Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

Senate Judiciary Committee
Testimony Regarding S.3 – Duty to Warn
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John H. Wallace General Counsel, Rutland Regional Medical Center

Chairman Sears, Vice Chair Benning and members of the Committee, thank you for inviting me to testify regarding my experience with duty to warn issues. I have provided legal advice to mental health professionals in duty to warn situations since 1999. As a compliance professional I have written policies and provided training regarding the Peck and Kuligoski standards. Over the last eight months, I have worked with many health care attorneys to develop a common understanding of how to comply the Supreme Court's Kuligoski decision. I have also worked with a broad group of advocates, providers, associations and attorneys to discuss our shared concerns regarding the new duties described in the court's decision and to develop policy recommendations for the Legislature. I am testifying on behalf of Rutland Regional Medical Center and my views do not necessarily reflect the views of the numerous stakeholders. However, I can state that the stakeholder group is unified in asking the Legislature to (1) overturn the Court's decision; and (2) clarify the mental health professional's legal duty so that all mental health professionals can consistently comply with law.

1. The Court recognized the need for the Legislature to consider policy arguments and evidence in evaluating the duties of mental health professional and those family members and friends that support patients.

The Court recognized at ¶77 the need for the Legislature to consider the "policy arguments and evidence" that are "appropriate for legislative action." Legislative action is needed because the Court did not have the opportunity to consider policy arguments and evidence that are necessary to establish a broad duty that is applicable to all mental health professionals. The Court emphasized throughout its decision that because the case involves a *motion to dismiss* it was required to accept all facts stated by the plaintiff as true (¶7). The procedural status of the case required the Court to reach conclusions based on the allegations in the complaint without the opportunity to weigh the evidence of competing policy arguments. The Court described its role as "limited to determining whether the bare allegations of the complaint are sufficient to state at claim." (¶18). The duty described in the decision that is not established facts and evidence is currently contributing to pervasive confusion for mental health professionals who are trying to understand their legal obligations and the legal obligations of patients' families and friends.

Broad policy that affects all mental health professionals, their patients, and family members and friends that support or assist patients should be based on the Legislature's evaluation of policy arguments and evidence. The evidence demonstrates that the Legislature needs to act to prevent the duties described in Kuligoski from being applied broadly to all mental health professionals and all families and friends that support patients. The testimony of numerous mental health professionals demonstrates that the decision does not include duties that mental health professionals can understand and comply with.

2. The Court's decision creates broad inflexible duties – not based on evidence – for all mental health professionals and family members and friends who support patients.

The Court describes the scope of the duty at ¶ 52 and ¶ 82 of the opinion. The duty applies whenever a "caregiver" is involved "with a patient's care or the patient's treatment plan." ¶52. The Court referred to a "discharge plan" as an example of a treatment plan: "the duty applies when. . . the patient's treatment plan (or in this case, discharge plan) substantially relies on that caregivers ongoing participation." ¶82. In addition, the Court did not limit it's holding to facilities that conduct discharge planning. Rather, the Court chose to extend the duty to mental health professionals that provide patient care in all settings and specifically stated that outpatient providers have the same duty that inpatient providers have. ¶81.

The duty described at ¶52 requires mental health professionals to first determine which of their patients have "dangerous propensities." The duty to identify dangerous propensities expands the mental health professional's duty from Peck's focus on present danger ("patient poses a serious risk of danger") to the broader duty to identify future dangerousness. The requirement to identify dangerous propensities is not based on evidence because clinical evidence demonstrates that mental health professionals cannot accurately predict future dangerousness and there are no established clinical guidelines for the broad class of "mental health professionals" to single out individual patients as having "dangerous propensities" from a large population of patients.[1]

Since there are no limitations on the duty to identify dangerous propensities, all mental health professionals will need to consider all information that is available to them regarding all patients. As mental health services are integrated in many other health care services there are fewer distinct separations between mental health series and emergency medicine, primary care, oncology, cardiology, pulmonology and others. As mental health professionals engage patients in their broader health care those professionals may have constructive knowledge of a patient's entire health history including circumstances that may have occurred decades ago that a future plaintiff could consider evidence of a dangerous propensity that implicates liability for the mental health professional.

3. The broad and inflexible duty imposed on family members and friends is not consistent with the evidence based Federal discharge planning regulations.

The Federal discharge planning regulations that apply to hospitals are included in the Conditions of Participation (CoPs) for Hospitals at 42 CFR § 482.43. The CoPs include 33 pages of evidence based standards and guidelines for discharge planning.[2] The Court's decision

[1] No psychological test or interview can predict future violence with high accuracy. C. Scott, *et al*., *Assessment of Dangerousness*, *in* THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY, 1655 (R. Hales, *et al*., eds. 2008). R. Simon, CLINICAL PSYCHIATRY AND THE LAW, 165-166 (2d ed. 1992) ("As is now widely known, not only are psychiatrists unable to predict dangerousness, but they also may err on the side of overprediction."); J. Cocozza, *et al*, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1099 (1976). J. Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 13 (1984)(The inaccuracy of clinical prediction is so well established that the issue should be declared officially dead.). C. Scott, *et al*., *Assessment of Dangerousness*, *in* THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY 1668 (R. Hales, *et al*., eds. 2008) (prediction of violence remains an inexact science).

[2] CMS State Operations Manual, Appendix A, Regulations and Interpretative Guidelines for Hospitals, 42 CFR § 482.43, Condition of Participation: Discharge Planning https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

conflicts with the evidence based discharge planning requirements because the Court imposes a legal duty on family members and friends without any evidence that family members and friends can reliably fulfill the legal duties that the Court now requires mental health professional to communicate to them.

The discharge planning regulations require hospitals to evaluate a patient's ability to provide for their own self-care and if the patient is not able to provide the required self-care the hospital must evaluate whether family or friends are willing and able to provide the required care. (Interpretative Guidelines for §482.43(b)(4)). The types self-care that a family member or friend can be trained to provide are generally described as the activities of daily living such as personal hygiene or taking medication. The Guidelines refer to numerous evidence based tools and resources to guide support persons to help meet a patient's needs. The discharge planning requirements require flexibility because they involve a professional evaluation of a support person's ability to meet the needs that a patient cannot manage on their own. The Court's decision conflicts with this need for flexibly because it imposes an inflexible legal duty that family members and friends need to be informed to continuously monitor an individual's mental state and identify situations that may occur in the future that will require them to act to protect third parties. There are no evidence based guidelines that demonstrate that family members or friends can reasonably comply with these new legal duties. The ability to evaluate an individual's mental state and identify risks to third parties is appropriately reserved for licensed professionals.

4. The Legislature should clearly articulate a standard that allows mental health professionals to understand and comply with their common law duty and comply with HIPAA.

The Courts' second decision recognized the need to comply with HIPAA in describing the mental health professionals' common law duty. The Court correctly states at ¶82 that a "provider has no duty to convey any information in violation of HIPAA." We believe that the duty described in Peck that is triggered by a "serous" present danger to a third party appropriately balances the needs of patients and mental health professionals with the interests of safety. However, Peck predates HIPAA and a mental health professional risks violating HIPAA if they rely on the "serious" standard in Peck without understanding that HIPAA requires that the risk must also be "imminent.[3]" Violating HIPAA in this context can have serious consequences including the potential for federal criminal prosecution. For example, a Virginia psychiatrist was subject to federal indictment for allegedly disclosing patient information that did not satisfy the "serious and imminent" standard.[4]

We believe that it is necessary for the Legislature to clearly communicate to mental health professionals and others the common law duty described in Peck along with the need to comply with the HIPAA standard for risks that are "serious and imminent."

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[3] A covered entity may use or disclose protected health information if the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the person is reasonably able to prevent or lessen the threat. 45 CFR § 164.512(j)

[4] FBI, Norfolk Division, Press Release: Doctor Charged with Disclosing Protected Individual Health Information (June 21, 2011). https://archives.fbi.gov/archives/norfolk/press-releases/2011/doctor-charged-with-disclosing-protected-individual-health-information