NO. A20-0711

State of Minnesota
In Supreme Court

David Smits, as trustee for the next of kin of
Brian Short, Karen Short, Madison Short, Cole Short, and Brooklyn Short,

Respondent,

vs.

Park Nicollet Health Services; Park Nicollet Clinic; Park Nicollet Methodist Hospital, Park Nicollet Enterprises, Group Health Plan, Inc. d/b/a HealthPartners Medical Groups,

Appellants.

BRIEF OF AMICUS CURIAE AMERICAN MEDICAL ASSOCIATION, MINNESOTA MEDICAL ASSOCIATION, AND MINNESOTA HOSPITAL ASSOCIATION

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INTRODUCTION AND STATEMENT OF INTEREST[1]

The American Medical Association ("AMA"), Minnesota Medical Association ("MMA"), and Minnesota Hospital Association ("MHA"), have a profound public interest in this case and urge the Court to reverse the court of appeals. The court of appeals' decision subjects health-care providers to an impossibly broad obligation to predict and protect against harm to third parties by patients who have not expressed homicidal—or suicidal—ideations or made any threat against anyone. The court's holding is highly problematic, contravenes precedent, substantially undermines this State's public policies expressed through clear legislation, and will have significant ramifications for health-care providers and those needing their services. This Court should reverse.

I. American Medical Association.

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core

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[1] The undersigned counsel authored this brief in whole. No one but *amici* and their counsel made a monetary contribution for the brief's preparation or submission. Minn. R. Civ. App. P. 129.03.

purposes today. AMA members practice in every medical specialty and in every state, including Minnesota.

The AMA and MMA join this *amicus* brief independently and on their own behalves, but also as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and medical societies in each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

II. Minnesota Medical Association.

The MMA is a non-profit professional association representing more than 11,000 physicians, residents, and medical students in Minnesota. The MMA seeks to be the leading voice of medicine to make Minnesota the healthiest State and best place to practice. The MMA advances health and health-system changes, fosters physician resilience, trust, and community, improves physician efficacy, and convenes physicians and partners to address emerging critical issues in health care. For more than 165 years, the MMA and its members have worked to safeguard the quality of medical care in Minnesota and to improve the health of all Minnesotans.

The MMA has a significant interest in improving mental-health services in Minnesota. Among many other activities, MMA has endorsed the development of effective community-based mental-health services and supported legislation for non-discriminatory insurance coverage for treatment of mental-health disorders.

III. Minnesota Hospital Association.

The MHA is a non-profit organization that represents Minnesota's hospitals and health systems, which employ more than 127,000 people and provide high-quality medical care to patients throughout the State. Founded in 1917, the MHA provides hospitals and health systems with resources and guidance they need to provide an exceptional patient experience and affordable care. The MHA regularly advocates for its members with lawmakers and other decision-makers, educating them on complex issues specific to health care to assure they make informed decisions.

Like the MMA, the MHA has a significant and ongoing interest in improving mental-health care services throughout the State. In 2019, the MHA identified mental-health care as one of its top priorities and has commissioned many studies regarding mental-health care in Minnesota.

DISCUSSION

I. The current state of mental-health treatment encourages persons to seek treatment, emphasizes outpatient care, and narrowly restricts providers' liability.

Mental illness strikes with a two-edged sword. On one side are the symptoms, distress, and—sometimes—disability. On the other is stigma associated with mental-health disorders. And as it relates to this case, "[p]erhaps the most damning is the stereotype that people with a mental illness are dangerous."[2] This Court, like many

[2] P.W. Corrigan & A.B. Link, *The Stigma of Mental Illness*, 4 ENCYCLOPEDIA OF MENTAL HEALTH 230, 230 (2016).

others, has stated that its decisions should reflect a policy of de-stigmatizing mental-health conditions. *See, e.g.*, *Lundgren v. Fultz*, 354 N.W.2d 25, 29 (Minn. 1984) (observing that in *Cairl v. State*, 323 N.W.2d 20 (Minn. 1982), the Court "refused to impose a duty to warn potential victims of a patient's dangerous propensities," and stating that "if such a duty were imposed, the resulting 'cacophony' of warnings would add greatly to the stigma of mental illness").

A. The evolution of mental-health treatment.

For many years, persons with mental ailments were put in prisons, shelters, or asylums. Society's view "was that persons with mental illness lacked the capacity to make decisions."[3] By the early 1950s, state-run asylums housed more than 500,000 people.[4]

Society's approach to mental illness, however, gradually changed. In 1951, the National Institute of Mental Health drafted and published the "Draft Act Governing Hospitalization for the Mentally Ill" to facilitate procedures to protect the due-process rights of mental-health patients. Then, in 1963, President John F. Kennedy signed into

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[3] Megan Testa, M.D. & Sarah West, *Civil Commitment in the United States*, PSYCHIATRY Vol. 7 No. 10, 32 (2010).

[4] *Id.*

law the Community Mental Health Centers Act to facilitate treating patients in their communities, not through forced commitment.[5]

In the 1970s, the United States Supreme Court issued a series of decisions reinforcing the constitutional rights of mental-health patients. *See, e.g.*, *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in custodial confinement."); *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation on liberty that requires due process protection" and holding that states, at minimum, must demonstrate need for confinement of a mental-health patient by clear-and-convincing evidence).

Legislatures, too, began establishing legal frameworks to focus mental-health treatment on community-based outpatient programs and to limit involuntary treatment and confinement. The medical community embraced this change, and it is now widely accepted that "mental health treatment and services can only be effective when the consumer embraces it, not when it is coercive."[6]

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[5] *See, e.g.*, Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 53 (2011).

[6] Justin M. Thompson & Theodore A. Stern, *Involuntary Hospitalization of Primary Care Patients*, PRIM. CARE COMPANION CNS DISORD. 16.3 (2014).

The American Medical Association—the largest professional association of physicians, residents, and medical students in the United States—has adopted formal policies to reflect this reality. The AMA advocates discrete steps to remove barriers to mental-health treatment:[7]

- reducing the stigma of mental illness by dispelling myths and providing accurate information to ensure a more informed public;
- improving public awareness of effective treatment for mental illness;
- ensuring that there is an adequate supply of psychiatrists and others mental-health professionals;
- tailoring diagnosis and treatment of mental illness to age, gender, race, culture, and other characteristics that shape a person's identity;
- facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or effectively addressing problems themselves; and
- reducing financial barriers to treatment.

It is these measures, the AMA believes, that will provide the best patient outcomes—not broad legal liability for providers where their patients suddenly commit harm to third parties.

B. This State's public policy regarding mental-health treatment.

Minnesota is no outlier. Like most other states, the Minnesota Legislature has declared that it is the policy of this State to encourage persons to seek mental-health

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[7] The AMA's formal policy regarding mental-health treatment is available at: https://policysearch.amaassn.org/policyfinder/detail/access%20to%20mental%20health?uri=%2FAMADoc%2FHOD.xml-0-2954.xml (last visited July 23, 2021).

treatment, to treat mental-health conditions in the least restrictive (or invasive) way possible, and to limit the potential legal liability of providers to a set of narrow, well-defined circumstances.[8] These policies permeate this State's statutes and administrative rules.

For example, administrative Rule 9520.0790 (governing the Human Services Department) states that "[c]linical services shall be . . . provided in the *least* restrictive manner." Minn. R. 9520.0790, subd.4 (emphasis added). The Rule also requires an individual treatment plan "jointly developed by the client and the mental health professional." *Id.*

Similarly, the Minnesota Commitment and Treatment Act ("MCTA"), Minn. Stat. § 253B.01 *et seq.*, restricts the circumstances under which the State may involuntarily admit an individual, and states that "[v]oluntary admission is preferred over involuntary commitment and treatment." Minn. Stat. § 253B.04, subd. 1. The State may involuntarily admit a patient only "when ordered by the court pursuant to a finding of necessity to protect the life of the proposed patient or others." *Id.* § 253B.045, subd. 1.

The MCTA *requires* the court to give "careful consideration" to "reasonable alternative dispositions including but not limited to dismissal of petition; voluntary outpatient care; voluntary admission to a treatment facility, state-operated program, [or] community-based treatment program." *Id.* § 253B.09, subd. 1. Even if there is no

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[8] In addition to the statutes and rules discussed in this section, *see* Mental Health America, *Position Statement 22: Involuntary Mental Health Treatment* (2013) ("Persons with mental health conditions can and should be treated in the least restrictive environment.").

reasonable alternative, the court may only "commit the patient to the least restrictive treatment program . . . which can meet the patient's treatment needs."[9] *Id.*

Another statute, the Minnesota Comprehensive Adult Mental Health Act, Minn. Stat. § 245.461 *et seq*., requires the Commissioner of Human Services to "ensure" a mental-health service system that, among other things, "recognizes the rights of adults with mental illness to control their own lives as fully as possible" and "promotes the independence" of "adults with mental illness." Minn. Stat. § 245.461, subd. 2. This includes the commissioner awarding grants "to eligible applicants to plan, establish, or operate programs to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals." *Id.* § 245.4662, subd. 2. Further, "[c]ounty boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county." *Id.* § 245.470, subd. 1.

The Minnesota Health Records Act, Minn. Stat. § 144.291 *et seq*., prioritizes confidentiality of mental-health treatment. That statute allows a provider to disclose a patient's mental-health records *only* where law enforcement "communicates" that the "patient is currently involved in an emergency interaction with law enforcement" or

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[9] The Childrens Mental Health Act, Minn. Stat. § 245.487 *et seq*., likewise requires that mental-health services "must be . . . provided in the most appropriate, least restrictive setting." Minn. Stat. § 245.4876, subd. 1(4).

"disclosure . . . is necessary to protect the health or safety of the patient or of another person." Minn. Stat. § 144.294, subd. 2.

The legislature has also limited the circumstances under which health-care providers can be liable for harm caused by mental-health patients. For example, the Minnesota Psychology Practice Act, Minn. Stat. § 148.88 *et seq*., includes these limitations:

> Subd. 2. **Duty to warn.** The duty to *predict*, warn of, or take reasonable precautions to provide protection from, violent behaviors arises *only* when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. . . .
>
> Subd. 3. **Liability standard.** If no duty to warn exists under subdivision 2, then no monetary liability and no cause of action may arise against a licensee for failure to *predict*, warn of, or take reasonable precautions to provide protection from, a client's violent behavior.

Minn. Stat. § 148.975, subds. 2, 3 (emphasis added).

The legislature's emphasis on outpatient mental-health treatment, patient confidentiality, and limiting provider liability makes sense and advances sound public policies. It encourages frank and open dialogue between patient and provider that is necessary to achieve successful treatment outcomes. Indeed, the effective treatment of mental-health conditions "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" and "the mere possibility of disclosure may impede development of

the confidential relationship necessary for successful treatment." *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

Perhaps more so than in any other setting, communication is paramount to the effective treatment of mental-health conditions.[10] Indeed, communication between the provider and the patient is the basis of psychiatric treatment. Open communication tangibly affects outcomes because:

- It allows for a fulsome, accurate diagnosis;
- The mere act of externalizing thoughts and feelings allows the patient to process his/her emotional or behavioral response to the underlying issue;
- Externalizing those thoughts and feelings prevents the patient from ruminating;
- Externalizing can simply vent the effects of the underlying issue and release internal pressures tied to the issue;
- The provider can better assess the depth of the problems facing the patient;
- The provider can add perspective (address underlying issues, provide coping skills, equate patient's condition to others, etc.).

To this end, Minnesota's statutes foster this critical dialogue because, absent express threats against himself or another person, the patient is free to confide in the

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[10] *See, e.g.*, Irmsen Hassan, Rosemarie McCabe & Stefan Priebe, *Professional-patient communication in the treatment of mental illness: A review*, 4(2) COMMUNICTION AND MEDICINE 141, 141, 142 (2007) (observing that "[a] better professional-patient relationship in the treatment of mental illness has been found to predict treatment outcome across a range of treatment settings," and further noting that "[h]ow the patient communicates in the diagnostic interview is a crucial source of information about their general mental state").

provider without fear of disclosure to others, and the provider is free to engage in the confidential dialogue necessary to treat the patient without fear of liability to third persons.

The legislature has also carried out its policies through appropriations and bonding:

- In 2015, the legislature invested $51 million in new state spending for mental-health care;[11]

- In 2017, the legislature approved funding for state-operated services and allocated $2.1 million for mental-health innovation grants to generate the care models for the future;[12]

- In 2018, the legislature expanded mental-health infrastructure, including $30 million in bonding for new behavioral health crisis centers to serve as an alternative to hospital emergency departments and another $30 million for housing infrastructure bonds for persons with serious mental illnesses;[13]

- In 2019, the legislature allocated an additional $10 million in school-linked mental-health funds and $13 million for mobile mental-health crisis intervention.[14]

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[11] *See* Minnesota Hospital Association "Fact Sheet" on "Mental and behavioral health priorities," at 3 (Nov. 2020), available at *https://www.mnhospitals.org/Portals/0/Documents/2020%20Fact%20Sheet%20-%20Mental%20and%20behavioral%20health%20priorities.pdf* (last visited July 22, 2021).

[12] *Id.*

[13] *Id.*

[14] *Id.* In addition, in 2021, the Minnesota Legislature created a new committee—the House Behavioral Health Policy Division—to allow lawmakers to focus on bringing improvements and innovation to Minnesota's mental-health care system.

These initiatives, in conjunction with this State's laws, have been effective. Increasing numbers of Minnesotans are obtaining mental-health treatment. Today, approximately 75% of that care is delivered in community or outpatient settings where providers do not have custodial control over the patient.[15]

II. The court of appeals' decision contravenes this State's public policies and wrongly takes this State in an opposite direction.

Where the legislature declares the public policy of the State, this Court has traditionally deferred to those decisions.[16] *See, e.g.*, *State ex rel. Meehan v. Empie*, 164 Minn. 14, 17, 204 N.W. 572, 573-74 (1925) ("Courts do not determine public policy when the legislature speaks."); *Dukowitz v. Hannon Sec. Servs.*, 841 N.W.2d 147, 153 (Minn. 2014) ("[I]t is not for us to extend the public policy that [the legislature] has declared."); *In re Peterson's Estate*, 230 Minn. 478, 483, 42 N.W.2d 59, 63 (1950) ("Primarily, it is the prerogative of the legislature to declare what acts constitute a violation of public policy and the consequences of such violation.").

This is because the legislature is a co-equal branch of government and, as a representative body, is better equipped to weigh public-policy ramifications of a particular law. *See, e.g.*, *State v. Minnkota Power Coop., Inc.*, 281 N.W.2d 372, 374

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[15] *Id.* at 2.

[16] This is particularly so as it relates to adopting a new cause of action. *Dukowitz*, 841 N.W.2d at 153 ("As numerous courts have recognized, adoption of a new cause of action is particularly inappropriate when the legislature has already provided other remedies to vindicate the public policy of the state.").

(Minn. 1979) (declining to extend law and stating that "weighing of considerations of public policy" is "a role best performed by the elected representatives of the people").

The legislature, through the mixture of protections and limitations described above, has struck a balance between fostering appropriate mental-health treatment, protecting the public, and shielding health-care providers from civil liability. Any expansion of provider liability, therefore, should be vetted by the legislature, not by judicial declaration, and should be grounded in policy based on legislative facts—not adjudicative facts arising out of the particular circumstances of this case (or any other single case).

A very recent decision from a sister jurisdiction underscores this point. In *Rodriguez v. Lasting Hope Recovery Center of Catholic Health Initiatives*, 955 N.W.2d 707 (Neb. 2021), the Nebraska Supreme Court considered a claim against a provider arising out of a patient's murder of his ex-girlfriend. As here, the patient never communicated to the provider any intent or desire to harm his ex-girlfriend. *Id.* at 720. ("[I]t is uncontroverted that Lloyd never actually communicated to Benton that he intended to harm Melissa.").

Like Minnesota, the Nebraska legislature limited provider liability for harm to third parties to circumstances where the patient communicated a "serious threat of physical violence" against a "reasonably identifiable" person.[17] The court declined to

[17] Nebraska's statute is very similar to the Minnesota Psychology Practices Act. It provides:

recognize a new "generalized duty of reasonable care," *Id*. at 717, and instead deferred to the legislature's public-policy decision:

> [T]he statutes . . . were drafted to reflect the Legislature's reasoned policy judgment. The language in §§ 38-2137(1) and 38-3132(1) represents the Legislature's effort to strike the appropriate balance between assuring patients that what they disclose to a mental health care provider will be held in confidence and protecting the safety of third parties the patient intends to harm. In other words, the statutory language is the result of [the Legislature's] balancing risk and utility, considering the magnitude of the risk, relationship of the parties, nature of the risk, opportunity and ability to exercise care, foreseeability of the harm, and public policy interest in the proposed solution.

Id. at 720.

The court of appeals' decision here, though, does something very different. Contrary to the public policy of this State, the decision significantly *expands* provider liability for harm to third persons using a generalized duty of reasonable care. It is incongruous to have, on the one hand, a statutory scheme that clearly and expressly

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> There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is licensed or certified pursuant to the Mental Health Practices Act for failing to warn or protect against a patient's threatened violent behavior except when the patient has communicated to the mental health practitioner a serious threat of physical violence against himself, herself, or a reasonably identifiable victim or victims.

Neb. Stat. § 38.2137(1). *See also* Neb. Stat. 3132(1) ("No monetary liability and no cause of action shall arise against any psychologist for failing to warn of and protect from a client's or patient's violent behavior except when the client or patient has communicated to the psychologist a serious threat of physical violence against a reasonably identifiable victim or victims.").

instructs health-care providers to implement the *least* restrictive mental-health care possible, but subject providers to unbounded liability for harm to third persons simply because the providers could have theoretically used more aggressive and invasive treatments on patients who have never expressed homicidal ideation.

Left undisturbed, the standard the court of appeals announced will incentivize health-care providers to implement overly aggressive treatments. Otherwise, providers risk later being accused of failing to predict the unpredictable: that an individual like Brian Short, who repeatedly denied suicidal ideation, had expressed no homicidal ideation, and who was forward looking and had a supportive family, would suddenly commit harm to third parties and himself.[18] This Court should reverse that unworkable standard.

III. The rule the court of appeals announced is amorphous, does not establish a workable professional standard, and creates a host of very real problems.

This State's statutory and common-law limitations on liability for harm to third parties create clear rules for health-care providers: a tort duty exists only where the patient has communicated a threat of physical violence against a specific, clearly identifiable third party or, alternatively, the provider assumes physical control of the

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[18] *Amici* and their counsel do not minimize the gravity of Mr. Short's actions. The facts underlying this appeal are tragic. But this case presents a legal issue that will have ramifications for the treatment of hundreds of thousands of people in Minnesota with mental-health conditions. Even before Covid-19, state data reflect that more than 1 in 5 adult Minnesotans had some form of mental illness. *See Mental Health in Minnesota*, available at https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/minnesota/ (last visited July 22, 2021).

patient and the harm is foreseeable. *See* Minn. Stat. § 148.975, subds. 2, 3; *Cairl*, 323 N.W.2d at 26 ("It is apparent, then, that if a duty to warn exists, it does so only when specific threats are made against specific victims."); *Lundgren*, 354 N.W.2d at 27 (discussing control).

These rules give mental-health care providers unambiguous guideposts to determine when, and under what circumstances, their duties to their patients yield to protecting third parties. They also recognize that mental-health conditions are an ill predictor of violent behavior, that such predictions are often wrong, and that such predictions have negative consequences for the patient by further stigmatizing the underlying condition and discouraging open dialogue. As the United States Supreme Court has observed:

> Manifestations of mental illness may be sudden, and past behavior may not be an adequate predictor of future actions. Prediction of future behavior is complicated as well by the difficulties inherent in diagnosis of mental illness. It is thus no surprise that many psychiatric predictions of future violent behavior by the mentally ill are inaccurate.

Heller v. Doe by Doe, 509 U.S. 312, 323 (1993) (internal citations omitted). *See also Barefoot v. Estelle*, 463 U.S. 880, 883 (1983) ("The use of psychiatrists . . . to make predictions about . . . future conduct was unconstitutional because psychiatrists, individually and as a class, are not competent to predict future dangerousness.").[19]

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[19] *See also* Jeffrey W. Swanson, Ph.D, E. Elizabeth McGinty, Ph.D, Seena Fazel, M.D. & Vickie M. Mays, Ph.D, *Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy*, 25(5) ANN. EPIDEMIOL., at 366-76 (2005) (discussing that only a small percentage of violent acts can be attributed to serious mental

The court of appeals, by contrast, held that mental-health care providers are susceptible to liability to third persons if a factfinder determines, with the benefit of hindsight, that the risk was foreseeable (even where the patient expressed no such ideations, much less a threat against a particular person). The court determined that a factfinder could conclude based on Mr. Short's prescription medicines, his status as breadwinner for his family, and the fact that he exhibited symptoms of Akathisia,[20] that Park Nicollet could have foreseen and, presumably, somehow prevented Mr. Short's actions.

This reasoning problematically subjects mental-health care providers to second-guessing and hindsight bias.[21] In addition, the generalized standard of care will yield inconsistent results and will force health-care providers to do the impossible: reliably predict future violence where the patient has expressed no such ideation. It will frustrate the policies interwoven in Minnesota's highly regulated statutory mental-health care

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illness and that most violence can be attributed to other risk factors, such as past history of violence and substance abuse); Peter Buckley, Leslie Citrome, Carmen Nichita & Michael Vitacco, *Psychopharmacology of Aggression in Schizophrenia*, SCHIZOPHRENIA BULL. Vol. 37, at 930 (Sept. 2011) (discussing prediction of future violent behavior and stating that "[u]nfortunately, clinical judgment is incorrect more often than correct.").

[20] Akathisia is "characterized by a state of subjective and motor restlessness" and is "common and unpleasant side effect of antipsychotic medication." E. Cem Atbasoglu, M.D., Susan K. Schultz, M.D., and Nancy C. Andreasen, M.D., Ph.D., *The Relationship of Akathisia With Suicidality and Depersonalization Among Patients With Schizophrenia*, J. NEUROPSYCHIATRY CLIN. NEUROSCI. Vol. 13:3, at 336 (Summer 2001). Notably, these authors concluded that Akathisia does not itself cause suicidal ideation. *Id.* at 339-40.

[21] *See, e.g.*, Hal R. Arkes, *The Consequences of Hindsight Bias in Medical Decision Making*, 22(5) CURR. DIRECTIONS IN PSYCH. SCI. 356, 239 (2013) ("The hindsight bias has particularly detrimental effects" in "important, highly consequential situations.").

scheme and it wrongly assumes that mental-health care providers are always able to predict that patients will commit violent acts even where the patients have not communicated any such threats.

The generalized reasonable-care standard is problematic in the context of third-party harm for other reasons, too. It begs this fundamental question: if the patient expresses no threat against any particular person, to whom does the provider owe a generalized duty? Put differently, how far does the sphere of foreseeability extend when the patient does not threaten anyone? Surely health-care providers cannot owe a duty to protect or warn the entire public. *Cf. Emerich v. Phil. Ctr. for Human Devel., Inc.*, 720 A.2d 1032 (Pa. 1998) ("[A] mental health care professional would have great difficulty in warning the public at large."). In addition, there is no discussion in the decision below concerning how a mental-health care provider could conceivably comply with the generalized standard of care as it relates to preventing harm to third parties without violating patient confidences or erring on the side of overly restrictive treatment modalities, both of which would directly contravene existing law.

In sum, *amici* urge this Court to reverse the court of appeals. The duties and obligations of mental-health care providers to their patients and potential victims of violence must be clear and consistent to prevent confusion and allow for reasonable compliance. These duties and obligations should also be limited—as they are by statute and this Court's precedent—to ensure that patients and providers can communicate openly and to make available to all who need it important outpatient mental-health services.

CONCLUSION

This Court should reverse the court of appeals. Minnesota law reflects an unmistakable policy choice that carefully balances mental-health care providers' obligations to their patients versus obligations to protect harm to third parties. The framework provided in Minn. Stat. § 148.975, in *Cairl*, and in *Lundgren* strikes the appropriate balance. The court of appeals' decision upsets that balance and directly undermines this State's mental-health policies. *Amici* urge this Court to reaffirm the limitations on provider liability for third-party harm.

BASSFORD REMELE
A Professional Association

Dated: July 26, 2021

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CERTIFICATE OF COMPLIANCE

The undersigned counsel for *amicus* American Medical Association, Minnesota Medical Association, and Minnesota Hospital Association, certifies that this brief complies with Minn. R. Civ. App. P. 132.01. The brief was prepared in Times New Roman 13-point, proportionately spaced typeface using Microsoft Word 2019. The brief contains 4,479 words, including headings, footnotes, and quotations.

BASSFORD REMELE
A Professional Association

Dated: July 26, 2021

By: s/ Mark R. Bradford
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