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Issue Brief

Duty to Warn, Duty to Protect, And Duty to Control:

The Exceptions to Mental Health Provider-Patient Confidentiality

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Introduction

Most individuals with mental illness do not commit acts of violence and are more often the victims of violence rather than the perpetrators. Research tells us that only 3 to 5 percent of the risk of violence in the U.S. can be attributed to mental illness,[1] and where individuals with mental illness do commit serious violence, there also can be a host of other factors at play that contribute to the violence.[2] In addition, specific mental disorders such as antisocial personality disorder and substance use-related disorders may carry greater risk of violence than serious mental illness.[3] However, the media often perpetuates the myth that perpetrators of mass violence do so because they are inevitably driven by a mental illness, and politicians often seize on that myth in their search for easy solutions or scapegoats to blame for all forms of violence—particularly gun violence—in the U.S.

With multi-fatality acts of public violence highly publicized, state and federal lawmakers and numerous stakeholders have been searching for solutions to prevent such violence from occurring.[4] In some of these searches, through litigation and some efforts at statutory reform, there have been jurisdictions that have examined whether mental health providers who may have treated individuals in mental health care could have taken some action to help prevent harm and to protect or warn others about potential mounting risks. This generally examines potential responses by mental health professionals working in outpatient settings, as well as in decisions about discharging inpatients to community settings and actions that might be taken to mitigate risk after discharge.

For the most part, existing state laws, professional ethics principles, and case law governing doctor-patient and counselor-patient confidentiality are constructed in such a way as to provide exceptions to doctor-client and counselor-client confidentiality in certain circumstances. Most familiar are mandated reporter statutes when concerns become known about child abuse, for example. Another exception, articulated differently in different states, is the exception to confidentiality that could arise when a patient presents a risk of harm to others. The laws in each state vary as to whether there is a mandate to take action or permission to take action that would breach a patient's confidentiality, what the action might entail (e.g., protecting the potential victim(s), which may or may not include warnings) and which potential victims are considered in these laws (e.g., known and named victims, the public at large, those directly threatened or implicitly at risk). Given the state by state variance, there can be confusion for clinicians as to what their obligations are. Separately, there are clinical and ethical standards that also require balancing tests in determining how to work with a patient who may appear at risk of harm to others.

Determining a client's risk of committing a violent act against another entails the use of evidence-based clinical methods and at times includes augmentation with violence risk assessment instruments. Clinical assessments generally weigh recognized risk factors such as the patient's history of behaviors, relationships, experiences, attitudes, and interpersonal

and societal responses, the patient's clinical symptoms, and the patient's personal ability to manage risks. Tools such as the Historical Clinical Risk Management-20 Version 3 (HCR-20V3) developed by psychologists Kevin S. Douglas, Stephen D. Hart, and Christopher D. Webster at Simon Fraser University in British Columbia,[5] enable the clinician to weigh all these factors using structured professional judgment, and to consider those factors which might need enhanced scrutiny because they have a higher correlation with violence. These tools are used primarily in forensic contexts but there are others that look at acute violence, risk of violence on inpatient units and the like.[6]

All this being said, there is no perfect way to predict future violence. This review is written to provide a background on some legal cases that helped develop contours related to clinician's roles with regard to a "duty to protect" third parties who might be at risk at the hands of a patient or client of a mental health professional. Often confused with a duty to warn, as this issue brief points out, the duty to warn can be subsumed under one way to protect third parties, but it might not be the only action and might not even be the necessary action, to effectuate protection. Also, this review puts these cases in clinical context, though it does not cover all the nuanced ways that clinicians can act to help develop risk management plans to mitigate risk, including hospitalizing patients, working with law enforcement and other approaches to reduce harm.

Historical Overview of Legal Cases Related to a Duty to Protect

Tarasoff v. Regents of University of California (1976)

The antecedent for many state statutes and case law creating duties to warn, protect, and control was the 1976 California case of *Tarasoff v. Regents of the University of California*,[7] in which psychologist Dr. Lawrence Moore of the University of California Berkeley's Cowell Memorial Hospital failed to inform student Tatiana Tarasoff and her parents of specific death threats to kill Ms. Tarasoff, made by Dr. Moore's voluntary outpatient client, Prosenjit Poddar.

Ms. Tarasoff had spurned Mr. Poddar's romantic intentions, triggering a serious emotional crisis in Mr. Poddar. In therapy, Mr. Poddar informed Dr. Moore that he was going to kill an unnamed female, readily identifiable as Ms. Tarasoff, when that female returned home from spending the summer in Brazil.

After Mr. Poddar expressed his intention to kill Ms. Tarasoff, Dr. Moore with the concurrence of Dr. Gold, who had initially examined Mr. Poddar, and Dr. Yandel, assistant to the Director of the Department of Psychiatry at Cowell Memorial Hospital, alerted campus police and verbally communicated that his client suffered from acute and severe paranoid schizophrenia, that he posed a danger to himself and others, and that he required observation in a mental hospital. Dr. Moore then sent a letter to Police Chief William Beall

requesting the assistance of the campus police department in securing Mr. Poddar's civil commitment.

Mr. Poddar was temporarily detained by officers, but they released him after he appeared rational and promised he would stay away from Ms. Tarasoff. At no time did anyone warn Ms. Tarasoff of the potential danger posed by Mr. Poddar.

Soon afterward, the Director of the Psychiatry Department, Dr. Harvey Powelson, directed that no further action be taken to place Mr. Poddar on watch and evaluation in a treatment facility and that Dr. Moore's letter to the police and his therapy notes on Mr. Poddar be destroyed. Mr. Poddar, stopped seeing Dr. Moore but moved in with Ms. Tarasoff's brother, continuing to stalk Ms. Tarasoff.

Two months after his previous temporary detainment, Mr. Poddar went to the Tarasoff home armed with a kitchen knife and a pellet gun. When Ms. Tarasoff screamed for help, Mr. Poddar shot her. When she fled into the yard, Poddar caught her and stabbed her to death with the kitchen knife. He was then arrested. He was then diagnosed with paranoid schizophrenia, the same diagnosis Dr. Moore had previously made.

When Ms. Tarasoff's parents sued the therapists and the University, contending their daughter should have been warned of the danger—that their failure to warn Tatiana or others constituted a breach of the therapists' duty to exercise reasonable care to protect Tatiana, the defendants responded that their only responsibility was to maintain the confidentiality of their client.

The lower courts agreed with the defendants, but the California Supreme Court noted that, under § 315 of the Restatement Second of Torts, a special relation was deemed to exist between a doctor or psychotherapist and his or her patient that supports affirmative duties for the benefit of third persons. The California court noted that courts in other jurisdictions had held that the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers arising from the patient's illness.[8]

The defendants, and the American Psychiatric Association and other professional associations, in various *amicus* briefs, had contended that imposition of a duty to exercise reasonable care to protect third persons was unworkable because therapists could not accurately predict, within the current state of the art, whether or not a patient would resort to violent acts. Since predictions of violence are often erroneous, the *amicus* briefs contended, the courts should not render rulings that predicate the liability of therapists on the validity of such predictions.

The court responded in its ruling that it:

> *recognize[d] the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously, we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.*

The court went on to say:

> *once 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. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances*.

The Tarasoff court concluded that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The court said "…the protective privilege ends where the public peril begins." It recognized the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. However, against this interest, it said it must weigh the public interest in safety from violent assault.

The court said the therapist's obligations to the patient require that the therapist not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that the disclosure be discreet, and in a fashion that preserves the privacy of the patient to the fullest extent compatible with the prevention of the threatened danger.

The case was heard, and a decision rendered in its first iteration.

- *Tarasoff I established the legal principle that the mental health clinician's ethical principle to maintain the confidential character of patient communications must yield where, and to the extent, that discrete disclosure is essential to avert a direct or implied threat of violence against specific others, where the intent to commit violence that arises from the patient's mental illness.*
- *In assessing whether there is a specific, viable threat of violence, the clinician need exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by his or her professional colleagues under similar circumstances.*

Though many would believe that the Duty to Warn ended the Tarasoff case, it is important to note that the case was reheard in 1976 (Tarasoff II, *Tarasoff v. Regents of the University of California*, 1976)[9] at which time the court redefined the duty to their persons as a "duty to protect," not merely a duty to warn. For clinicians this is a critical distinction. The duty to protect may require the mental health professional to take one or more "reasonably necessary" steps beyond warning the intended victim of the danger and notifying law enforcement, such as involuntary commitment or other forms of intervention.

- *Tarasoff II expanded the duty to warn to a duty to protect where the clinician stands in a special relationship to either the person whose conduct needs to be controlled or to the reasonably foreseeable victim.*
- *The duty to protect requires the clinician to take reasonably necessary steps beyond warning the intended victim of the danger to notify law enforcement and, where appropriate, recommend an involuntary commitment or other form of intervention*

Jablonski by Pahls v. U.S. and the Duty to Review the Patient's History

In the 1983 case of *Jablonski by Pahls v. U.S. (1983)*,[10] the 9th U.S. Circuit Court of Appeals confirmed a District Court judge's findings of malpractice for failure to record and transmit information from the police regarding the client's prior bad conduct, for failure to obtain the client's past medical records for purposes of evaluation, and for failure adequately to warn a homicide victim, each of which the district court found proximately caused the victim's death.

In the case, Meghan Jablonski, a minor, brought suit *via* a *guardian ad litem* action under the Federal Tort Claims Act, for the wrongful death of her mother, Melinda Kimball, who was murdered by the man she was living with, Phillip Jablonski. Meghan charged that psychiatrists at the Loma Linda Veterans Administration Hospital had committed malpractice proximately resulting in her mother's death by failing to review the defendant's prior medical records and prior criminal record.

On July 7, 1978, Mr. Jablonski threatened Isobel Pahls, Kimball's mother, with a sharp object, and apparently attempted to rape her. Ms. Pahls had also been the object of anonymous obscene telephone calls and other malicious acts which the police believed had been committed by Mr. Jablonski. Although Ms. Pahls did not file formal charges against Mr. Jablonski, she discussed with the police the possibility of his receiving psychiatric treatment. Shortly thereafter, Mr. Jablonski volunteered to undergo a psychiatric examination at the Loma Linda Veterans Hospital. The police were informed by phone that Mr. Jablonski would be treated by Dr. Kopiloff. Because Dr. Kopiloff was unable to come to the telephone, the policeman spoke instead with Dr. Berman, the head of Psychiatric Services. The policeman advised Dr. Berman of Mr. Jablonski's prior criminal record, and the recent history of obscene telephone calls and malicious damage, and stated that, in his opinion, Mr. Jablonski needed

to be treated on an in-patient basis. Although Dr. Berman stated that he would transmit this information to Dr. Kopiloff, he failed to do so. Dr. Kopiloff later testified that, had he received this information from the police, he would have moved to involuntarily hospitalize Mr. Jablonski.

On Monday, July 10, Ms. Kimball drove Mr. Jablonski to the hospital. In an interview with Mr. Jablonski and Ms. Kimball, Dr. Kopiloff learned that Mr. Jablonski had served a five-year prison term for raping his wife, and that four days earlier he had attempted to rape Ms. Pahls. Mr. Jablonski informed Kopiloff that he had undergone psychiatric treatment previously, but refused to state where he had received the treatment. Dr. Kopiloff noted that the patient was vague, non-communicative, and unwilling to share his prior medical history. Dr. Kopiloff diagnosed Mr. Jablonski as an "anti-social personality" and "potentially dangerous." He recommended that Mr. Jablonski voluntarily hospitalize himself, but the client refused. Dr. Kopiloff concluded that there was no emergency that dictated a basis for involuntary hospitalization and directed Mr. Jablonski to return for additional therapy in two weeks.

In a private conference following the diagnostic interview, in which Ms. Kimball told Dr. Kopiloff that she felt insecure around Mr. Jablonski and was concerned about his unusual behavior. Dr. Kopiloff recommended that she leave Mr. Jablonski, at least while he was being evaluated. No attempt was made by Dr. Kopiloff to locate Mr. Jablonski's prior medical records.

Ms. Kimball continued to see Mr. Jablonski, and drove him to the hospital for the second appointment where, although Mr. Jablonski volunteered that he had had frequent problems all his life with violent reactions, he was again vague as to his prior treatment and again refused a request to admit himself as an in-patient. Dr. Kopiloff and a colleague, a Dr. Hazle, concluded that Mr. Jablonski possessed an "anti-social personality with explosive features", both doctors concluded that there was no basis for involuntary hospitalization. Again, no effort was made to seek and examine Mr. Jablonski's prior medical records. Instead, Mr. Jablonski was scheduled for more tests and prescribed valium.

During Mr. Jablonski's appointment, a third doctor, Dr. Warnell, chief of the Mental Health Clinic, invited Ms. Kimball from the hallway where she was standing into his office where she expressed fear for her personal safety. Dr. Warnell replied that, "if she was afraid of her husband and that he didn't fit the criteria to be held in the hospital, that she could consider staying away from him." Dr. Warnell later relayed this information to Drs. Kopiloff and Hazle, but they concluded that Mr. Jablonski was not homicidal or suicidal, and that he could not be involuntarily hospitalized. Another appointment was made for Mr. Jablonski for Monday, July 17. On Sunday, July 16, Ms. Kimball went to Mr. Jablonski's apartment where he murdered her.

A later review of the client's previous medical records by the plaintiff's expert witness revealed that in 1968 Mr. Jablonski had received extensive care at an Army hospital in El Paso. The El Paso records reported that Mr. Jablonski had a "homicidal ideation toward his wife," that on numerous occasions he had tried to kill her, that he "had probably suffered a psychotic break and the possibility of future violent behavior was a distinct probability," and that he was "demonstrating some masculine identification in beating his wife as his father did frequently to his mother." The final diagnosis concluded in part that Mr. Jablonski had a "schizophrenic reaction, undifferentiated type, chronic, moderate; manifested by homicidal behavior toward his wife."

The Court of Appeals confirmed the District Court's finding that Meghan Jablonski had proven several claims of malpractice against the hospital psychiatrists. The District Court judge's findings of malpractice stemmed from their failure to record and transmit the information from the police, the failure to obtain the past medical records, and their failure adequately to warn Ms. Kimball.

- *The Jablonski case ruled that there would be a legal duty to examine the patient's history, including specifically his or her medical records and prior diagnoses, in determining whether the patient has previously evidenced a violent nature.*

Parameters of the Duty to Protect

Following legal cases like the ones above, many states adopted statutes that helped guide clinicians on balancing confidentiality and a duty to breach it in order to protect others. This, however, spawned an important discussion about the parameters that would be needed to act toward protection. Different states define, either in case law or in statute, whether a threat of harm needs to be credible or explicit, and other factors (such as a history of violence and a means to carry out violence toward others) that might warrant some protective action.

For clinicians, an assessment of a potential threat may be considered in the same way that a therapist would assess suicide risk. The therapist might consider the seriousness and specificity of the threat itself, the client's past history of violent or aggressive behavior, and recent symptom progression, as well as risk to potential victims, among other factors.[11]

A 2001 article by Drs. Randy Borum and Marisa Reddy, *Assessing Violence Risk in Tarasoff Situations: A Fact-Based Model of Inquiry*[12] suggests that, when faced with a client's threat of violence, the appraisal of risk should be guided by a fact-based and deductive method, rather than a more inductive risk assessment approach for general violence recidivism guided by base rates and historical risk factors. They contend the question should be whether the client is on a pathway toward a violent act toward the specified target, and, if so, where he or she is on that

path and how quickly he or she is moving. If the therapist deduces that the client is on a pathway to violence, then some action on the part of the therapist might be required according to local legal schemes and professional clinical standards. In a separate piece, Dr. Borum and colleagues write that, over the past 20 years, there has been an evolution in the way mental health professionals have thought about and conducted assessments of violence potential—a shift from the violence prediction model, where dangerousness was viewed as dispositional (residing within the individual), static (not subject to change) and dichotomous (either present or not present) to the current risk assessment model—where danger or "risk" as a construct is now predominantly viewed as contextual (highly dependent on situations and circumstances), dynamic (subject to change), and continuous (varying along a continuum of probability).[13]

They contend that, in the office-based *Tarasoff*-type assessment, and arguably in other emergency assessment contexts, the clinician is typically not given advance notice that a risk assessment will be required, and so the assessment must be made fairly quickly in the context of therapeutic discourse, and perhaps with limited collateral information. The objective is typically to appraise whether the patient poses a serious risk of harm to an identified or identifiable person.[14]

The Clinician's Ethical Responsibility in Performing the Assessment

In the October 2011 American Psychiatric Association's Joint Reference Committee's *Resource Document on Psychiatric Risk Assessment*,[15] authors Alec Buchanan, Rene Binder, Michael Norko, and Marvin Swartz review both inductive and structured (actuarial tool-based) approaches to measuring a patient's risk of violence, but note that "even when risk of harm to others becomes the focus of the doctor's interaction with his or her patient, the principles underlying its assessment are the same as those underlying psychiatric practice more generally."

An evaluation will be based on both the patient's history and examining the patient's current mental state. Drs. Buchanan and colleagues suggest that an accurate assessment depends on information obtained from collateral sources, such as medical records, informants and, where the police have been involved, police reports. They note that assessments carried out at the point of hospital admission are of necessity often limited in these respects, and unresolved issues of risk require continued attention in the course of an admission. They suggest that additional investigation, including psychological testing, may be required.

They suggest that if the assessment of violence risk is intended to address whether the risk can be managed in a community setting, the questions should be clear, specific, and clinically focused. An assessment of current mental state can be helpful in predicting future actions.

Psychiatrists assessing violence risk look for the presence of factors associated with violence. However, Buchanan and colleagues caution that some of what clinicians know about the correlates of violence derives from empirical research, and that while empirical research can increase confidence that a risk factor is associated with violence, it cannot be relied upon to identify all such risk factors. To be confirmed empirically, risk factors have to occur frequently enough to be studied and be capable of being measured. But some reported risk factors are uncommon while others are tied up in interpersonal relationships whose complexity renders them difficult to define for purposes of empirical research.

Nevertheless, the APA *Resource Document* provides useful information about common risk factors as well as information summarizing research on violence risk assessment instruments and their utility and limitations.

The Risk Exists: What to Do Next?

Once the clinician determines there is a risk of violence to another specific person or persons, it is imperative that he or she consider strategies that can help mitigate such risk. This might include immediate hospitalization or other action if warranted such as notification of police or an intended victim. Because these situations are nuanced, the information in this document cannot provide guidance for all situations, and clinicians should consider consultation with other expert clinicians and seek legal advice for a particular situation in which they are unsure of how to respond.

Emergency issues must be dealt with emergently, including taking action for protection. Clinicians would do well gaining familiarity with their relevant state statutes and case law regarding any duty to warn or protect persons at risk (or seeking legal guidance on these statutes) to determine his or her responsibilities in reporting that risk. Below we outline some general observations from statutes. In all states where a duty is addressed in statute,[16] it is usually addressed similarly, if not identically, for all types of clinical mental health providers licensed by the state—psychiatrists, psychologists, social workers, marriage and family therapists, and often the catch-all "counselors". In almost all states, the statutory obligation of the clinician to report a threat of harm is constructed as permissive, *i.e.,* as an exception to the clinician's duty to maintain the confidentiality of the client's communications and records.

Five states and Puerto Rico condition the report of a threat on the clinician's professional evaluation of the likelihood of the threat being carried out,[17] but most require only that there be a threat against a specific identified person. In a dozen states, a report can be made of a threat of a crime or harmful act.[18] In five states[19] and Puerto Rico, statutes permit the

reporting of threats against property; Vermont case law also permits reporting of crimes against property.[20] Again, there may be nuances to practicing in a particular state with other case law that shapes the contours of clinical responses.

All but about a dozen states[21] explicitly require in statute that the clinician report a threat of harm to law enforcement as well as to the specific person threatened. In one or two states, the statue specifies that the report to law enforcement be for purposes of involuntarily committing the alleged person posing the risk. Statutes and the various clinician ethical codes limit the communication of a threat to only the information necessary to put the potential victim (and where applicable, law enforcement) on notice.

In the few states where it has been addressed, case law states that clinicians are not required to report the threatened violence where there is evidence the individual knows or should have known of a threat of violence or of the alleged offender's violent tendencies.[22] New Mexico law imposes by case law a duty to control the alleged offender when the clinician has custody of the individual as an inpatient, but the case law emphasizes the duty arises from the clinician's duty to control "his offices" and not from a duty to control a patient with known dangerous propensities.[23]

Non-Clinical Providers

Montana is a state with a statute that provides for the duty of a certified behavioral health peer support specialist to warn of a client's threat of imminent harm to an individual, and then—once again—as an exception to the peer support specialists' mandate that provider-patient confidentiality be maintained.[24] However, at least four state peer certification programs teach that peer support specialists have a duty to warn potential victims of danger from a client in order to protect them from harm.[25]

Conclusion

Legal obligations to warn or protect individuals who might be at risk from the actions of a mental health professional's patient vary across states. Conducting risk assessments and taking action to mitigate risk is part of clinical practice.

Although laws differ across states, treating mental health providers are generally expected, under relevant statute and case law, to take some action to protect potential victims of a realistic threat of harm from their client. The duty applies generally to all types of providers—psychiatrists, psychologists, social workers, marriage and family therapists, the all-inclusive "counselor", and even nonprofessional certified peer support specialists (although the expectation may not be universal for the last category of provider).

The duty, where it exists, supersedes the expectation that the provider maintain client confidentiality, at least to the extent that a threat of violence has been made or, in some states, where it is clear to the treater that a patient with a known history of violence is again at risk of specific harm to others. How such notifications are executed can be another area for consultation. Patient communications other than the fact of the threat should be withheld, unless relevant to the threat, and communicating the threat should generally be limited to the specific individual(s) against whom the threat was made.

Across the United States and in other parts of the world, there has been a growing interest in addressing threatening behavior and understanding violence risk. The cases and background described above provide contexts for those interests. Clinicians working with patients who present as threatening to others would do well to familiarize themselves with local jurisdictional practices, consult with colleagues and liability carriers, and exercise judgment consistent with general clinical guidelines with careful documentation of the patient encounter and steps taken to mitigate risks.

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[18] Ariz. Rev. Stat. Ann. §36-509; Ark. Stat. Ann. § 20-45-202; Del. Code Ann. Tit. 16 §§1212 & 5402; Georgia Code § 37-3-166; Hawaii Rev. Stat. §626-1 Rule of Evidence § 504.1; Ill. Rev. State. Ch. 225 §§20-16, 55/70 & 107/75; Indiana Code § 25-23.6-1-3.8 & 25-23.6-6-1; Mont. Code Ann. §§27-1-1101 through 1103, 37-22-401, 37-23-301 & 37-38-106; N.Y. Civil Practice Law § 4508; S.C. Code Ann. §19-11-95; , S.D. Codified Laws Ann. §§36-26-30 & 36-22-37, 36-33-29, 36-33-31 & 36-33-32; and Revised Code of Washington § 18-19-180.

[19] Ark. Stat. Ann. § 20-45-202; Cal. Evidence Code § 1024; Conn. Gen. Stat. § 52-146c; Del. Code Ann. Tit. 16 § 5402; N.H. Rev. Stat. Ann. §§329:31, 329-B:29, 330-A:2, 330-A:35; 326-B:3, and 330-C:25 and Puerto Rico Laws tit 24, § 6153q.

[20] Peck v. Counseling Serv. Of Addison County, Inc., 499 A.2d 422 (1985).

[21] The exceptions are Indiana, Kansas, New Mexico, North Carolina, North Dakota, Pennsylvania, South Carolina, Tennessee, Vermont, Washington, West Virginia, and Wyoming.

[22] *Kelly v. Board of Trustees*, 87 N.M. 112, 529 P.2d 1233 (Ct. App.), *cert. denied*.; *Weitz v. Lovelace Health System, Inc., and Cigna Corporation*, 214 F3d 1175 (10th Cir. 2000)

[23] *Ibid.*

[24] Mont. Code Ann. § 37-38-106.

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