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Case Number 446,2014

IN THE SUPREME COURT OF THE STATE OF DELAWARE

JOANN F. CHRISTIAN, individually and as Administratrix of the Estate of Bruce J. Christian, NICOLE C. CHRISTIAN, LYNDSEY M. CHRISTIAN and BRUCE J. CHRISTIAN, JR.,	No. 446, 2014
Plaintiffs-Below, Appellants,	**On Appeal from the Superior Court of the State of Delaware in and for New Castle County C.A. No. N09C-10-202 EMD**
v.	
COUNSELING RESOURCE ASSOCIATES, INC., a Delaware Corporation and J. ROY CANNON, LPCMH, ARLEN STONE, M.D., individually and doing business as Abby Family Practice, and THE FAMILY PRACTICE CENTER OF NEW CASTLE, P.A., a Delaware Professional Association, individually and doing business as Abby Family Practice	
Defendants-Below, Appellees.	

APPELLEES ARLEN STONE, M.D. AND ABBY FAMILY PRACTICE'S ANSWERING BRIEF

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Date: November 5, 2014

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NATURE OF PROCEEDINGS

This is a medical negligence/wrongful death action involving medical care and mental health counseling provided to Bruce Christian, who attempted suicide on January 8, 2008 and died from his self-inflicted injuries six days later. The Plaintiffs claim that negligent treatment by Mr. Christian's primary care physician, Arlen Stone, M.D. and a mental health counselor, J. Roy Cannon, LPCMH either caused or failed to prevent Mr. Christian's death by suicide. A1-18.

Dr. Stone, joined by Mr. Cannon, moved for summary judgment on the basis that Mr. Christian's suicide was a deliberate, intentional, intervening act for which they could not be held liable as a matter of law, and that neither the "uncontrollable impulse" exception nor the "special relationship" exception to this general rule applied. A2763-2936, B85-86. The trial court granted the Defendants' motion, holding that: Plaintiffs, had affirmatively chosen not to pursue the "uncontrollable impulse" exception; and that neither Dr. Stone nor Mr. Cannon had the requisite custody or control over Mr. Christian to support a finding of a "special relationship" such that Dr. Stone or Mr. Cannon had a duty to prevent Mr. Christian's suicide. A3008-25. Plaintiffs appealed the trial court's order granting summary judgment to all Defendants.

Dr. Stone also moved *in limine* to limit the causation testimony of Plaintiffs' family practice expert Terrance L. Baker, M.D., because, as a family practitioner,

Dr. Baker was not qualified to offer expert opinion as to the cause of Mr. Christian's suicide. A1314-1769. The trial court granted Dr. Stone's motion in part, limiting Dr. Baker's causation opinions to those that fell within the purview of Family Practice. A1837-38, A3065-68. The trial court specifically held that Dr. Baker could not offer opinions about the cause of Mr. Christian's suicide because that required psychiatric knowledge and training, which Dr. Baker did not have. A3065-68. Plaintiffs also appealed the trial court's order limiting Dr. Baker's testimony.[1]

[1] In their appeal, Plaintiffs incorrectly claim that Dr. Baker's causation testimony was precluded on a "but for" or "magic word" basis. Appellants' Second Substituted Opening Brief, pp. 5, 9, 29-34. Plaintiffs have confused the trial court's rulings on the Motions in Limine filed by the Defendants. Specifically, Plaintiffs have confused the trial court's proper *limitation* of Dr. Baker's causation opinions to his field of specialty with the trial court's denial of the Cannon Defendants' Motions in Limine regarding expert testimony and the use of "but for" and "probabilities" language. A1837-38, A3065-68.

SUMMARY OF ARGUMENT

1. Denied. The trial court's grant of summary judgment was not contrary to this Court's holding in *Naidu v. Laird.*[2] In *Naidu*, the duty to prevent foreseeable harm to a *third party* (as opposed to suicide) was not addressed until the Court first determined that a "special relationship", defined by custody and control, existed between the patient and his psychiatrist.[3] In this case, because both Defendants treated Mr. Christian on an outpatient basis, neither Dr. Stone nor Mr. Cannon had the requisite custody or control over Mr. Christian to support the finding of a special relationship. Thus the trial court correctly held that there was no duty to act to prevent Mr. Christian's suicide.

2. Denied. The trial court properly granted summary judgment to Mr. Cannon based on the general rule that negligence actions seeking damages for the suicide of another are not permissible because suicide is a deliberate, intentional intervening act and the decedent is responsible for the harm.[4]

3. Denied. The trial court properly granted summary judgment to Dr. Stone based on the general rule that negligence actions seeking damages for the suicide of another are not permissible because suicide is a deliberate, intentional

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[2] *Naidu v. Laird,* 539 A.2d 1064 (Del. 1988).

[3] *Id.,* at 1071-72.

[4] *Mikell v. School Administrative Unit #33*, 972 A.2d 1050, 1054 (N.H. 2009).

intervening act and the decedent is responsible for the harm.[5] There are only two exceptions to the common law ban on liability for suicide: the "uncontrollable impulse" exception[6] and the "special relationship" exception"[7] and neither exception applies to this case. Plaintiffs did not offer any evidence supporting a theory of uncontrollable impulse and they failed to demonstrate that a special relationship, as defined by custody and control, existed between Dr. Stone and Mr. Christian. Because Plaintiffs failed to establish a viable exception to the maxim prohibiting liability for suicide, Dr. Stone cannot be held liable, as a matter of law, for Mr. Christian's suicide.

4. Denied. The trial court did not abuse its discretion when it properly limited, the causation opinions of Dr. Baker, Plaintiffs' Family Practice expert, to those within his field of specialty.

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[5] *Mikell*, 972 A.2d, at 1054.

[6] *Porter v. Murphy*, 792 A.2d 1009, 1015 (Del. Super. 2001); *Mikell,* 972 A.2d, at 1054.

[7] *Rogers v. Christina School District*, 73 A.3d 1, 7-12 (Del. 2013); *Mikell,* 972 A.2d, at 1054.

STATEMENT OF FACTS

A. Medical History

Dr. Stone became Mr. Christian's primary care physician in February of 2001. A1101. Through September 2007, Mr. Christian saw Dr. Stone for various complaints including: influenza, rash, drug withdrawal (August–September 2001), depression (February 2002), cellulitis, bronchitis, foot pain, hypertension, tobacco abuse, erectile dysfunction, insomnia (May 2005, September 2006–December 2007), sinusitis, pharyngitis, Benign Prostatic Hyperplasia (BPH) (February 2006–November 2007), elevated lipids, atypical chest pain, abdominal pain, and GERD. A1102-39.

The care at issue in this case began on October 30, 2007, only ten weeks before Mr. Christian's January 8, 2008 suicide attempt. On that day, Mr. Christian sought care for a "constant urge to urinate" and a cold. A1140-41, A151. Dr. Stone examined Mr. Christian, including his prostate, diagnosed him with Prostatitis (an infection of the prostate gland) and referred him to a urologist. A1141, A151-52. In addition to the urology referral, Dr. Stone ordered an antibiotic, Levaquin, and gave Mr. Christian a note to be off work until November 5, 2007. A1141, A152.

Mr. Christian returned to Dr. Stone on November 5, feeling very anxious and nervous with a loss of appetite as well as having concerns about returning to

work. A1142, A152. Dr. Stone examined Mr. Christian and diagnosed him with panic attacks and anxiety. A1143, A153. Dr. Stone prescribed Xanax, an anti-anxiety medication, noted that Mr. Christian was to see a urologist in a week and extended his off work excuse until then. A1143-44, A153. He also noted that if Mr. Christian's symptoms persisted, he would need to see a mental health professional. A1143, A153. On November 13, Mr. Christian returned to Dr. Stone reporting "frequent urination – pressure", but was otherwise "doing better". A1145, A154-55. Dr. Stone continued the Xanax and noted that Mr. Christian should return to work. A1146, A154-55. Dr. Stone's diagnoses were prostatitis and anxiety, but he did not believe that Mr. Christian's symptoms warranted referral to a mental health care professional at that time. A1146, A154-55.

Mr. Christian came back to Dr. Stone on November 26, reporting left head pain, dizziness/spaciness with loss of appetite and panic attacks. A1147, A155. After talking to Mr. Christian, Dr. Stone noted in his chart that he "*denied suicidal thought*". A1147, A155-56, A158. Dr. Stone's diagnosis at the time was anxiety/panic attacks, depression and congestion. A1148, A156. Dr. Stone continued the Xanax, and added an antidepressant, Effexor. He also prescribed Rhinocort (nasal spray), and ordered a CT scan of the head and sinuses, and recommended that Mr. Christian seek counseling. A1148, A156-57. Mr. Christian was also advised to call Dr. Stone if he felt worse and to follow up in one month.

A1148, A158. Three days later, on November 29, Mr. Christian returned to Dr. Stone reporting that he had to leave work the night before, that he was dizzy, had loss of appetite and wanted to be off of work until his CT results were available. A1149, A160. Mr. Christian again assured Dr. Stone that he was "*not suicidal*". A1150. Mr. Christian was advised to get his CT, continue his medications and call if his symptoms worsened. A1150, A160.

On December 5, Mr. Christian was seen in the office by Dr. Stone who reviewed the CT scan results. A1151, A161. Mr. Christian *denied depression*, but noted he still felt "spacey". A1151, A161. Dr. Stone referred Mr. Christian to an ear, nose and throat specialist for evaluation and treatment regarding the CT results and again recommended that Mr. Christian seek counseling and see a psychiatrist for his persistent mental health issues. A1152, A161-62. At that time, Mr. Christian did not give Dr. Stone any indication that he was a danger to himself or others. A162.

On December 11, Mr. Christian returned to Dr. Stone reporting that his symptoms were unchanged. A1153, A163. Dr. Stone spoke with Mr. Christian about his recent ENT visit and they discussed scheduling an appointment with a psychologist and a psychiatrist, which Mr. Christian agreed to do. A1154, A163-65. On December 22, Mr. Christian called Dr. Stone and reported that he had "stopped his Effexor cold and was not feeling well". A1155, A166, A170-71. Mr.

Christian again specifically "*denied any suicidal thoughts or plan*". A1155, A166. Dr. Stone told Mr. Christian that he could not stop Effexor cold and suggested a plan for gradually reducing the medication, to which Mr. Christian agreed. A1155, A166. Dr. Stone advised Mr. Christian that if he was really feeling bad, he should go to MeadowWood,[8] for evaluation. A1155, A171. Mr. Christian reported that he was not feeling that bad, he *denied suicidal thoughts or a plan* and felt that re-starting Effexor and seeing Dr. Stone in his office would be sufficient. A1155, A171. Dr. Stone instructed Mr. Christian to contact him or go to the hospital for help if he felt worse or felt he was going to harm himself. A1155, A166, A171.

Dr. Stone last had contact with Mr. Christian before his suicide attempt in his office on December 28, 2007. A1156. They discussed Mr. Christian coming off of the Effexor and again Mr. Christian *denied a suicidal plan*. A1156-57, A168-69. Dr. Stone gave Mr. Christian an Effexor titration schedule and they discussed that Mr. Christian had an appointment to see a psychologist. A1157, A168. Dr. Stone continued also to recommend that Mr. Christian see a psychiatrist, although Mr. Christian reported that this was denied by his insurance. A1157, A168. Dr. Stone again instructed Mr. Christian to call if his symptoms worsened and to follow up in two weeks, or sooner, if needed. A1157, A168. At that time, Mr. Christian was *denying suicidal thoughts*, he had an appointment with

[8] MeadowWood Behavioral Health System offers psychiatric health and addiction treatment services.

a mental health counselor, and he was not giving Dr. Stone any indication that he was in any way suicidal or that he was a danger to himself or others. A1156, A172. Dr. Stone heard nothing further from or about Mr. Christian until eleven days later when he was advised, on January 8, 2008, of Mr. Christian's suicide attempt. A1158.

On January 3, 2008, less than one week before his suicide attempt, Mr. Christian was evaluated by mental health counselor Mr. Cannon. A1257-59, A58. During this evaluation, Mr. Christian for the ***first time admitted that he had felt suicidal in the past and that he had considered shooting himself***. A1258, A66, A69, A71-72. Mr. Christian nevertheless assured Mr. Cannon that he did not have any current suicidal ideations, and contracted for his safety. A1258, A69, A71, A74. On January 8, Mr. Christian attempted suicide, apparently by putting a gun in his mouth and pulling the trigger. A1158. He was rushed to Christiana Hospital where he remained until his death on January 14.

B. Plaintiffs' Expert, Terrance Baker, M.D.

In discovery, Plaintiffs identified Terrance Baker, M.D. as offering standard of care and proximate cause expert opinions against Dr. Stone. A178-262. Dr. Baker received an M.D. from George Washington School of Medicine in 1984. He completed an Internship and Residency in Family Practice at Riverside Hospital in 1987. Dr. Baker is board certified in Family Practice, Geriatrics, Forensic

Medicine[9] and Emergency Medicine; he has a general family practice, rounds on patients in nursing homes and does some evening/weekend shifts in the Emergency Department. A203, 235-242.

In his discovery deposition, Dr. Baker opined that Mr. Christian had a major depressive disorder complicated by suicidal ideations, anxiety, substance abuse, insomnia, and panic attacks and that his mental health symptoms were such that he required acute admission and needed a higher level of treatment. A184-89, 191-93, 199. Dr. Baker also criticized Dr. Stone's alleged failure to refer Mr. Christian for evaluation and treatment to someone more qualified to address his symptoms, i.e. a psychiatrist.[10] Dr. Baker's opinion was unequivocal that Mr. Christian's mental health needs, while identifiable by a family practitioner, were beyond the skill set of a family practitioner.[11] Dr. Baker opined that Dr. Stone's alleged failure to refer Mr. Christian to a psychiatrist for treatment of his mental health symptoms was the proximate cause of his suicide. A191-92, 196-98, 201. More specifically, Dr. Baker offered opinions on how psychiatric treatment, if Mr Christian had received it, would have prevented his suicide.

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[9] A203 (Dr. Baker explained that forensic medicine is "that part of medicine where physicians examine medical facts and then answer the questions in a legal setting").

[10] A184-88, 191-92, 196, 198-99 (opining that Mr. Christian needed substance abuse rehab/treatment, mental health counseling, therapy, appropriate physicians for intervention, psychiatric intervention and hospitalization).

[11] *Id.*

ARGUMENT

I. THE SUPERIOR COURT PROPERLY HELD THAT NEITHER DR. STONE NOR MR. CANNON HAD A SPECIAL RELATIONSHIP WITH MR. CHRISTIAN SUCH THAT THEY HAD A DUTY TO PREVENT HIS SUICIDE.

A. QUESTION PRESENTED

Did the Superior Court properly find that, as a matter of law, neither Dr. Stone nor Mr. Cannon had the requisite custody or control over Mr. Christian such that a special relationship existed between them creating a duty on the part of Dr. Stone and/or Mr. Cannon to prevent Mr. Christian's suicide?

Issue preservation pursuant to Supreme Court Rule 8 refers to the preservation of issues by the appellant, not the appellee.[12]

B. STANDARD AND SCOPE OF REVIEW

The Supreme Court reviews the trial court's decision to grant summary judgment *de novo*.[13] "Summary judgment is proper when there are no genuine issues of material fact, thus entitling the moving party to judgment as a matter of law".[14] "The Court must analyze the entire record, including the trial court's opinion, the pleadings, depositions and other relevant evidence contained in the

[12] See *Danby v. Osteopathic Hosp. Ass'n of Delaware*, 104 A.2d 903, 907-08 (Del. 1954).

[13] *Oakes v. Clark*, 69 A.3d 371, 2013 WL 3147313 at *1 (Del. 2013).

[14] *Merrill v. Crothall-American, Inc.,* 606 A.2d 96, 99-100 (Del.1992).

record."[15] The Court will "examine all legal issues to determine whether the trial court "erred in formulating or applying legal precepts."[16] Determining the existence and parameters of a duty is a question of law which this Court must review *de novo* based on the particular facts presented.[17] The Court treats all facts in a light most favorable to the non-moving party and will draw its own factual conclusions only if the trial court's rulings are clearly wrong.[18] The Supreme Court gives a high level of deference to the factual findings of a trial court and will not set these findings aside "unless they are clearly wrong and the doing of justice requires their overturn."[19]

C. MERITS OF ARGUMENT

As a general rule, negligence actions seeking damages for the suicide of another are not permissible because suicide is considered a deliberate, intentional intervening act and the decedent is responsible for the harm.[20] Because the decedent is responsible for the harm caused by suicide, the "act of suicide breaks the causal connection between the wrongful or negligent act and the death"[21] and is considered a "superceding cause which is neither foreseeable nor a normal

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[15] *Stroud v. Grace*, 606 A.2d 75, 81 (Del. 1992)(internal citations omitted).
[16] *Stroud*, 606 A.2d, at 81.
[17] *Naidu*, 539 A.2d, at 1070.
[18] *Stroud*, 606 A.2d, at 81.
[19] *DV Realty Advisors v. Policeman's Annuity*, 75 A.3d 101, 108 (Del. 2013).
[20] *Mikell*, 972 A.2d, at 1054.
[21] *Id*. (citing *Bruzga v. PMR Architects*, 141 N.H. 756, 757-8 (N.H. 1997)).

incident of the risk created".[22] There are only two exceptions to the common law ban on liability for suicide, the "uncontrollable impulse" exception[23] and the "special relationship" exception.[24] While the "uncontrollable impulse" exception and the "special relationship" exception are recognized under Delaware law, the trial court properly granted summary judgment to Dr. Stone and Mr. Cannon because neither of these exceptions apply to this case.

1. The trial court's grant of summary judgment was proper and consistent with the Restatement (Second) of Torts and the law of Delaware.

a. The "Uncontrollable Impulse" Exception

The "uncontrollable impulse" exception permits liability for suicide on the basis that the defendant, rather than the decedent, actually *caused* the suicide.[25] Its roots trace back to the concept of misfeasance, the "improper doing of an act which a person might lawfully do", as defined by the Restatement (Second) of Torts.[26] "In the case of misfeasance, the party who does an affirmative act owes a general duty to others to exercise the care of a reasonable man to protect them against an

[22] *DeMontiney v. Desert Manor Convalescent Center*, 695 P.2d 255, 259 (A.Z. 1985)(internal citations omitted).
[23] *Porter*, 792 A.2d, at 1015; *Mikell,* 972 A.2d at 1054.
[24] *Rogers*, 73 A.3d, at 7-12; *Mikell,* 972 A.2d at 1054.
[25] *Mikell,* 972 A.2d, at 1054.
[26] *Doe v. Bradley*, 58 A.3d 429, 447 (fn 83) (Del. Super. 2012).

unreasonable risk of harm to them arising out of the affirmative act."[27] However, in order to overcome the general rule against liability for the suicide of another, a negligent wrong, that is a misfeasance, must cause mental illness in the decedent which results in an *"uncontrollable impulse*" to commit suicide.[28] If the injured decedent "is able to realize the nature of the act of suicide and has the power to control it if he so desires", then the suicide is a deliberate, independent intervening force which precludes a finding of liability for the wrongdoer.[29]

This "uncontrollable impulse" exception typically involves cases where there is the "infliction of severe physical injury or the intentional infliction of severe mental or emotional injury through wrongful accusation, false arrest or torture".[30] However, it has also been applied in cases arising from automobile accidents and medical negligence.[31] Delaware recognizes a medical negligence action as an action for *misfeasance*.[32] Accordingly, liability for suicide allegedly *arising from negligent medical care,* that is, arising from the general duty of care

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[27] *Doe, 58* A.3d, at 448.

[28] *Porter*, 792 A.2d, at 1015.

[29] *Id*.; *Mikell*, 972 A.2d, at 1054.

[30] *Mikell*, 972 A.2d, at 1054.

[31] See *Porter*, 792 A.2d, at 1015-16 and *Eidson v. Reproductive Health Services*, 863 S.W.2d 621 (Mo. App. 1993).

[32] *Snavely v. Wilmington Medical Center*, 1985 WL 552277 at *3 (Del. Super. Mar. 18,1985). See also *Livingston v. En-Consultants*, 115 A.D. 3d 650 (N.Y.A.D. 2 Dept. Mar. 2014).

owed by a physician to his patient, must proceed – if at all – via the "uncontrollable impulse" exception.[33]

Although the Plaintiffs did not pursue the "uncontrollable impulse" exception against Dr. Stone and Mr. Cannon[34] and Plaintiffs do not now raise the "uncontrollable impulse" exception as a basis for their appeal[35], the above discussion of this exception and its connection to misfeasance and medical negligence highlights the narrow scope of the Plaintiffs' special relationship/duty claim and why the trial court properly dismissed that claim.

b. The "Special Relationship" Exception

The "special relationship" exception is the second exception to the general rule prohibiting liability for suicide. This exception permits liability for the suicide of another when the defendant had a *duty of care to prevent the suicide* specifically arising from the defendant's *special relationship* with the suicidal individual.[36]

The concept of duty examines whether there is a relationship between the

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[33] See *Eidson*, 863 S.W.2d, at 626-28.

[34] A3014, A178-262, A318-430, A973-93 (Plaintiffs failed to present any expert testimony that negligence on the part of Dr. Stone or Mr. Cannon resulted in mental illness such that Mr. Christian had an "uncontrollable impulse" to commit suicide.)

[35] Appellants Second Substituted Opening Brief; Supr. Ct. R. 14(b)(vi)(A)(3) (providing that appellant must state merits of argument in opening brief or argument will be waived); *Lum v. State*, 2014 WL 4667089, at *1 (Del. 2014).

[36] *Mikell*, 972 A.2d, 1054; *McLaughlin v. Sullivan*, 461 A.2d 123,125 (N.H. 1983). See also *Farwell v. Un*, 902 F.2d 282 (4th Cir. 1990)(examining the duty of care of a psychiatrist to prevent suicide under Delaware law).

actor and the injured party such that the actor has a legal obligation to act, in the circumstances at issue, for the benefit of the injured party.[37] Whether a duty exists and the parameters of that duty is a question of law for the Court.[38] This determination by the court must be formulated in each particular case in light of its particular facts.[39]

When examining whether one party owes another a duty of care in a particular circumstance, Delaware Courts look to and follow the guidance of the Restatement (Second) of Torts.[40] The Restatement (Second) instructs that whereas misfeasance is the performance of a negligent act, non-feasance is the negligent omission of an act which a person ought to do.[41] The Restatement's discussion of non-feasance makes clear that a party is under no duty to act for the benefit of another *unless* there is a special relationship between himself and the other which gives rise to that duty.[42] Neither the gravity of the risk of harm nor the defendant's awareness of the risk abates the "no duty to act" principle expressed in Restatement (Second) §314.[43] "The fact that an actor realizes, or should realize

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[37] *Doe*, 58 A.3d, at 447(*internal citations omitted*).
[38] *Id*. (citing *Reidel v. ICI Americas*, 968 A.2d 17, 20 (Del. 2009)).
[39] *Naidu*, 539 A.2d, at 1070.
[40] *Doe*, 58 A.3d, at 447 (citing *Reidel*, 968 A.2d, at 22).
[41] *Doe*, 58 A.3d, at 447 (citing Restatement (Second) of Torts, Section 314).
[42] *Doe,* 58 A.3d, at 448 (quoting *Price v. E.I. Dupont de Nemours & Co.*, 26 A.3d 162, 167 (Del. 2011)).
[43] *Doe,* 58 A.3d, at 448.

that action on his part is necessary for another's aid or protection does not itself impose upon him a duty to take such action".[44]

While Section 314 provides the general rule that there is no duty to act for the benefit of another, Section 314A provides several notable "special relationship" exceptions to this maxim including: "common carriers, innkeepers, possessors of land, and those required by law or who voluntarily take *custody* of another under circumstances such as to deprive the other of his normal opportunities for protection. . .."[45] If the relationship in question does not implicate common carriers, innkeepers, or possessors of land, it will not be deemed "special" unless the party, as required by law or through a voluntary action, takes *custody* of another or exercises *control* over another under circumstances such as to deprive the other of his normal opportunities for protection.[46]

Pursuant to Section 314 and 314A, when considering whether a defendant has a duty to act to prevent the suicide of the decedent, the Court must first determine whether the relationship between the defendant and the decedent was "special" such that it triggered the duty to act to prevent the suicide. Where, as

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[44] *Id.* (citing *Reidel*, 968 A.3d, at 22).

[45] *Rogers*, 73 A.3d, at 7-8 (*emphasis added*); *Doe,* 58 A.3d, at 448-449 (citing Restatement (Second) of Torts, Section 314(A)).

[46] *Rogers*, 73 A.3d, at 7-8; *Doe,* 58 A.3d, at 448-449 (citing Restatement (Second) of Torts, Section 314(A)).

here, the first three exceptions to Section 314A are not satisfied, there will be no liability for the suicide unless it can be established that the defendant had the requisite custody or control over the decedent such that a duty was created on the part of the defendant to prevent the decedent's suicide.[47] Typically, a defendant in a case alleging breach of the duty to prevent suicide "is someone who has a duty of ***custodial*** care, is in a position to know about suicide potential, and fails to take measures to prevent the suicide from occurring".[48] Liability for the failure to prevent the suicide of another is typically imposed only upon: (1) institutions (jails, hospitals, and reform schools) having physical *custody* of, and *control* over, persons; and (2) those with special training and expertise in detection of mental illness and/or the potential for suicide *who also possess the power or control* necessary to prevent that suicide, such as mental hospitals, psychiatrists, and other mental-health trained professionals.[49] Across jurisdictions, there is only one type of special relationship that consistently imposes a duty to act to prevent the suicide of another – a *custodial* relationship.[50]

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[47] *Rogers*, 73 A.3d, at 7-8; see also *Lee v. Corregedore*, 925 P.2d 324, 330-331 (Haw. 1996)(citing extensive case law from various jurisdictions that a duty to prevent suicide is only permissible where there is custody or control); and *Estate of Eric S. Haar v. Ulwelling, M.D.,* 154 P.3d 67, 72 (N.M. Ct. App. 2007).

[48] *McLaughlin*, 461 A.2d, at 125 (emphasis added).

[49] *Mikell*, 972 A.2d, at 1054 (emphasis added).

[50] *Lee*, 925 P.2d, at 330.

Even where a defendant has custodial control over a suicidal individual, most jurisdictions are reluctant to impose liability for the suicide.[51] Liability for outpatient suicides is "rarely imposed, . . . and some commentators have suggested that liability under these circumstances should never be imposed".[52] In an outpatient situation, the patient is able to care for his own daily needs which affords a health care provider a limited opportunity for supervision.[53] Therefore,

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[51] *Mikell*, 972 A.2d, at 1057 (citing *Bruzga*, 693 A.2d 401).

[52] *Lee*, 925 P.2d, at 331-332 (following the Restatement (Second) of Torts §314A(4) "and recogniz[ing] a reasonable duty of care to prevent suicide only on the part of a defendant who had *actual custody* of a suicidal person"); *Maloney v. Badman*, 938 A.2d 883, 890 (N.H. 2007); *Trapnell v. United States*, 926 F. Supp. 534, 536 (D.Md. 1996)(noting that the law "recognizes that the vagaries of human conduct, especially conduct leading to self-destruction, are so unpredictable as to warrant great caution in imposing liability on the care-giver in the event of a patient's suicide when not in the care-giver's actual custody); *Runyon v. Reid*, 510 P.2d 943, 950 (Ok. 1973) (finding no liability for the suicide of the decedent who was being treated by defendants on an outpatient basis noting that, "it [was] obvious that defendants could not exercise the degree of control over decedent which a hospital could exercise over a patient."); *McLaughlin*, 461 A.2d, at 126 (noting that even in the case of individual psychiatrists, imposing liability for suicide is only appropriate if the patient is hospitalized at the time of the suicide because, otherwise the psychiatrist does not have sufficient control over the non-hospitalized patient to prevent his suicide.); *Farwell*, 902 F.2d, at 289 (noting that to hold that physicians have an unbounded duty to prevent a patient's suicide is "such a stringent duty [that] could only be discharged by a physician's assuming actual physical custody of the patient, or at the very least, mounting such continuous and close physical surveillance that effective physical intervention could occur at any time"; that such a stringent duty of care is practically impossible, unfair and imposing; and that patients have the right to be free from the paternalistic actions of their physicians, "no matter how well-meaning and professionally warranted, that might intrude on their patients' dignity and privacy interests").

[53] *Haar*, 154 P.3d, at 72; *Lee*, 925 P.2d, at 336.

imposing a duty to control a patient on an outpatient basis would require the exercise of a "degree of care and oversight that would be practically unworkable".[54]

Not only is imposing a duty to control an outpatient unworkable, but in Delaware, primary care physicians and mental health counselors do not have the legal authority to make their outpatients custodial. For involuntarily commitment, i.e. the exercise of custodial control over a mental health patient, a *psychiatrist* must provide written certification that he examined the patient and that A) the patient suffers from a disease or condition that requires he be observed and treated at a mental hospital for his own welfare; and B) the disease or condition renders the patient unable to make responsible decisions regarding hospitalization; or C) the patient poses a present threat, based on manifest indications, that he is likely to commit harm to himself or others.[55]

Finally, the viability of claims arising from non-feasance, including the duty to prevent the suicide of another, depends on the existence of a special

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[54] *Haar*, 154 P.3d, at 72 (citing *Weitz v. Lovelace Health*, 214 F.3d 1175 (10th Cir. 2000)). See also *Lee*, 925 P.2d, at 331-332, 339 (holding that liability for the decedent's suicide would be improper because: he was an independent adult with the right to enter and leave the clinic as he pleased; he had the right to make his own decisions regarding his health care; and that a counselor had little, if any, control over the client's decisions outside of the counselor's office).

[55] 16 *Del. C.* §5003

relationship.[56] It is not until a relationship is deemed special, such that the defendant has a duty to act to prevent the suicide, that the analysis turns to whether or not the suicide was foreseeable.[57] And pursuant to the Restatement (Second), foreseeability alone is insufficient to create a duty to prevent the suicide of non-custodial patients.[58] Moreover, this Court has declined to create a duty where, at common law, there previously was no duty.[59]

The trial court properly ruled that neither Dr. Stone nor Mr. Cannon had a duty to prevent the suicide of Mr. Christian. Because Dr. Stone and Mr. Cannon treated Mr. Christian on an outpatient basis, neither defendant had the requisite custody or control necessary, pursuant to Section 314A, to create a special relationship. Not only were Dr. Stone and Mr. Cannon not required by law to take custody of Mr. Christian, they were specifically precluded from doing so.[60] Further, neither Dr. Stone nor Mr. Cannon voluntarily took custody of Mr. Christian so as to deprive him of his normal opportunities for protection.[61] As an

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[56] *Doe,* 58 A.3d, at 437.

[57] *Lee*, 925 P.2d, at 330-331; *Trapnell*, 926 F. Supp., at 535.

[58] *In re: Asbestos Litigation*, 2007 WL 4571196 at *6-7 (Del. Super. Dec. 21, 2007); *Lee*, 925 P.2d, at 337.

[59] *Reidel*, 968 A.2d, at 20 (rejecting the Restatement (Third) of Torts because it "redefined duty in a way that [was] inconsistent with this Court's precedents and traditions").

[60] 16 *Del. C.* §5003; A3022-23.

[61] *Rogers*, 73 A.3d, at 7-8; *Doe*, 58 A.3d, at 448-449 (citing Restatement (Second) of Torts, Section 314(A)).

outpatient of Dr. Stone and Mr. Cannon, Mr. Christian took care of his own daily needs and came and went as he pleased.[62] Further, he had the right to make his own decisions regarding his health care and the record reflects that "Mr. Christian actively pursued and participated in his own care…, cooperated with his health care providers and was responsive to their recommendations."[63] Consistent with the law of Delaware, the guidance of the Restatement (Second), and the case law of several other jurisdictions, the trial court properly found that a special relationship did not exist between either Dr. Stone or Mr. Cannon and Mr. Christian because neither Dr. Stone nor Mr. Cannon had custody or control over Mr. Christian.[64]

Because the Plaintiffs failed to establish a special relationship between either Dr. Stone or Mr. Cannon and Mr. Christian, the trial court properly held that the Plaintiffs failed to establish a viable exception to the Restatement (Second) §314 – No duty to Act for the Benefit on Another, and that neither Dr. Stone nor Mr. Cannon had the duty to prevent Mr. Christian's suicide.

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[62] *Haar*, 154 P.3d, at 72 (citing *Weitz*, 214 F.3d 1175). See also *Lee*, 925 P.2d, at 331-332, 339.

[63] A3023, A2782-2843.

[64] *Rogers*, 73 A.3d, at 7-8; *Doe*, 58 A.3d, at 448-449 (citing Restatement (Second) of Torts, Section 314(A)); *Lee*, 925 P.2d, at 330-331; *Mikell*, 972 A.2d, at 1057 (citing *Bruzga*, 693 A.2d 401). See also *Maloney*, 938 A.2d, at 890; *Trapnell*, 926 F. Supp., at 535-36; *Runyon*, 510 P.2d, at 950; *McLaughlin*, 461 A.2d, at 126; *Farwell*, 902 F.2d, at 289; Restatement (Second) of Torts §314A(4).

2. Plaintiffs' opening brief misapprehends both the trial court's ruling and the law of Delaware.

The arguments in their brief suggest that Plaintiffs do not understand the trial court's rulings or the relevant Delaware law. First, there is no dispute as to the existence of a physician/patient and counselor/patient relationship between Mr. Christian and the Defendants.[65] What Plaintiffs apparently fail to appreciate, however, is that while the existence of a physician/patient or counselor/patient relationship could form the basis for a medical negligence claim of misfeasance leading to an "uncontrollable impulse" to commit suicide[66], such a relationship does not equate with a "special relationship" as required by §314A, or even §315, such that Dr. Stone and Mr. Cannon had a duty to act to prevent Mr. Christian's suicide.[67] A special relationship creating a duty to act to prevent the suicide of another requires custody and control which was not established in this case.[68]

In their Argument A, Plaintiffs claim that the trial court held, contrary to *Naidu*[69], that physicians and mental health counselors who treat their patients do not have a duty to prevent foreseeable harm to their patients because they do not

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[65] Appellants' Second Substituted Brief, pp. 13-14.

[66] See *Eidson*, 863 S.W.2d 621.

[67] *Rogers*, 73 A.3d, at 7-8; *Doe*, 58 A.3d, at 448-449 (citing Restatement (Second) of Torts, Section 314(A)).

[68] *Id.*; A3022-25.

[69] 539 A.2d 1064.

have a special relationship.[70] However, as addressed below, the trial court's holding is not contrary to *Naidu*.

Likewise, Plaintiffs' first Question Presented misstates the trial court's holding.[71] The trial court did not hold that physicians and mental health counselors do not owe a duty to their patients because they do not have a special relationship with their patients in an outpatient setting. Rather, the trial court's holding was much narrower and factually specific – Dr. Stone and Mr. Cannon did not have a duty to act affirmatively to prevent Mr. Christian's suicide because they did not have the requisite custody or control over Mr. Christian that would trigger a duty to act in that context under The Restatement's special relationship exception.[72]

a. Plaintiffs' reliance on *Murphy v. Godwin* is misplaced.

Plaintiffs rely on both *Murphy v. Godwin*[73] and the opinions of their medical experts to support their legal argument that where a physician/patient relationship exists, physicians owe their patients a "total duty of care" and so a special relationship exists.[74] Not only does *Murphy* not address "special relationship" in any context, but the existence of duty is not a fact question for the jury based on

[70] Appellants' Second Substituted Opening Brief, p. 12.
[71] *Id*.
[72] A3025.
[73] 303 A.2d 668 (Del. Super. 1973).
[74] Appellants' Second Substituted Opening Brief, p. 13.

the opinion of medical experts, it is a legal question for the Court.[75] In *Murphy*, where the physician advised the husband of his patient that he would fill out an insurance form but ultimately did so too late, the court answered a very narrow question based on the particular circumstances presented – and wholly unrelated to the case at bar: "is the relationship of doctor and patient such as justifies the imposition upon the doctor of a duty to act where the patient needs the doctors help in filling out a short routine form…?"[76] *Murphy* sets no relevant precedent because it is factually distinct from this case, its holdings were premised on a very limited set of circumstances and the court was clear that it would "not go so far as to attempt to formulate a general description of the doctor's duty to provide his patient with reasonable services *ancillary* to medical care."[77]

b. The trial court's grant of summary judgment is not contrary to *Naidu*

The trial court's grant of summary judgment also is not contrary to the holding in *Naidu*. As the trial court aptly noted, *Naidu* and this case are factually and posturally distinct.[78] In *Naidu*, the duty to prevent foreseeable harm to a *third party* (as opposed to suicide) was not addressed until the Court first determined that a special relationship, defined by custody and control, existed between the

[75] 303 A.2d 668; *Naidu*, 539 A.2d, at 1070.
[76] *Murphy*, 303 A.2d, at 674.
[77] *Id*.
[78] A3021-24.

patient and his *psychiatrist*.[79] In *Naidu*, the finding of a special relationship between the patient and a psychiatrist was premised on the fact that the care at issue occurred while the patient was hospitalized in the state mental hospital and therefore under the custody and control of the defendant psychiatrist.[80] Because a special relationship, as defined by custody and control, was established, the Court turned to the next part of the evaluation of liability – foreseeability.[81]

In this case, unlike *Naidu*, the defendants treated Mr. Christian on an outpatient basis and there is no evidence that they had any custody or control over him.[82] Further, unlike in *Naidu*, the defendants here are not psychiatrists and did not have the legal authority to independently exercise custody or control over Mr. Christian.[83] Contrary to Plaintiffs' assertions, the mere fact that Mr. Christian actively sought assistance from his healthcare providers does not create a "special relationship".[84] In this case, because the Plaintiffs failed to establish the existence

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[79] 539 A.3d, at 1071-72.

[80] *Id*., at 1069-1070.

[81] *Id*., at 1073. (While the Court in *Naidu* discussed steps other than involuntary commitment that the defendant could have pursued, those steps would all have been made a condition of discharge, at a point when the defendant had custody and control over the patient).

[82] A3023-24.

[83] 16 *Del. C.* §5003.

[84] Appellants' Second Supplemental Brief, p. 16.

of a special relationship, there is no duty to act and therefore no need to analyze the foreseeability of injury.[85]

c. The duty to warn in *Tarasoff v. Regents of the University of California* does not apply to suicide.

Plaintiffs also point to the *Naidu* Court's approval of *Tarasoff v. Regents of the University of California* as support for their position that Dr. Stone and Mr. Cannon had a duty to act to prevent Mr. Christian's suicide.[86] Plaintiffs' reliance upon *Tarasoff* is misplaced. The *Tarasoff* court's decision addresses only the duty of a mental health provider to warn a third person of danger and/or the duty to take steps to protect the third party from danger.[87] *Tarasoff* does not address the duty of a mental health care provider to take steps to prevent a patient's suicide, and in *Bellah v. Greenson*, the California appellate court specifically declined to extend *Tarasoff* to include suicide.[88]

d. The trial court's reliance on *Rogers* is well placed.

Finally, demonstrating still further their confusion about the special relationship exception, Plaintiffs criticize the trial court's reliance on *Rogers* in

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[85] *Lee*, 925 P.2d, at 330-331; *Trapnell*, 926 F. Supp., at 535.

[86] 551 P.2d 334 (Cal. 1976).

[87] *Id*., at 340.

[88] 146 Cal.Rpt. 535, 539-540 (Cal. Ct. App. 1978). See also *Lee*, 925 P.2d, at 334 (noting that the California Supreme Court in *Nally v. Grace Community Church*, 253 Cal. Rptr. 97, 107-108 (Cal.1988), "specifically rejected the notion that *Bellah* had imposed an affirmative duty on psychiatrists to prevent their non-custodial patients from committing suicide.")

support of its determination that the defendants did not have a special relationship with Mr. Christian. Plaintiffs suggest *Rogers* is inapposite because it addressed whether the defendants had ***custodial control*** over the decedent and the defendants in *Rogers* were not physicians.[89] However, custodial control is precisely the touchstone for the determination of special relationship under the Restatement and is the central issue of this appeal.[90] Just like in *Rogers*, Dr. Stone and Mr. Cannon's lack of custodial control over the decedent precluded the finding of a special relationship.[91]

Plaintiffs also are incorrect in asserting that the trial court's requirement of custody in determining a special relationship in the case of a non-feasance claim against a physician for failure to prevent suicide forever precludes a finding of medical negligence in any context without first proving custody.[92] This assertion again misconstrues the narrow focus of the special relationship exception in the context of a non-feasance claim of failure to prevent suicide. Custody is an element used to determine whether a special relationship exists, thereby creating a duty to act for the benefit of another.[93] It is not an element of medical negligence where the duty of reasonable medical care between a physician and patient (i.e.

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[89] Appellants' Second Supplemental Brief, pp.21-22.
[90] *Rogers*, 73 A.3d, at 7-8; A3025.
[91] A3025.
[92] Appellants' Second Supplemental Brief, p.22.
[93] *Rogers*, 73 A.3d, at 7-8.

misfeasance) is applicable. In other words, there is nothing about the trial court's holding that precludes a finding of medical negligence in another case where there is no custody. Moreover, there is nothing about the lower court's holding that precludes a finding – in another case – of liability for suicide in the context of medical negligence (misfeasance) under the "uncontrollable impulse" theory.[94]

3. The American Medical Association does not define whether Mr. Christian had a special relationship with Dr. Stone.

In their opening brief, Plaintiffs raise for the first time the contention that pursuant to the tenets of the American Medical Association (AMA), Mr. Christian had a special relationship with Dr. Stone.[95] This argument was never presented to the trial court and so is not properly before this Court.[96] "[P]arties are not free to advance arguments for the first time on appeal. Only questions fairly presented to the trial court may be presented for review."[97]

Even if this Court were to consider the merits of this new argument, it fails to support a finding of a special relationship, and subsequently a legal duty, on the part of Dr. Stone. Under Delaware law, there is no legal duty that arises from the

[94] See *Eidson*, 863 S.W. 2d 621.
[95] Appellants Second Supplemental Brief, pp. 23-25.
[96] Supr. Ct.R. 8.
[97] *Delaware Electric Coop. v. Duphily*, 703 A.2d 1202, 1206 (Del. 1997).

statement of aspirational goals, codes of ethics or standards of conduct of a professional organization.[98]

In conclusion, Plaintiffs have failed to demonstrate that the trial court in granting summary judgment to the defendants "erred in formulating or applying legal precepts"[99] and so Plaintiffs' appeal must be denied.

[98] *Doe*, 58 A.3d, at 455; *Brehm v. Eisner*, 746 A.2d 244, 256 (Del. 2000).
[99] *Stroud*, 606 A.2d, at 81.

II. THE SUPERIOR COURT PROPERLY LIMITED DR. BAKER'S CAUSATION TESTIMONY TO OPINIONS WITHIN HIS FIELD OF SPECIALTY, FAMILY PRACTICE

A. QUESTION PRESENTED

Did the Superior Court properly limit Dr. Baker's causation testimony to the field of his specialty, Family Practice?

Issue preservation pursuant to Supreme Court Rule 8 refers to the preservation of issues by the appellant, not the appellee.[100]

B. STANDARD AND SCOPE OF REVIEW

The Supreme Court reviews trial court decisions on expert testimony for abuse of discretion.[101] The trial judge is granted "broad latitude to determine whether expert testimony contains reasonable measures of reliability in a particular case".[102]

C. MERITS OF ARGUMENT

On appeal, Plaintiffs allege that the trial court improperly precluded Dr. Baker's causation testimony because the trial court misapprehended the "but for" proximate cause and "magic words" requirements of Delaware law.[103] Further

[100] See *Danby*, 104 A.2d at 907-08.

[101] *Tumlinson v. Advanced Micro Devices*, 2013 WL 4399144 at *2 (Del. 2013)

[102] *Id*.

[103] Appellants' Second Supplemental Brief, pp. 5, 9, 29-34.

Plaintiffs allege, without any citation to the record[104], that the court additionally precluded Dr. Baker's testimony for failing to testify using the "but for" standard.[105] Contrary to Plaintiffs' assertions, Dr. Baker's causation testimony was not precluded on a "but for"[106] or "magic word"[107] basis. Rather it was properly limited to opinions within the scope of Family Practice, his field of specialty.[108]

This Court has ruled, consistent with *Daubert v. Merrell Dow Pharm. Inc.*[109], that a "witness is qualified as an expert by knowledge, skill, experience, training or education."[110] An expert may be generally qualified and competent to offer certain opinions, but lack qualifications to offer opinions in a given specific

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[104] Although Plaintiffs took this Court's deficiency letter of 10/9/14 as an opportunity to rewrite the fact section of their brief, correct rampant citation errors and make style edits throughout, Appellants' Supplemental Brief and their Second Supplemental Brief still failed to cite any support for their claim that the court precluded Dr. Baker's testimony for failing to testify using the "but for" standard.

[105] Appellants' Second Supplemental Brief, pp. 5, 9, 29-34.

[106] A3052, A1837-38 (*Cannon Defendants' Motion in Limine to Bar Questions or Comments on Causation that are not Stated or Asked in Terms of the "But For" Standard* was denied by the trial court).

[107] A3068, A1837-38 (*Cannon Defendants' Motion in Limine to Bar Questions or Comments on Causation that are not Stated or Asked in Terms of Probabilities* was also denied by the trial court).

[108] A3066-68, A1837-38

[109] *Daubert v. Merrell Dow Pharm. Inc., 5*09 U.S. 579 (1993).

[110] *Bowen v. E.I. DuPont de Nemours & Co*., 2005 WL 1952859 at * 9 *(*Del. Super. June 23, 2005*)(internal citations omitted)(affm'd, Bowen v. E.I. DuPont de Nemours & Co.,* 906 A.2d 787, 795 (Del. 2006)).

factual setting.[111] An expert's "methodology, as well as his ultimate conclusion, must have '*a reliable basis in the knowledge and experience of the relevant discipline*"'.[112] The knowledge imparted must be more than unsupported beliefs; "it must be derived from supportable facts".[113]

The basic competency of an expert who will offer medical or scientific testimony goes to the very heart of the trial court's gate keeping function to ensure that expert testimony is trustworthy and reliable.[114] Not only is the trial court granted broad latitude in determining whether an expert's testimony is reliable[115], but the trial court's findings will not be overturned unless there was an abuse of discretion.[116]

In this case, the trial judge ruled that Dr. Baker, a board certified family practitioner, was qualified to offer family practice standard of care opinions against Dr. Stone and was also was qualified to offer causation opinions within the scope

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[111] *Eskin v. Cardin,* 842 A.2d 1222 (Del. 2004); *Friedel v. Osunkoya,* 994 A.2d 746 (Del. Super. 2010).

[112] *Kapetanakis v. Baker*, 2008 WL 172003, at * 3 (Del. Super. Jan. 18, 2008)(citing *Price v. Blood Bank of Delaware Inc*., 790 A.2d 1203 (Del. 2002)(emphasis added)).

[113] *Scaife v. Astrazeneca LP,* 2009 WL 1610575 at *14 *(*Del. Super. June 9, 2009) *(*citing *Daubert,* 509 U.S. at 589).

[114] *See generally, Daubert, 5*09 U.S. 579; *Eskin,* 842 A.2d at 1228; *Minner v. Am. Mortgage & Guar. Co.,* 791 A.2d 826 (Del. Super. 2000).

[115] *Tumlinson*, 2013 WL 4399144 at *2.

[116] *Id*.

of his family practice expertise.[117] However, the trial judge properly precluded Dr. Baker, who had no psychiatric knowledge, skill, experience, training or education, from offering any causation opinions about the outcome of the psychiatric care that he contended the standard of care required.[118] Because he did not have the requisite psychiatric qualifications,[119] Dr. Baker's opinions on the outcome of psychiatric medical care were nothing more than unsupported beliefs[120] that would not have assisted the trier of fact in understanding the evidence or determining whether a breach of the standard of care on the part of Dr. Stone caused Mr. Christian's suicide.[121] In conclusion, the trial court's ruling limiting Dr. Baker's causation testimony to opinions based in family practice, his field of specialty, was consistent *Daubert* and the holdings of this Court; was not an abuse of discretion; and should be affirmed.[122]

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[117] A3066-68, A1837-38.

[118] A3066-68, A1837-38.

[119] *Bowen*, 2005 WL 1952859 at * 9 *(affm'd, Bowen,* 906 A.2d, at 795). See also *Eskin,* 842 A.2d 1222; *Friedel,* 994 A.2d 746; *Kapetanakis*, 2008 WL 172003 at * 3; A3066-68.

[120] *Scaife,* 2009 WL 1610575 at *14*(*citing *Daubert,* 509 U.S. at 589).

[121] D.R.E. 702.

[122] *See generally, Daubert, 5*09 U.S. 579; *Eskin,* 842 A.2d at 1228; *Minner,* 791 A.2d 826; *Scaife,* 2009 WL 1610575 *at *14.*

CONCLUSION

Based on the foregoing, Defendant Arlen Stone, M.D. and his practice, Abby Family Practice, respectfully request this Honorable Court affirm the trial court's grant of summary judgment in their favor and affirm the trial court's ruling limiting the causation testimony of Terrance Baker, M.D. to Family Practice.

Respectfully submitted,

Date: November 5, 2014

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