to which the defendant must adhere. This standard may vary among the different types of psychotherapists. See text & note 146 *infra*.

Psychiatric negligence, or malpractice, has been characterized as being either somatic or psychotherapeutic; that is, physical or nonphysical. Note, *Psychiatric Negligence*, 23 DRAKE L. REV. 640, 642 (1974). Somatic treatment involves physically treating the patient in some manner, possibly by the use of drugs or electroshock treatment. *Id.* at 643-44. Psychotherapeutic treatment involves the use of the therapeutic relationship between patient and therapist. *Id.* at 650-51. Somatic treatment cannot be used by social workers or psychologists because it constitutes the practice of medicine and can only be performed by licensed physicians. *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1455 (1976). Thus, the standard of negligence in the use of somatic treatment that is applied to psychiatrists would not apply to social workers or psychologists. See generally text & notes 1-6 *supra*. Psychotherapeutic negligence would be applicable because social workers and psychologists employ a psychotherapeutic relationship with their patients. See text & note 7 *supra*.

140. *See* text & notes 14, 16 *supra*.

141. *E.g.*, ALASKA STAT. § 08.86.200 (1973) (psychologist privilege statute); ARIZ. REV. STAT. ANN. § 32-2085 (1976) (psychologist privilege statute); ARK. STAT. ANN. § 72-1516 (1957) (licensing of psychologists); CAL. BUS. & PROF. CODE § 9043 (West 1975) (licensing of clinical social workers); CAL. EVID. CODE § 1010 (West 1966) (psychotherapist privilege); N.Y. EDUC. LAW § 7603 (McKinney 1972) (licensing of psychologists).

142. "[Public policy] may be said to be the community common sense and common conscience, extended and applied throughout the state to matters of public morals, public health, public safety, public welfare and the like." Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 796 (N.D. Ohio 1965) (quoting Pittsburgh, Cin., Chi. & St. L. Ry. v. Kinney, 95 Ohio St. 64, 68, 115 N.E. 505, 507 (1916)).

143. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801-02 (N.D. Ohio 1965).

terest applies a fortiori to the psychotherapist-patient relationship.[144] The law must recognize that psychologists and social workers who perform psychotherapy, as well as psychiatrists, owe a duty of confidentiality to their patients.[145] However, while all psychotherapists owe a duty of care to their patients, it should be noted that the standard of care naturally will vary according to the type of psychotherapist; that is, social workers should be held to the standard of care and skill of reasonably prudent social workers, and not to the standard imposed upon psychiatrists.[146]

The final element of the malpractice cause of action requires that an injury be suffered as a direct result of the breach of duty. The problem of showing actionable harm that is the proximate cause of the disclosure is much the same as in the previously discussed causes of action. If, as a result of a breach of confidentiality, a patient incurs emotional problems, loses his job, or his marriage suffers, he can demonstrate the required harm. On the other hand, if the harm is to the relationship with the therapist, thus threatening the success of the therapy, the patient may find that any assertion that the disclosure was the proximate cause of the breakdown will be difficult to prove, especially where his therapist indicates otherwise.[147] Nonetheless, the malpractice action is a viable remedy and reflects the public's interest in confidentiality between psychotherapist and patient. The duty of confidentiality—whether characterized as falling within contract, fiduciary duty, invasion of privacy, or malpractice—is predicated on this public policy. However, public policy is a double-edged blade: It has also been invoked by courts to justify the imposition of an affirmative duty upon psychotherapists and physicians to disclose patient confidences in certain situations.[148] Therefore, since the duty of confidentiality will be limited by the duty to disclose, the latter duty must now be explored.

144. *See* text & notes 1-6 *supra*.

145. Hammer v. Rosen, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960). *See also* D. DAWIDOFF, *supra* note 61, at 40; Dawidoff, *supra* note 75, at 617; Rothblatt & Leroy, *supra* note 116, at 261; Note, *supra* note 116, at 702-15.

146. *Accord*, Note, *supra* note 114, at 718-20 (naturopaths, osteopaths, and chiropractors must each be held to the standard of their own profession and not to the standards of medical doctors). *See generally* Vold, *Legally Responsible Cause Flexibly Construed*, 19 VAND. L. REV. 285, 290-91 (1966).

147. *See* Morgan v. State, 40 App. Div. 2d 891, 891, 337 N.Y.S.2d 536, 536 (1972); Rothblatt & Leroy, *supra* note 116; Note, *supra* note 116.

148. Davis v. Rodman, 147 Ark. 385, 391-92, 227 S.W. 612, 614 (1921) (physician owed duty to family of typhoid fever patient to advise them of the danger); Skillings v. Allen, 143 Minn. 323, 325-26, 173 N.W. 663, 664 (1919) (physician owed a duty to advise parents that patient had communicable disease); Wojcik v. Aluminum Co. of Am., 18 Misc. 2d 740, 746-47, 183 N.Y.S.2d 351, 358 (Sup. Ct. 1959) (cause of action will lie against employer who fails to inform employee that physical examinations indicated presence of tuberculosis). *See also* Derrick v. Ontario Community Hosp., 47 Cal. App. 3d 145, 154, 120 Cal. Rptr. 566, 571 (1975); Dawson, *The Duties of a Doctor as a Citizen*, BRIT. MED. J. 1474 (1954).

PUBLIC POLICY—THE DUTY TO DISCLOSE

Public policy demands disclosure by physicians when they treat patients who threaten the safety or welfare of the community.[149] This is a common law duty that takes precedence over any duty of confidentiality imposed by the state.[150] However, the interplay between the two competing policies creates difficulty for the psychotherapist in determining when the duty of confidentiality is owed to the patient and when a duty to disclose is owed to society or to a particular individual. The resolution of this problem has greatest significance to a psychotherapist who conducts therapy with a patient whose violent tendencies may represent a potential danger to the public.

The California Supreme Court confronted the issue in *Tarasoff v. Regents of University of California.*[151] There, the court held that a psychotherapist had a duty to protect a young woman from a patient of his who had indicated a desire to kill her.[152] The cause of action against the psychotherapist was sustained on the ground that public policy requires that the therapist take reasonable steps to protect a third party whom he knows or should know may be harmed by his patient.[153] The court in *Tarasoff* went beyond holding a psychotherapist liable for severely aggravating his patient's dangerous tendencies—a traditional basis for imposing liability which the facts alleged in *Tarasoff* would surely have supported.[154] Instead, the supreme court stated that the

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149. *See* cases cited note 148 *supra.*

150. *See* Derrick v. Ontario Community Hosp., 47 Cal. App. 3d 145, 152-54, 120 Cal. Rptr. 566, 571 (1975); *see also* Simonsen v. Swenson, 104 Neb. 224, 227, 177 N.W. 831, 832 (1920); Berry v. Moench, 8 Utah 2d 191, 197, 331 P.2d 814, 817-18 (1958).

151. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), *vacating* 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

The *Tarasoff* controversy arose when Prosenjitt Poddar, a student at the University of California at Berkeley, informed his psychotherapist, Dr. Lawrence Moore, who was employed as a psychologist at a hospital on the campus, that he intended to kill Tatiana Tarasoff when she returned from spending the summer in Brazil. *Id.* at 430-32, 551 P.2d at 339-41, 131 Cal. Rptr. at 19-21. Dr. Moore, who considered Poddar dangerous, decided to request commitment for him and asked the campus police to pick Poddar up. However, the police did not hold Poddar and he was released. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21. Subsequently, Poddar persuaded Tatiana's brother to accept him as a roommate, and when Tatiana returned from Brazil, Poddar went to her home and killed her. *Id.* at 433, 551 P.2d at 341, 131 Cal. Rptr. at 21.

152. *Id.* at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.

153. *Id.*

154. In the first disposition of *Tarasoff*, the California Supreme Court specifically found that the actions of the psychotherapist may have exacerbated the patient's condition:

> [F]ollowing Poddar's encounter with the police, Poddar broke off all contact with the hospital staff and discontinued psychotherapy. From those facts one could reasonably infer that defendants' actions led Poddar to halt treatment which, if carried through, might have led him to abandon his plan to kill Tatiana, and thus that defendants having contributed to the danger, bear a duty to give warning.

Tarasoff v. Regents of Univ. of Cal., 529 P.2d 553, 559, 118 Cal. Rptr. 129, 135

duty to protect could encompass a duty to warn threatened third persons any time a patient seriously indicates that he might be a danger to those individuals.[155]

The *Tarasoff* court recognized a need for confidentiality,[156] but stated that the countervailing public interest in preventing violent attacks on innocent citizens is the more important concern.[157] Moreover, the court emphasized that not all patients present a serious danger.[158] Although acknowledging that the task of recognizing dangerous threats may be difficult, the majority claimed this task to be no more difficult than other expert judgments required of doctors or other professionals.[159] In addition, the court stated that psychotherapists could only be held to a malpractice standard of care, and therefore would not be unduly burdened in attempting to predict the dangerousness of their patients.[160] The court reasoned that a psychotherapist is required to exercise the standard of skill and care that is ordinarily possessed and exercised by members of his profession. Thus, no liability would result from situations where a reasonably prudent psychotherapist would not have predicted dangerousness.[161]

A close examination of the two *Tarasoff* decisions and the decision of the same court in the criminal prosecution of the patient,[162] reveals that the suggested malpractice standard of care may be of very

(1974) (the first opinion was not printed in *California Reporter 3d*), *vacated* 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). The court arguably could have based its holding imposing liability solely on the psychotherapist's failure to warn the victim after aggravating the situation. Ironically, although the notification destroyed the communication between therapist and patient, this kind of breach of confidentiality was encouraged by the court by imposing a duty to warn. *See* 28 VAND. L. REV. 631, 639 (1975).

155. In the California Supreme Court's first disposition of *Tarasoff*, the court found a specific duty to warn the potential victim of a dangerous patient: "We conclude that a doctor or a psychotherapist treating a mentally ill patient, just as a doctor treating physical illness, bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment." 529 P.2d at 559, 118 Cal. Rptr. at 135. On rehearing, the holding was modified somewhat; a general duty was found to protect the potential victim: "[O]nce a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger." 17 Cal. 3d at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25. The court went on to say that the duty to protect may involve giving the potential victim a warning, and that such an act would be less of a violation of the patient's rights than commitment. *Id.* at 439, 551 P.2d at 346, 131 Cal. Rptr. at 26. Thus, the distinction between the two holdings is not one that will affect the practical decisions of psychotherapists in determining whether or not to disclose a threat to a potential victim.

156. 17 Cal. 3d at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

157. *Id.* at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

158. *Id.*

159. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

160. *Id.* For a discussion of professional negligence, or malpractice, and its applicability to psychotherapists, see generally text & notes 99-128 *supra*.

161. *See* 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

162. People v. Poddar, 10 Cal. 3d 750, 518 P.2d 342, 111 Cal. Rptr. 910 (1974).

little practical significance; a reasonable and prudent psychotherapist may well have failed to characterize the patient's threats as indicative of imminent danger. Since the second hearing of *Tarasoff* was decided on the pleadings,[163] no proof was presented as to whether the psychotherapist involved should reasonably have predicted the patient's act. The American Psychiatric Association, which submitted a brief as amicus curiae on rehearing, stated:

> The Court's formulation of the duty to warn fundamentally misconceives the skills of the psychotherapist in its assumption that mental health professionals are in some way more qualified than the general public to predict future violent behavior of their patients. Unfortunately, study after study has shown that this fond hope of the capability accurately to predict violence in advance is simply not fulfilled. The burden of this new duty to warn, therefore, is formulated and imposed without reference to the actual ability of the therapist to sustain it.[164]

The degree of dangerousness that a reasonable psychotherapist exercising the proper care and skill would attribute to the patient is therefore in doubt.[165] The court in *Tarasoff* thus seems to impose a standard of care beyond the capabilities of the ordinary psychotherapist.

In regard to threats by patients, then, the question whether the therapist's primary obligation is to his patient or to society is left in a muddled state. The inability of psychotherapists to accurately determine a patient's dangerousness leaves them with constantly conflicting duties to patients and the public. Although unable to accurately predict the dangerousness of their patients, they are faced with the

163. 17 Cal. 3d at 430-31, 551 P.2d at 340, 131 Cal. Rptr. at 20.

164. Brief Amicus Curiae for American Psychiatric Association at 6, Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

165. The inability of psychotherapists to accurately measure dangerousness was brought out by Justice Mosk in his separate opinion in the rehearing of *Tarasoff*. 17 Cal. 3d at 451-52, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring in part and dissenting in part). *See* Justice & Birkman, *An Effort to Distinguish the Violent From the Nonviolent*, 65 S. MED. J. 703, 705 (1972); Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972).

It has also been shown that psychiatrists tend to overpredict dangerousness in patients. *See* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 711-16 (1974). *See also* Anderson & Whitman, *The Control of Behavior Through Law: Theory and Practice*, 47 NOTRE DAME LAW. 815 (1972). Here it was pointed out that psychiatrists not only overpredict dangerousness, *id.* at 848, but, interestingly enough, they were less accurate than social workers. *Id.* at 898. The dissent in the rehearing of *Tarasoff* voiced the view that the therapist-patient relationship should not be infringed, 17 Cal. 3d at 359-60, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting), and that placing psychotherapists in the position of having to predict and report dangerousness could deter people from seeking help. The dissent argued further that this might ultimately result in increasing the likelihood of violence. *Id.* at 360, 551 P.2d at 360-62, 131 Cal. Rptr. at 40-42. This point of view is apparently based on the assertion that where the threat of disclosure is present, many disturbed individuals fail to seek out needed help. See text & note 2 *supra*.

necessity of predicting. The aim of the *Tarasoff* court in imposing this duty to predict is obviously the protection of the public from dangerous patients, effectuated by forcing disclosure of a patient's malevolent intentions. The threat of disclosure, however, may cause a patient who is seeking help to terminate or forego therapy and become even more dangerous to the public.[166] A lack of definite guidelines for disclosure further confuses the problem.

The *Tarasoff* court said only that the psychotherapist, in making the decision whether or not to breach confidentiality, should exercise the skill of a reasonably prudent therapist under the circumstances; no further standard is suggested. This is the crux of the problem: With no specific guidelines, a psychotherapist can do nothing more than guess at the dangerousness of his patients and at the degree of dangerousness requiring a warning. The problem of a psychotherapist guessing in favor of disclosure and being held liable for breach of confidentiality looms large for future litigation. After *Tarasoff*, he is faced with choosing the lesser of two evils where a potentially dangerous patient is concerned: liability for breaching confidentiality or liability for failing to inform about a dangerous patient. However, because the liability is likely to be substantially higher for wrongful death or serious bodily injury than for a breach of confidentiality, the safer choice will always be disclosure. This problem, although recognized by the *Tarasoff* court,[167] was not resolved.

Guidelines are necessary, then, not only to aid the psychotherapist in weighing each of his duties, but also to recognize the kind of dangerous behavior which necessitates his making a disclosure.[168] A threat of murder is far different from a threat to confront someone angrily.

166. For a discussion of the effect of the duty imposed by *Tarasoff*, see Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

167. 17 Cal. 3d at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26. *See* Berry v. Moench, 8 Utah 2d 191, 331 P.2d 814 (1958); Stone, *supra* note 144, at 372. In *Berry*, the Utah Supreme Court stated:

> One purveying such information about one person to protect another is obliged to consider the likelihood and the extent of benefit to the recipient, if the matter is true, as compared with the likelihood of injury and the extent thereof to the subject, if it prove false, or improper to reveal. Whether the privilege exists, depends upon generally accepted standards of decent conduct. Applying that standard, it exists if the recipient has the type of interest in the matter, and the publisher stands in such a relation to him, that it would reasonably be considered the duty of the publisher to give the information. If the facts upon which the privilege would rest are not in dispute, whether the privilege exists is a question for the court to determine. If they are in dispute the jury must determine the facts and upon them the court determines the question of privilege.

8 Utah 2d at 198, 331 P.2d at 818.

168. *See* People v. Hopkins, 44 Cal. App. 3d 669, 119 Cal. Rptr. 61 (1975) (disclosure to police by psychiatrist permitted in criminal case regarding a burglar who had beaten but not killed an old woman, and had not threatened any individuals for the future); 44 U. CIN. L. REV. 368, 375 (1975).

Suggested guidelines for determining dangerousness have included the following requirements: That a specific threat be made against an identifiable individual; that the patient have the intent and capacity to carry out the threat; that the psychotherapist get a second opinion as to the dangerousness of the patient; and that the psychotherapist have access to the intended victim.[169] It has also been suggested that psychotherapists inform their patients ahead of time about subject matter that will warrant disclosure—somewhat in the manner of a mental health "*Miranda* warning."[170] An obvious disadvantage of the latter suggestion is the "chilling effect" this may have on the therapeutic relationship by immediately putting the patient on the defensive.

These proposed guidelines tend to rely on the ability of therapists and courts to accurately measure and assess the dangerousness of patients. A more practical approach—in light of the fact that therapists are primarily skilled in treating rather than measuring patients—is to put the problem in terms of the therapist's duty to the patient. The therapist's primary duty is to help his patient. Carrying out this duty may involve preventing the patient from harming himself. A therapist therefore has a duty to inform his patient that he will be harming himself if he pursues a dangerous course of action—such as murder—and that the therapist will try to stop him. After so informing the patient, the therapist has a responsibility to commit a dangerous patient to a hospital.[171] If the attempt to have the patient committed is not successful, the therapist may then be compelled to make a disclosure to an intended victim or to the police. In such a case, however, the test would not be whether the countervailing interests of society are served, but whether the harm that will accrue to the patient as a result of his actions will be greater than the harm done by the breach of confidentiality.

Although such a test still would require some degree of measurement, the emphasis would be on the proper care of the patient. A psychotherapist would be required to assess the problem in terms he is familiar with, and make a clinical judgment within the context of his

169. Comment, *Tort Liability of the Psychotherapist*, 8 U. SAN FRANCISCO L. REV. 405, 433 (1974).

170. Fleming & Maximov, *supra* note 70, at 1059.

171. *See* Comment, *supra* note 169, at 426. The Comment just cited suggests that because the psychotherapist works for the patient rather than the third party, his duty is to the patient. Therefore, before a disclosure can be made, the therapist must commit the patient, restrain him, prescribe drugs to control his illness, or use any other method available to keep the patient from harming others. *Id.* at 427. This is a fairly complete solution, because if the therapist can foresee harm to a third person, commitment is appropriate. The power to involuntarily confine someone, however, lies with the state mental health authorities, and therefore, the therapist should be free from liability if the patient is not actually confined. *Id.* at 426. *See also* Dawson, *supra* note 128, at 1479 (in certain situations a physician owes the patient the duty to explain that he must be reported if he fails to abide by the physician's orders).

relationship with his patient, rather than in terms of his responsibility to society. To some extent, at least, the problem of prediction is also resolved. If a patient is not dangerous enough to warrant legal commitment, or if the psychotherapist is not so convinced of his patient's dangerousness to risk destroying the therapeutic relationship, he is meeting the requisite standard of care even though he does nothing. This test would provide a therapist with an affirmative defense against a third-party victim: that he acted with the requisite standard of care under the circumstances, and thus breached no duty to the patient, the individual injured, or society.

CONCLUSION

Causes of action against psychotherapists for extrajudicial disclosure of their patients' confidences appear to be possible under any of the theories presented. All of the alternative theories are predicated on a duty of confidentiality that stems from a public policy favoring the confidential psychotherapist-patient relationship. The usefulness of each of the causes of action must be determined by the appropriateness of the case for recovery of damages for mental distress, punitive damages, and considering problems of proximate cause. The most viable approach will depend on the individual case. Each alternative will be available regardless of the therapist's label as psychiatrist, psychologist, or social worker; the emphasis is properly on the protection of the relationship between the therapist and patient.

The problem of maintaining confidentiality is made more complex for the psychotherapist who deals with dangerous patients because of the recently created duty of disclosure when the public is threatened. Such a psychotherapist is presented with a "damned if you do, damned if you don't" situation, where he must guess correctly whether to make a disclosure or suffer the consequences of a suit from a third party or his patient if his guess is incorrect. Because the greater liability may follow from damages in a wrongful death or personal injury action, the safer gamble may be for the psychotherapist to overpredict dangerousness and make disclosures in many cases. Such a result would severely limit the positive effects of therapy for the patients who need it most. Other standards must be sought to allow the therapist to use his professional skills to decide whether disclosure is warranted. Such standards must focus on the needs of the patient and the therapist-patient relationship, rather than on a duty to society in general.