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Does *Volk v DeMeerleer* Conflict with the AMA *Code of Medical Ethics* on Breaching Patient Confidentiality to Protect Third Parties?

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Abstract

A recent Washington State case revisits the obligation of mental health clinicians to protect third parties from the violent acts of their patients. Although the case of *Volk v DeMeerleer* raises multiple legal, ethical, and policy issues, this article will focus on a potential ethical conflict between the case law and professional guidelines, namely the American Medical Association's *Code of Medical Ethics*.

Introduction

A recent Washington State case, *Volk v DeMeerleer* [1], revisits the obligation of mental health clinicians to protect third parties from the harmful acts of their patients. Mental health clinicians' obligations to warn or protect third parties from the violent acts of their patients are known generally as *Tarasoff*-type duties after the landmark 1976 California Supreme Court decision in *Tarasoff v Regents of the University of California* [2]. In *Tarasoff*, the California Supreme Court held that when a psychotherapist determines, or should determine, that his patient "presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger" [3]. Following *Tarasoff*, most states responded (either through statute or case law) by detailing when a mental health clinician could (permissive) or must (mandatory) take steps to notify the victim or police or take other protective steps in an effort to mitigate harm. States vary as to the exact requirements [4].

Although the *Volk* case concerned a psychiatrist, its ruling reasonably applies to other types of mental health clinicians in Washington State. Given the vagueness of the *Volk* ruling and the fact that other types of clinicians could, similarly, see patients at risk of harming third persons, future cases could also extend the holding to other clinicians in Washington State, such as primary care clinicians. Thus, it is useful for clinicians to appreciate the legal and ethical tensions involved in breaching patient confidentiality to

protect third parties.

This article will summarize the recent *Volk* decision and discuss a potential ethical conflict between the case law and the American Medical Association's *Code of Medical Ethics* [5]. Although the *Volk* case raises multiple practical, legal, ethical, and policy issues, the focus of this article will be on describing the case and the potential conflict for mental health clinicians (particularly psychiatrists) between their legal responsibilities outlined in *Volk* and their ethical obligations outlined in the *Code*. Since the *Volk* ruling, mental health clinicians in Washington State face conflicting legal and ethical obligations because the *Volk* decision permits (and, arguably, encourages) clinicians to breach patient confidentiality and issue warnings to protect third parties more broadly than permitted by the *Code*. *Volk* permits disclosure of patient confidences in three important ways that differs from the *Code*: (1) it mandates clinicians to take measures to protect any foreseeable victim (rather than an identifiable victim); (2) the clinician incurs responsibility when his or her patient has dangerous propensities (rather than when the patient presents a threat of serious physical harm); and (3) it calls for clinicians to take action when there is a possibility (rather than a probability) of harm to third persons.

Volk v DeMeerleer

Facts of the case. On July 18, 2010, Jan DeMeerleer entered the home of Rebecca Schiering, his ex-fiancée, and murdered Ms. Schiering and one of her sons. Her other son escaped. Mr. DeMeerleer then shot and killed himself.

Mr. DeMeerleer carried a diagnosis of bipolar disorder and had been in psychiatric care on and off with Dr. Howard Ashby of the Spokane Psychiatric Clinic for nine years. Intermittently over the years, he had thoughts of harm to himself and others, but he had made no suicide attempts during his nine years of treatment with Dr. Ashby. He had his last appointment with Dr. Ashby approximately three months before the event at issue. At that appointment, Mr. DeMeerleer voiced no thoughts of violence and, specifically, reported no thoughts of harm directed at Ms. Schiering, her children, or anyone else. He disavowed intent to harm himself. Subsequently, his relationship with his fiancée ended.

Following the deaths, Ms. Schiering's mother and surviving son sued Dr. Ashby and the Spokane Psychiatric Clinic for failure to follow the standard of care, arguing that Dr. Ashby "might have prevented the attacks by either mitigating DeMeerleer's dangerousness or warning" the victims [6].

Ruling and reasoning. Defendant Dr. Ashby moved to dismiss the case by summary judgment on the basis that he owed no professional duty to third parties in general or the Schierings in particular since Mr. DeMeerleer never disclosed any plan to harm them. Dr. Ashby filed no affidavit or expert material on the standard of care for psychiatrists since any battle of the experts would preclude summary dismissal of the case. Instead,

Dr. Ashby relied on a legal argument and the undisputed fact that Mr. DeMeerleer had not threatened the Schierings in the presence of Dr. Ashby. Citing Washington law, specifically Revised Code of Washington (RCW) 71.05.120 [7], he asserted that a mental health clinician owes a duty to third parties only when the patient has "communicated an actual threat of physical violence against a reasonably identifiable victim or victims," which had not occurred in this case. The trial court agreed and granted summary judgment to Dr. Ashby [1].

On appeal, the appellate court ruled that the state's statute (RCW 71.05.120) applied only in the context of involuntary psychiatric treatment and reversed and remanded the trial court's decision [8]. The Washington Supreme Court affirmed the appellate court. Relying on prior case law in the context of inpatient psychiatric care [9], the Washington Supreme Court ruled that a mental health professional owes a duty of "reasonable care to act consistent with the standards of the mental health profession, in order to protect the foreseeable victims of his or her patient" [10]. Under *Volk*, the outpatient mental health clinician "incurs a duty to take reasonable precautions to protect *anyone* who might foreseeably be endangered by the patient's condition" (italics in original) [11]. Once there is a "special relationship" between the patient and clinician, the clinician's duty attaches based on the patient's dangerous propensities, even if the patient voices no threat of violence and even if no victim is identified (or reasonably identified) [11]. In *Volk*, Dr. Ashby conceded that he had a special relationship with Mr. DeMeerleer [10]. This case was remanded to the trial court to resolve the liability claims.

Conflict between *Volk* and Professional Guidelines

Confidentiality is both a legal and an ethical issue. Generally, health care professionals are prohibited from disclosure of patient confidences unless such disclosure is required or permitted by law. For clinicians, unauthorized breach of a patient's confidentiality can result in lawsuits and adverse actions by state licensing boards or professional organizations.

The *Volk* standard raises several challenges for practicing mental health clinicians in Washington State. Among them are that clinicians, following *Volk*, could find themselves at odds with state and federal privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA) [12]), as well as professional ethical guidelines that aim to protect patient confidences. The *Volk* decision permits clinicians to disclose patient confidences more broadly than privacy laws and some professional guidelines. By way of example, the discussion here focuses on the potential conflict between *Volk* and the *Code*, which provides ethical guidance for all physicians, including psychiatrists.

The importance of the confidentiality of communication between patients and their clinicians is recognized in professional guidelines. The *Code* states:

> Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient [13].

This guidance is supported by the American Psychiatric Association (APA). The APA's "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" [14], adopted from the AMA, includes the following statement: "A physician shall respect the rights of patients … and shall safeguard patient confidences and privacy within the constraints of the law" [15]. The AMA's and APA's guidance recognizes that confidentiality encourages candid communication, which is vital to psychotherapy and for providing appropriate treatment to patients with mental health conditions.

Although confidentiality is not absolute, patients generally expect their comments to mental health professionals to be confidential absent some clearly defined exceptions. For example, the APA's annotations permit (not mandate) psychiatrists to reveal certain patient confidences when, according to clinical judgment, "the risk of danger is deemed to be significant" [16].

Physicians' ethical obligations to protect confidentiality, however, can conflict with their legal responsibilities outlined in *Volk*. As noted earlier, many *Tarasoff*-type laws, including the 1976 case itself and RCW 71.05.120, balance the interests of the patient and third parties by enjoining a psychotherapist's duty to third persons only when there is a specifically identifiable (or reasonably identifiable) victim and, in the clinician's judgment, the patient presents with sufficient risk of harm. The APA's model statute on the duty of physicians to take precautions against patient violence prohibits clinician liability for breaching a duty to prevent harm unless the clinician fails to take reasonable measures when a patient has communicated an explicit threat to "*kill or seriously injure a clearly identified or reasonably identifiable victim or victims*" (italics added) [17]. Similarly, the *Code* permits disclosure of confidential information to mitigate the threat when there is a reasonable *probability* that "the patient will inflict *serious physical harm* on an *identifiable individual or individuals*" (italics added) [13].

Comparing *Volk* to the *Code*

The language of the *Volk* ruling conflicts with the *Code* in several important ways. Among these, under *Volk*, the duty of outpatient mental health clinicians in Washington has been expanded to all *foreseeable* victims of a patient's violent acts, even those who have *not* been identified by the patient. Under the *Volk* ruling, then, can (or must, if there is not another appropriate protective measure to take) the clinician contact family if the patient has some risk factors for violence? What about employers? Neighbors? Bus drivers? How

far does the sphere of foreseeability extend if the patient does not reasonably identify anyone? Although the court in *Volk* stated that the standard requires clinicians' actions to be "informed by the standards and ethical considerations of the mental health profession" [18], the holding could, in fact, put clinicians at odds with their professional ethics code by extending the duty to foreseeable victims rather than identifiable victims. Although sanctioned by the *Volk* ruling, every communication by a clinician to a foreseeable (but not an identifiable) victim would put the clinician at odds with the *Code*, as well as expose him or her to possible legal claims for breach of confidentiality. With *Volk* as precedent, the scope of foreseeability will be decided on a case-by-case basis by the trier of fact (judge or jury) as future cases move through the courts. There is no defined professional standard for what constitutes sufficiently foreseeable victims or harm.

In addition, the *Volk* duty is triggered by a patient's "dangerous propensities," whereas the *Code* permits breach of patient confidences only to mitigate a threat of "serious physical harm" [5]. "Dangerous propensities" is not defined in medicine, or under Washington State law, leaving clinicians without clear guidelines as to what triggers their duty under *Volk*, except that an actual threat is not required. Could the clinician's duty be triggered by a patient's expression of hostile emotions? Angry words? History of violence? History of substance use? Arguably, yes, under *Volk*, even when the patient is not manifesting a current actual threat of physical harm. The vague definition of dangerous propensities begs clinicians to consider protective measures—including disclosing patient confidences—without more than a general concern that a patient might present a risk of danger to another. As a consequence of *Volk*, patients with dangerous propensities, but who are actually nonviolent, risk loss of privacy and liberty as a means of protecting other members of society.

What is more, pursuant to the *Code*, for a clinician to breach confidentiality to protect a third person there must be a "reasonable probability," based on clinical judgment, that the patient is at risk for inflicting harm on another [13]. In law, the term probability generally means more likely than not, or reasonable likelihood. Clinicians performing risk assessments can consider whether the level of risk is more probable in comparison to the base rate of occurrence of the type of violence (e.g., homicide) at issue. In contrast, *Volk* creates a duty for clinicians to take an affirmative measure to protect another when there is a mere *possibility* of harm (i.e., a third person "*might* foreseeably be endangered"), even when it is improbable. In law, a possibility equates with "chance" of something happening. Under *Volk*, in combination with the case's other parameters—needing to protect any foreseeable victim from a patient's dangerous propensities— the number of victims to protect increases as the level of risk (probability and specificity of violent action) needed to trigger a clinician's action decreases. In an effort to comply with *Volk*, clinicians could take measures (including breaching patient confidences by issuing warnings) that are not likely to mitigate risk and could actually have unintended

consequences of harming the patient and, in some cases, needlessly causing distress to the warned foreseeable victim.

Although *Volk* permits clinicians to take measures other than warning to protect foreseeable victims, the pressure on clinicians to issue warnings is high, especially in the outpatient context and when patients do need to meet criteria for an involuntary hold under the state's civil commitment laws. When clinicians take other protective measures (such as seeking involuntary or voluntary hospitalization or referring a patient to specialty substance use treatment), they can avoid conflict with the AMA *Code* as discussed here when the other protective measures do not require breach of patient confidences. However, the issuance of warnings might be seen by some as a safe way to discharge one's duty as it is relatively easy to prove (should there be a legal suit against the clinician) that measures to notify were taken (e.g., by obtaining phone records). Clinicians' employers and insurers commonly want to avoid litigation and could instruct (or guide) clinicians to take the safest route to demonstrate they followed the legal mandate, which is to issue warnings. When warnings are to be issued, the law commonly requires clinicians to take reasonable steps to notify both the intended victim(s) and law enforcement [7].What constitutes reasonable efforts to notify the victim(s) and law enforcement is subject to legal determination and is based on factors such as the measures taken by the clinician (e.g., repeated phone calls, letter), timeliness of the steps taken, characteristics of the intended victim (e.g., whether he or she has a working phone), and the seriousness of the anticipated harm. It is prudent for clinicians to record these efforts.

Ramifications of *Volk* Related to Confidentiality

Applying the legal mandate of *Volk* is likely to lead to some unnecessary breaches of patient confidentiality. Despite advances in violence risk assessment since *Tarasoff*, health care clinicians are poor predictors of when a patient will act violently [19]. Even if a patient expresses violent thoughts to a clinician, it is important to recognize that the expression of violent thoughts is not altogether uncommon. To illustrate, reflect on how many times you may have heard or said things like "I'm so mad I could kill him!" or "I want to tear his head off!" Indeed, there is a weak overall association between threats and acts of violence [20]. What is more, recent studies indicate that only a small percentage of violent acts can be attributed to serious mental illness and that most violence can be attributed to risk factors other than mental illness alone, such as past history of violence and substance use [21].

Volk's requirement for clinicians to take measures to protect anyone who "might foreseeably be endangered" could encourage clinicians to make disclosures to protect themselves from liability, even if they don't believe the patient is likely to harm anyone in particular. Under *Volk*, what is best for the individual patient may be sacrificed for the perceived good of the public. When mental health clinicians take protective measures,

such as issuing warnings or seeking to hospitalize patients, patients' face real consequences, including having their private information disclosed and loss of freedom. Patients also face possible embarrassment, loss of privacy, negative impacts on their relationships and employment standing, and damage to their social standing. Issuances of broad warnings perpetuate the misperception that people with mental illnesses are typically violent.

These ramifications can also have negative effects on the treatment relationship. A cannon of psychotherapy is for patients to be open and truthful about their thoughts, emotions, and behaviors so that these can be addressed through therapeutic means. As articulated by the US Supreme Court, effective treatment "depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.... [T]he mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment" [22]. Under *Volk*, patients could be left uncertain as to what (and to whom) information they share with their therapist could be disclosed. The *Volk* decision could lead some patients to avoid or withdraw from treatment due to concerns that their private information could be revealed to others, even if they do not reasonably identify a victim or demonstrate current risk of physical harm.

To reduce stigma and engage patients in treatment, the better approach, rather than issuing broad warnings, is for clinicians to perform reasonable violence risk assessments and identify targets of intervention in collaboration with their patients. Risk management interventions are focused on identifying causes of violence for the particular patient and working to reduce each patient's modifiable risk factors for violence [4]. As such, breaching patient confidentiality by issuing warnings should occur only in narrowly tailored circumstances in order to balance other obligations clinicians have to the therapeutic relationship, ongoing treatment, and protection of the public.

Conclusion

The *Volk* case established legal precedent for outpatient mental health clinicians in Washington State. Future cases against clinicians for their patients' harm to third parties (e.g., medical negligence, wrongful death) will be tried under the *Volk* standard. It will be up to the trier of fact to determine whether the victims of a patient's violence were foreseeable and, if so, whether the clinician acted reasonably to protect them.

Without changes to this law, there is increased likelihood that future clinicians and employers in similar situations, fearful of being in Dr. Ashby's position, will more willingly (and likely unhelpfully) breach patient confidentiality. This creates a dilemma for clinicians in Washington State, who could find themselves caught between trying to meet the requirements of the legal case and also adhering to their professional ethical guidelines. Mental health clinicians have largely come to recognize a need for balancing

the interests of patients, clinicians, and potential victims with clearly and rationally defined measures. The *Code* strikes a balance in respecting confidentiality while providing an exception to allow disclosures of patient confidences under reasonable and narrow circumstances to protect identifiable third persons. Concrete legal and ethical standards are better understood and executed by clinicians [23]. A legislative remedy in Washington could better align clinicians' legal and ethical responsibilities and create a clearer standard for clinician duties.

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