No. 91387-1
THE SUPREME COURT OF WASHINGTON

BEVERLY R. VOLK, as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Respondents/Cross-Petitioners,

v.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D., and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and healthcare provider; and DOES 1 through 5,

Petitioners/Cross-Respondents.

BRIEF IN SUPPORT OF RECONSIDERATION OF *AMICI CURIAE* WASHINGTON STATE MEDICAL ASS'N, WASHINGTON STATE HOSPITAL ASS'N, WASHINGTON STATE PSYCHIATRIC ASS'N, WASHINGTON ASS'N FOR MENTAL HEALTH TREATMENT PROTECTION, WASHINGTON STATE COALITION OF MENTAL HEALTH PROFESSIONALS AND CONSUMERS, WASHINGTON STATE SOCIETY FOR CLINICAL SOCIAL WORK, NATIONAL ASS'N OF SOCIAL WORKERS–WASHINGTON CHAPTER, WASHINGTON COUNCIL FOR BEHAVIORAL HEALTH, WASHINGTON CHAPTER–AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, WASHINGTON ACADEMY OF FAMILY PHYSICIANS, AMERICAN PSYCHIATRIC ASS'N, AND AMERICAN MEDICAL ASS'N

Gregory M. Miller, WSBA #14459
Rory D. Cosgrove, WSBA #48647

CARNEY BADLEY SPELLMAN, P.S.
701 Fifth Avenue, Suite 3600
Seattle, Washington 98104-7010
(206) 622-8020
Attorneys for Amici Curiae

TABLE OF CONTENTS

Page

I. IDENTITY AND ISSUE OF CONCERN TO *AMICI*

Amici are the state and national physicians, and state social work and mental health professionals providing mental health care in Washington, and the public and private hospitals in which emergency care, inpatient treatment, and psychiatric boarding occur.[1] *Amici* provide psychiatric care to those who need it. They and their patients are profoundly affected on a daily basis by the majority decision.

First, the majority decision creates a conflict between requiring an early warning of "potential dangerousness" and health-care providers' obligation to comply with federal health care privacy law, which allows disclosure only for "a serious and imminent threat" to health or safety. Absent clarification the duty to warn is triggered by not less than a "***serious and imminent*** threat," the decision violates the U.S. Constitution's Supremacy Clause and is legally unsound. RAP12.4(i).

Second, the majority decision does not give mental-health providers clear guidance how to comply with ***both*** the state law duty to warn—for which the majority holds they can be liable—***and*** with federal health care disclosure law under the Health Insurance

[1] *Amici* are the Washington State Medical Association; Washington State Hospital Association; Washington State Psychiatric Association; Washington Association for Mental Health Treatment Protection; Washington State Coalition of Mental Health Professionals and Consumers; Washington State Society for Clinical Social Work; National Association of Social Workers—Washington Chapter; Washington Council for Behavioral Health; Washington Chapter–American College of Emergency Physicians; Washington Academy of Family Physicians; American Psychiatric Association; American Medical Association.

Portability and Accountability Act (HIPAA). This makes their practices untenable.

The majority holds there is potential liability where the tragic assaults occurred over three months after the final visit between the patient DeMeerleer and Dr. Ashby, that a jury could find a duty to warn or take protective measures arose at some unstated point during Dr. Ashby's treatment, up to the final visit. But DeMeerleer never gave Dr. Ashby reason to believe he was confronted with a "serious and imminent threat to the health or safety" of others such that he had to disregard the physician–patient privilege and privacy law to warn potential victims or others to prevent such harm. Nor did the patient assault anyone close in time (imminently) to any of his therapy visits. Dr. Ashby could not have warned anyone without violating federal law. Yet the majority decision requires just such an early warning and disclosure, requiring the duty to warn for less than serious, ***imminent*** threats. *See Amici's* motion for leave to file, ("*Amici* Motion"), p. 4-6 (psychiatrists describing the conflict in their practices created by the majority decision and federal law).

HIPAA's use of the phrase "serious and imminent threat" is similar to a "true threat." Only a genuine, serious, imminent threat, or facts showing a serious and imminent threat of harm, should require a health-care provider to breach the physician–patient privilege that is

reinforced by the federal privacy laws.[2] Though plaintiffs cited HIPAA in their final brief, they did not emphasize the threshold standard for disclosure under HIPAA of "a serious and imminent threat" to health and safety. Rather, they argued for the lower foreseeability standard of the Restatement (Volk Answer, p. 12), and did not highlight it conflicted with the more stringent HIPAA standard. This is *Amici's* first chance to clarify the issue.

II. DISCUSSION

A. The majority's decision that a clinician in the outpatient setting must take reasonable precautions to protect *anyone* who might foreseeably be endangered by the patient's condition must be clarified to define what triggers this duty to warn and if it was met here.

The majority decision does not specify criteria for triggering the duty to warn or to protect third parties once a special relationship arises, or find that they occurred here, or that a jury could find they occurred here. Foreseeability is only a preliminary, incomplete step in imposing the duty to warn without a triggering event or circumstances showing an imminent threat of serious harm. Under the majority's rationale, once a clinician and her outpatient form a special relationship, that psychiatrist owes a "duty to take reasonable precautions to protect *anyone* who might foreseeably be endangered

[2] In fact, plaintiffs recognized in their final briefing that Washington privacy law must comport with this federal threshold standard for disclosure. *See* Volk's 11/6/15 answer to medical groups' amicus brief ("Volk Answer"), pp. 13-14 (quoting and attaching HHS letter and 45 CFR § 164.512(j)).

by [the outpatient's] dangerous propensities." *Volk v. DeMeerleer*, ___Wn.2d ___, 386 P.3d 254, 272 (2016) (emphasis added).

But whenever a "special relationship" arises, there still must be something during that relationship – *i.e.,* an event or circumstance that the psychiatrist sees or knows – that triggers the duty to warn, since a patient's risk of violence changes over time. That a patient has "dangerous propensities" is not the same as determining the patient will likely act on them and constitutes "a serious and imminent threat" of harm to specific persons or the public. "Dangerous propensities" is a lower threshold for warning or taking other action with the consequent disclosure of health information than is permitted under HIPAA. It does not help clinicians such as *Amici's* members to determine when a warning is required that will require disclosure of otherwise protected patient information.

The majority decision does not specify what constitutes a triggering event for purposes of activating the duty to warn or act. A special relationship may be a ***predicate*** to imposing the duty, but it does not ***trigger*** the duty or tell when it arises. What does? Words and demeanor or events sufficient for the practitioner to believe they could and should disregard the normally inviolate privilege because the threat is "serious," a genuine threat, and likely to happen soon

such that action must be taken "now" to prevent it, as in *State v. Hansen*, 122 Wn.2d 712, 721, 862 P.2d 117 (1993).[3]

The majority uses incidents occurring over eight years to conclude the "special relationship requirements were met." *Volk*, 386 P.3d at 272. The majority holds that these incidents *together*, some occurring years before the tragic events at issue, created a duty to warn. But nowhere does the decision pinpoint when, under what facts a jury could conclude the duty to warn had arisen such that Dr. Ashby should have ***warned*** or taken protective measures. There is no "triggering event" or circumstance in the record that put Dr. Ashby on notice that a latent, potential duty to warn based on patient's "dangerous propensities" had progressed to the point of a serious and ***imminent*** threat to anyone's safety, and thus triggered the requirement that he jettison his therapeutic role and breach otherwise inviolate patient privilege and privacy law and ethics to warn or protect third parties from a risk of harm.[4] Nor does the majority decision hold that there was.

---

[3] *Hansen* illustrates what is a "serious threat" confronting a professional that calls for disregarding a strict privilege, similar to HIPAA. Attorney Chris Youtz was confronted with the statements and demeanor of a prospective client that he had to evaluate and decide whether he would disregard the attorney–client privilege because of a "serious threat." *Id.* at 715. Youtz immediately consulted with the WSBA and his law partner, determined he had to take action, and gave warnings. *Id.*

[4] Dr. Ashby began treating DeMeerleer in 2001. DeMeerleer's last homicidal thought occurred in 2003—seven years before the tragic event in July 2010. *Volk*, 386 P.3d at 259. Nor did DeMeerleer ever tell Dr. Ashby that he wanted to or thought about hurting specific persons. In December 2009, DeMeerleer's wife, Schiering, moved out of DeMeerleer's home and terminated her pregnancy with their child. At the same time DeMeerleer was laid off from his job. *Id.* Despite these three stressful events at the same time, DeMeerleer did not hurt

B. Any test the Court adopts to define the trigger for the duty to warn or protect third parties should meet the requirements for disclosure under HIPAA.

1. HIPAA's "serious and imminent threat" threshold for disclosing protected health information should be used as the basis for triggering the duty to warn.

The majority decision instructs that even when an outpatient fails to make a threat or otherwise evidence an imminent safety concern, or fails to disclose a readily identifiable target of his or her homicidal thoughts, the psychiatrist at some undefined time must warn all "foreseeable" victims. *Volk*, 386 P.3d at 272 n.14. The decision does not limit the duty temporally. The threat need not be legitimate nor imminent but, apparently, arises once the special relationship is created.

But while a special relationship may be one predicate for a duty to warn, the fact of the relationship alone does not trigger that duty. The need for a warning may ***never*** arise during long-term outpatient treatment, and does not in most. The key question becomes, ***when*** during outpatient treatment, under what circumstances, does the duty arise, what triggers it? The majority decision does not answer these questions, yet imposes liability for failing to timely warn or protect. Washington clinicians need to

---

himself or others; he sought out Dr. Ashby and resumed therapy. *Id.* At the last visit with Dr. Ashby in April 2010, DeMeerleer stated that he and his wife were improving their relationship. Although he told Dr. Ashby he was having suicidal ideation in April, and Dr. Ashby knew he had a history of noncompliance with his medication, he also told Dr. Ashby that he would not act on those suicidal thoughts. Dr. Ashby also knew that DeMeerleer had never up to that point harmed anyone, including after the hugely stressful events of December 2009.

know when they ***must*** act. *Amici* suggest the federal standard for disclosing patients' private personal health information is the correct standard and would give the necessary clarity.

HIPAA imposes a clear three-part test before disclosure is allowed. Disclosure must be: 1) "***necessary*** to prevent or lessen"; 2) "a ***serious and imminent*** threat to the health and safety of a person or the public"; ***and*** 3) disclosure is only to "a person[(s)] . . . reasonably able to prevent or lessen the threat, including the target of the threat." 45 CFR § 164.512(j)(1) (emphasis added).

Absent a "serious and imminent threat" to specific persons or the public, HIPAA precludes disclosing a patient's confidential information. The HIPAA test calibrates the interests in protecting public safety with encouraging patients to disclose pertinent facts relating to treatment without fear of involuntary commitment.

2. Imposing on outpatient providers the duty to warn of only "dangerous propensities," or any other standard that also is less than knowledge of, or circumstances constituting a "serious and imminent threat" would violate HIPAA and thus also violate the U.S. Constitution's Supremacy Clause.

The Supremacy Clause provides that "the laws of the United States ... shall be the supreme law of the land; and the ***judges*** in every state shall be bound thereby." U.S. CONST. art. 4, cl. 2 (emphasis added). It requires state court judges to conform to federal law. *Testa v. Katt*, 330 U.S. 386, 394 (1947). A state court ruling that is contrary to or thwarts the intended effect of federal

regulations "violates both the spirit and the letter of the Supremacy Clause." *Boron Oil Co. v. Downie*, 873 F.2d 67, 71 (4th Cir. 1989).

HIPAA expressly preempts any "contrary" state law on disclosure of patient information, unless the state law is "more stringent" than the HIPAA requirements. 45 C.F.R. § 160.203(b). A state law is "contrary" to HIPAA if a health care provider would find it impossible to comply with both the state and federal provisions regarding disclosure, or if the state law is an obstacle to the accomplishment of the purposes of HIPAA. 45 C.F.R. § 160.202.

Under the Supremacy Clause and the text of HIPAA, the federal rules are the "floor" of the minimum standard for disclosure. If Washington's disclosure regulations are more stringent,[5] they would not conflict with federal law, similar to Washington's right to have more privacy rights under article 1 § 7 of the state constitution than under the Fourth Amendment. But Washington law that is less stringent, such as the majority decision, would fail to meet HIPAA's minimum requirement and be in conflict.

---

[5] Washington's mental health privacy regulations provide greater protections than the federal regulations standing alone, while simultaneously incorporating the requirement for mandatory disclosure under HIPAA. *See, e.g.,* RCW 70.02.050(1)(c), RCW 70.02.230(2)(h)(i) &(ii) and RCW 70.02.230(2)(i)(i)&(ii) ("disclosure under this subsection is mandatory for the purposes of the health insurance portability and accountability act"). This means the majority decision is also in conflict with practitioners' responsibilities under existing state law. Because the majority decision alone does not qualify as a mandatory disclosure under HIPAA (*see* 45 C.F.R. § 164), reconsideration is necessary to clarify disclosure standards in a manner that allows providers to comply with both state and federal health care disclosure law.

The majority decision is partly premised on *Petersen v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983), using its "dangerous propensities" as the apparent basis for when the duty to warn arises. *E.g., Volk*, 386 P.3d at 272. "Dangerous propensities" is a far lesser standard than HIPAA's of a serious and imminent threat, or of a "serious" threat as in *Hansen.* The *Petersen* standard may have made sense for the in-patient setting where the clinician controls whether a person with "dangerous propensities" is released into the public. But using an inpatient standard is unsound reasoning in the outpatient context because of a lack of the same genuine and complete control over the patient that attends the inpatient setting. The difference in patient control between in-patient and outpatient settings is also why it is critical for the ultimate decision to be congruent with federal law on disclosure of health information ***only*** when confronted with a serious ***and*** imminent threat of harm. The outpatient clinician does not control the patient.

Any clinician can act only based on the information he or she has. It is faulty reasoning for a clinician to be faulted for not giving a warning when he never got the information of the events that made a threat of harm to others imminent and triggered the duty.

C. The majority decision will fail to advance the goals of protecting public safety, allowing psychiatrists to provide effective treatment, and safeguarding individual rights.

The majority decision has consequences that fail to advance the goals of protecting public safety, allowing psychiatrists to provide effective treatment, and safeguarding individual rights. Mentally-ill patients may fear disclosing their thoughts in therapy for fear of involuntary civil commitment which "is a substantial curtailment of individual liberty." *See In re Det. of Danforth*, 173 Wn.2d 59, 74, 264 P.3d 783 (2011). Access to appropriate mental-health treatment will likely decrease for those who need it most because providers will try to avoid this unclear duty-to-warn liability in several ways. Some will give warnings or seek involuntary treatment prematurely, at the first mention of any suicidal or homicidal ideation, not trying to treat and work with the patient until circumstances show a serious and imminent threat of the sort seen in *Hansen*. *See* Motion to File Amicus Brief, p. 2-3, 7. Others will stop serving patients altogether, or stop seeing those most likely to present such problems and who, ironically, most need treatment. *Id.* This result helps neither individual health nor public safety.

III. CONCLUSION

Amici respectfully request the Court grant reconsideration to clarify the standard for outpatient clinicians for triggering the duty to warn of a patient's potential, imminent dangerousness that does not violate federal health care privacy law.

Respectfully submitted this 31st day of January, 2017.

CARNEY BADLEY SPELLMAN, P.S.

By _____
Gregory M. Miller, WSBA #14459
Rory D. Cosgrove, WSBA #48647
Attorneys for Amici Curiae