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IN THE SUPREME COURT OF FLORIDA

JOSEPH S. CHIRILLO, JR., MD.
JOSEPH S. CHIRILLO, M.D., P.A., and MILLENNIUM PHYSICIAN GROUP, LLC,

Case No.: SC14-898
DCA Case No.: 2D12-5244

Petitioners,

v.

ROBERT GRANICZ, as Personal Representative of the Estate of JACQUELINE GRANICZ, Deceased,

Respondent.

_____________________________________ /

PETITIONERS' INITIAL BRIEF ON MERITS

On Review from the District Court of Appeal, Second District Case No. 2D12-5244

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INTRODUCTION AND STATEMENT OF THE CASE

The Respondent, ROBERT GRANICZ, as Personal Representative of the Estate of JACQUELINE GRANICZ ("Mr. Granicz"), the plaintiff in a medical malpractice action, filed suit against Petitioners and defendants below, JOSEPH S. CHIRILLO, JR., M.D., JOSEPH S. CHIRILLO, M.D., P.A., and MILLENNIUM PHYSICIAN GROUP, LLC ("Petitioners" or "Dr. Chirillo" as appropriate), following his wife's ("Mrs. Granicz") suicide. (R. V1, 16-21). The undisputed evidence demonstrated that outpatient Mrs. Granicz showed no signs of suicidal tendencies during the time she was under the care of Dr. Chirillo, her primary care physician. (R. V2, 384-86, V3, 413, 464).

Petitioners moved for summary judgment, and the trial court, citing *McCain v. Florida Power Corp.*, 593 So. 2d 500 (Fla. 1992), found it was required to "make some inquiry into the factual allegations of the case to determine whether a foreseeable, general zone of risk was created by the defendant's conduct." (R. V3, 463-67). The trial court carefully analyzed both the lay and expert testimony with respect to the foreseeability of Mrs. Granicz's suicide to determine whether Dr. Chirillo owed Mrs. Granicz a legal duty. (R. V3, 463-67). The trial court then granted Petitioners' motion, concluding that "[t]o hold that Dr. Chirillo had a duty to prevent the suicide of an outpatient which, by the record evidence including testimony of

Plaintiff's experts, was not foreseeable, would be contrary to the laws of this state." (R. V3, 467).

On appeal, the Second District Court of Appeal reversed the judgment and certified conflict with *Lawlor v. Orlando*, 795 So. 2d 147 (Fla. 1st DCA 2001), which the trial court had found persuasive. *Granicz v. Chirillo*, 147 So. 3d 544 (Fla. 2d DCA 2014). In reversing, the Second District held that the trial court had incorrectly analyzed Dr. Chirillo's duty under the standard for proximate cause, and that the issue of duty in medical malpractice cases "is generally resolved . . . by expert testimony." *Id.* at 548. The Second District held that the testimony of Mr. Granicz's expert witnesses was "sufficient to establish that Dr. Chirillo owed a legal duty to [Mrs. Granicz] that precluded summary judgment." *Id.* at 548-49. Critically, the district court expressly disagreed "with the *Lawlor* court's description of [a] psychotherapist's legal duty as a duty to prevent the patient's suicide" after noting that, in *Lawlor*, the First District determined that the psychotherapist did not have a legal duty to prevent the patient's suicide because the suicide was unforeseeable. *Id.* at 548.

This Court accepted jurisdiction to resolve the conflicts. In this Merits Brief, references to the Record are abbreviated as "R. [volume number], [page number]."

STATEMENT OF THE FACTS

A. Dr. Chirillo's Care of Mrs. Granicz and the Absence of Evidence of Suicidal Ideations.

On October 9, 2008, fifty-five-year-old Mrs. Granicz committed suicide by hanging herself in her home's garage. (R. V2, 384). Mrs. Granicz suffered from previously-diagnosed depression and was taking Prozac when she began to see Dr. Joseph Chirillo, a family practitioner, as her primary care physician, in July 2005.[1] (R. V2, 206, 208). Mrs. Granicz had been doing well on her medication when Dr. Chirillo started treating her. (R. V2, 206). Dr. Chirillo characterized Mrs. Granicz's depression as mild and well-controlled by medication. (R. V2, 207). Dr. Chirillo prescribed the anti-depressant Effexor in 2005, of which Mrs. Granicz was taking the minimum dose. (R. V2, 207-08, 217, 243). Mrs. Granicz mentioned during one appointment that the Effexor appeared therapeutic for her, and Dr. Chirillo felt that Effexor effectively controlled her symptoms. (R. V1, 160, 164) Mrs. Granicz picked up a refill of Effexor in June of 2008, but had stopped taking it at an unknown point, and for unknown reasons, between July 2008 and the date of her suicide. (R. V1, 167).

[1] According to Mr. Granicz's expert Dr. Michael Yaffe, the majority of patients in the United States being treated for depressive disorders are under the care of primary care physicians. (R. V2, 306).

Until the day before Mrs. Granicz committed suicide, Dr. Chirillo believed she was taking the prescribed Effexor. (R. V2, 215-16). That day, Mrs. Granicz called Dr. Chirillo's office and spoke to his medical assistant, reporting that she had not felt right since late June or July, and had stopped taking the Effexor, thinking it might be the cause of her symptoms. (R. V2, 216). Mrs. Granicz described her symptoms as crying easily, having mental strain, feeling funny for a few weeks, not sleeping well, having belly pain, a burning sensation in her esophagus, and loose, clear stools. (R. V2, 218). She did not ask for an appointment. Upon learning of the call, Dr. Chirillo made samples of a different anti-depressant, Lexapro, available at his office for Mrs. Granicz. (R. V2, 212). Dr. Chirillo also referred Mrs. Granicz to a gastroenterologist for her other symptoms. (R. V2, 335). Based on the Lexapro found in her system after her death, the record suggests that, after her phone call but before her suicide the following day, Mrs. Granicz picked up the Lexapro samples from Dr. Chirillo's office.[2] (R. V1, 180).

Mrs. Granicz's daughter, Renee, a registered nurse, spoke to Mrs. Granicz on October 7, 2008, two days before her suicide. (R. V3, 406, 415). According to Renee, Mrs. Granicz never told Renee she had thoughts of suicide. (R. V3, 410). During the

[2] No member of Dr. Chirillo's staff recalled seeing Mrs. Granicz come to the office to pick up the Lexapro samples. (R. V1, 147-48).

conversation two days before her death, Mrs. Granicz did not express any signs or symptoms that she might be preparing for suicide. (R. V3, 416). Mrs. Granicz also did not give the impression of being near to ending her life.[3] (R. V3, 406, 415). Mrs. Granicz's suicide shocked Renee, who had never contemplated her mother would take her own life. (R. V3, 416).

According to Mr. Granicz, Mrs. Granicz grappled with heartburn issues and discomfort in her chest and esophagus two days before her death. (R. V2, 375). Mrs. Granicz was agitated, had difficulty sleeping, and was tired and not feeling well. (R. V2, 376). That date, she said she would go see the doctor. (R. V2, 378). Mr. Granicz spoke to Mrs. Granicz later that evening, and she did not relay to him any concerns at that time. (R. V2, 379).

The next day, the day of Mrs. Granicz's death, Mr. Granicz left the house while Mrs. Granicz slept. (R. V2, 382). Mr. and Mrs. Granicz met in passing, in their respective cars, at about 2:00 P.M., as Mr. Granicz left their housing community while Mrs. Granicz returned home. (R. V2, 382-83). Mr. Granicz asked Mrs. Granicz how she felt, and she said she was not feeling well, pointing to the general area of her upper chest. (R. V2, 383). To Mr. Granicz, his wife's distress appeared primarily

[3] Renee only had concerns for Mrs. Granicz's physical health, since she said she was not feeling well, was crying easily, and her stomach hurt. (R. V3, 416).

physical, as opposed to emotional. (R. V2, 383). Mr. Granicz asked her if she had seen the doctor, to which she responded she had not. (R. V2, 383). Mr. Granicz said he would call Dr. Chirillo; Mrs. Granicz responded that she appreciated it. (R. V2, 383). Mr. Granicz called Dr. Chirillo and left a voicemail to tell him that Mrs. Granicz was feeling a great deal of discomfort. (R. V2, 383).

Mr. Granicz did not think his wife would go home and commit suicide or harm herself. (R. V2, 384). Mr. Granicz did not know something was going on in her mind that could cause her to later commit suicide. (R. V2, 384). He had no idea she was contemplating suicide and did not ever anticipate it. (R. V2, 384-85). Mrs. Granicz had never given Mr. Granicz an indication she might harm herself. (R. V2, 384). When Mr. Granicz arrived home at approximately 5:30 P.M., three-and-a-half hours after encountering her on the road in their community, he found her hanged in their garage. (R. V2, 384). Dr. Chirillo was “floored” when he heard of Mrs. Granicz’s suicide. (R. V2, 223-24).

B. Mr. Granicz’s Experts’ Opinions

Mr. Granicz filed deposition transcripts of Dr. Tonia L. Werner, M.D., a psychiatrist, and Dr. Michael E. Yaffe, M.D, an internist. (R. V2, 201-349). Dr. Werner opined that, on October 8, 2008, Dr. Chirillo should have had Mrs. Granicz come in to the office to see her, and that this led to her suicide. (R. V2, 247, 251).

Dr. Werner testified there was no way to know if Mrs. Granicz's suicide was planned or spontaneous and admitted there was no charted documentation where Mrs. Granicz denied or expressed suicidal ideation. (R. V2, 252-53, 267). Dr. Werner testified that, had Mrs. Granicz come in and described her symptoms consistently with the telephone call, "she would still benefit from in-patient hospitalization and stabilization."[4] (R. V2, 256). Dr. Werner stated she did not have enough information to render an opinion as to whether Mrs. Granicz would have been hospitalized had she seen Dr. Chirillo. (R. V2, 266).

Dr. Yaffe opined that on October 8, 2008, Dr. Chirillo failed to provide a direct face-to-face evaluation and assessment of Mrs. Granicz, and that this deviation from the standard of care prevented Mrs. Granicz "the opportunity to have an intervention and treatment for her illness that ended the next day in a suicide." (R. V2, 323-24). Dr. Yaffe could not say, within a reasonable degree of medical certainty, that the Lexapro was the cause of Mrs. Granicz's suicide. (R. V2, 326). Dr. Yaffe opined that if Dr. Chirillo had seen Mrs. Granicz, and she then expressed suicidal ideations, the proper action would have included a referral to a psychiatrist

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[4] According to Dr. Werner, "[s]he appears to be an individual that warranted an in-person face-to-face evaluation, and she didn't get it. And that evaluation would tell you whether she needed to be hospitalized or not." (R. V2, 256-57).

or the emergency room.[5] (R. V2, 333). If she had not expressed suicidal ideations, Dr. Chirillo's prescription of Lexapro and gastroenterologist referral would have been appropriate. (R. V2, 338). Dr. Yaffe recognized that Mrs. Granicz had never expressed suicidal thoughts or ideations to Mr. Granicz or Dr. Chirillo. (R. V2, 337).

C. Procedural Background: The Second District, Certifying Conflict, Rejects Florida Law Holding there is No Duty to Prevent Suicide in an Outpatient Setting and Removes Judicial Responsibility for Determining whether a Suicide is Foreseeable

Mr. Granicz filed suit against Petitioners, alleging that Dr. Chirillo negligently a) failed to recognize that when Mrs. Granicz called his office she was depressed; b) failed to speak with Mrs. Granicz and directing his staff to advise her to come to the office; c) failed to refer her to a physician trained in depression-management; and d) failed to conduct an evaluation before prescribing Lexapro. (R. V1, 19-20). Petitioners moved for summary judgment on the basis that Dr. Chirillo had no duty to prevent Mrs. Granicz from injuring herself while she was not under his custodial

[5] Dr. Werner's and Dr. Yaffe's opinions necessarily involve speculating about numerous hypothetical scenarios and are based on multiple assumptions. *See* Answer Brief, No. 2D12-5244, at 26. For example, even before speculating about what Mrs. Granicz may have relayed once in Dr. Chirillo's office, Dr. Werner and Dr. Yaffe presuppose that Mrs. Granicz would have agreed to come in to the office if requested to do so. Further, at the least, Dr. Werner's and Dr. Yaffe's opinions assume that had Mrs. Granicz complied with a request to come in, that she would have felt suicidal at that time, that she would have expressed suicidal ideations, and that any remedy proposed by Dr. Chirillo would have prevented her suicide. *See id.*

care, and because Mrs. Granicz's suicide was in no way foreseeable to Dr. Chirillo. (R. V1, 84-95). In his response, Mr. Granicz suggested that case law from the Second District "view[ed] the question of duty in suicide cases differently" than the cases cited by Petitioners. (R. V2, 350-52). Mr. Granicz argued that jury questions on both causation and the standard of care were created by the testimonies of Drs. Werner and Yaffe, and that Petitioners' arguments addressed "foreseeability" in the context of proximate causation, rather than duty. (R. V2, 353-55).

The trial court granted Petitioners' motion, concluding that Dr. Chirillo did not owe a legal duty to prevent the suicide of an outpatient which all record evidence demonstrated was not foreseeable:

> It is well settled in Florida law that the foreseeability aspect of "duty" is a question of law to be determined by the trial court as a minimum threshold legal requirement for opening the courthouse doors to a negligence action. *See McCain v. Florida Power Corporation*, 593 So. 2d 500 (Fla. 1992). The *McCain* court held that to determine this legal question, the court must make some inquiry into the factual allegations of the case to determine whether a foreseeable, general zone of risk was created by the defendant's conduct. *McCain*, 593 So. 2d at 503.
>
> . . . .
>
> The testimony from Mrs. Granicz's husband, Robert Granicz, daughter, Renee Granicz and Dr. Chirillo was that her suicide was a shock to all of them. The testimony was that Mrs. Granicz had never spoken of suicidal thoughts, she had never expressed or been diagnosed with suicidal ideations, and she had never attempted suicide. Robert Granicz testified that he saw Mrs. Granicz just hours before she committed suicide and he testified she did not appear to him like a woman about to take her life. Plaintiff's expert psychiatrist, Dr. Tonia

> Werner, testified that there was no way to know if her suicide was planned or spontaneous. Plaintiff's expert internal medicine physician, Dr. Michael Yaffe, testified that Mrs. Granicz never expressed suicidal ideations to her doctor or her husband. . . .
>
> [The trial court summarized the facts and holding of *Lawlor v. Orlando*, 795 So. 2d 147 (Fla. 1st DCA 2001)]
>
> Defendants in the instant case presented testimony to the court demonstrating that prior to her passing and during Dr. Chirillo's treatment of her, Mrs. Granicz had not shown any indication of suicidal tendencies, there was no evidence of suicidal attempts, no evidence of threats of suicide and never any mention of suicide to her family or Dr. Chirillo.
>
> . . . .
>
> Based upon analysis of the relevant case law, consideration of oral argument and the testimony and evidence presented at the evidentiary hearing on September 24, 2012, this court finds that this case is most factually similar to the *Lawlor* case whose holding this court finds persuasive. Prior to determining whether a duty was breached, plaintiff must establish that a legal duty was owed. To hold that Dr. Chirillo had a duty to prevent the suicide of an outpatient which, by the record evidence including testimony of Plaintiff's experts, was not foreseeable, would be contrary to the laws of this state.

(R. V3, 463-67).

Mr. Granicz appealed (R. V3, 486-92), arguing "that summary judgment was improper because he provided expert testimony setting forth the applicable standard of care, how it was breached, and how the breach proximately caused [Mrs. Granicz's] suicide." 147 So. 3d at 546. Petitioners requested that the summary judgment be affirmed, contending that the trial court delineated the type of

foreseeability that can give rise to the existence of a duty, and correctly found no duty on Petitioners' part because Mrs. Granicz's suicide was not foreseeable.

The Second District reversed. *Id.* at 544. While the Second District recognized, per *McCain*, "the trial court's role in assessing foreseeability in the context" of duty, the Second District held that here, "the trial court analyzed Dr. Chirillo's duty under the standard for proximate cause." *Id.* at 548. The Second District stated that the issue of the aspects of the standard of care owed by a physician to his or her patient, under section 766.102(1), Florida Statutes, "is generally resolved in medical malpractice cases by expert testimony." *Id.* The Second District held Mr. Granicz's experts' testimonies sufficient to preclude summary judgment, in that, according to Drs. Werner and Yaffe, "the standard of care requires physicians to personally assess the patient's condition to determine if she is having thoughts of suicide and intervene if necessary." *Id.* at 548. In concluding, the Second District reiterated that "the expert testimony" setting forth that Dr. Chirillo had a duty to treat Mrs. Granicz in accordance with the prevailing standard of care" precluded summary judgment. *Id.* at 549.

The Second District certified conflict with *Lawlor v. Orlando*, 795 So. 2d 147 (Fla. 1st DCA 2001), because, in *Lawlor*, the First District "determined that [a] psychotherapist did not have a legal duty to prevent the patient's suicide because the

suicide was unforeseeable," and because it had "rejected the plaintiff's expert testimony setting forth the applicable standard of care, how it was breached, and how the breach proximately caused the patient's suicide." *Id.* The Second District expressly disagreed with the "*Lawlor* court's description of the psychotherapist's duty as a duty to prevent the patient's suicide," stating that the psychotherapist should have been deemed to have a "duty to provide 'appropriate psychotherapy,'" and that the plaintiff's expert testimony should have precluded summary judgment. *Id.* at 548-49.

In moving for rehearing, rehearing *en banc*, and certification of a question of great public importance, Dr. Chirillo suggested that the court overlooked pertinent facts that would have caused it to conclude that Petitioners created no foreseeable zone of risk despite the conclusion of Mr. Granicz's experts. Dr. Chirillo suggested that the Second District certify to this Court the question of whether, in a medical malpractice action, a trial court is required to defer to the patient's experts' allegations as to the standard of care, or independently examine the evidence to determine whether a physician's conduct created a foreseeable zone of risk. On April 11, 2014, Dr. Chirillo's post-opinion motions were denied.

Dr. Chirillo thereafter timely filed a Notice to Invoke the Discretionary Jurisdiction of this Court, and following jurisdictional briefing, this Court accepted jurisdiction by Order dated December 17, 2014.

SUMMARY OF THE ARGUMENT

The Second District erred by disagreeing with Florida law characterizing a physician's "legal duty as a duty to prevent the patient's suicide" where a physician treating an outpatient for mental illness is sought to be held liable for medical malpractice. The First, Third, and Fifth Districts have recognized that Florida does not "impose[] a legal duty on a psychotherapist for the suicide of a client who is being treated in an outpatient situation." *Lawlor*, 795 So. 2d at 148; *Kelley v. Beverly Hills Club Apts.*, 68 So. 3d 954 (Fla. 3d DCA 2011); *Garcia v. Lifemark Hosps. of Fla.*, 754 So. 2d 48 (Fla. 3d DCA 1999); *Paddock v. Chacko*, 522 So. 2d 410, 415-16 (Fla. 5th DCA 1988). In Florida, a specific duty of care to take affirmative steps to prevent the suicide of another only arises where the patient is under the custody and control of the defendant.

There are sound legal and practical reasons—already explained by Florida courts—for a physician to be held not to owe a legal duty to an outpatient who commits suicide, and thus, for this unique injury to be governed by different rules than those applicable to physical injuries alleged to be caused by medical malpractice. First, absent confinement, suicide, by its very nature, is generally

unforeseeable as it is self-inflicted. *See Wyke v. Polk. Cnty. Sch. Bd.*, 129 F.3d 560, 574 (11th Cir. 1997) (applying Florida law). Second, imposition of a legal duty to prevent outpatient suicide ignores the limits of outpatient psychiatric and psychological treatments in that it inappropriately requires physicians to be clairvoyant. *See Tuten v. Fariborzian*, 84 So. 2d 1063, 1067 (Fla. 1st DCA 2012); *Boynton v. Burglass*, 590 So. 2d 446, 450 (Fla. 3d DCA 1991). Third, in contrast to a hospitalized patient who has expressed suicidal tendencies, an outpatient is not under the physical control of his or her treating physician or psychotherapist; thus, the relationship between a treating physician and his outpatient is not a "special relationship" that can give rise to an affirmative legal duty prevent another from intentionally harming oneself. *See* Restatement (Second) of Torts, §§ 314-318. Indeed, in recognizing the need for patient confinement in order for liability to attach to patient suicide, Florida courts have already implicitly adopted a version of the widely accepted "special relationship" test.

Applying the correct Florida law here, it is undisputed that Mrs. Granicz was an outpatient, implicating the general rule that Petitioners cannot be held liable for her suicide as a matter of law. Therefore, Petitioners respectfully request this Court to quash *Granicz* and approve *Lawlor*, confirming the established proposition (except in the Second District) that a physician may only owe a legal duty for a

suicide in the case of a hospitalized patient under his care or control, and to remand for entry of judgment for Petitioners.

The Second District also incorrectly reversed the summary final judgment based exclusively on its declared statement of law that "[t]he specific aspects of [a physician's duty of care] . . . is generally resolved in medical malpractice cases by expert testimony." *Granicz*, 147 So. 3d at 548. While this is a correct statement of law with respect to physical injuries alleged to be caused by medical negligence, its application to the unique injury here—outpatient suicide—was error. In deferring to Respondent's experts' testimony opining that the standard of care required Dr. Chirillo to personally assess Mrs. Granicz's condition, the Second District ignored the body of Florida law concluding that the foreseeability of suicide is essential to a determination of the existence of a legal duty. *See Lawlor*, 795 So. 2d at 148 (noting that mere evidence of depression "does not necessarily create a foreseeable zone of risk *of suicide* for imposing a legal duty on [patient's] psychotherapist") (emphasis added); *Kelley*, 68 So. 3d at 958 ("[I]t is the suicidal tendencies of a specific person . . . which is determinative of the existence of a duty owed to that person."); *Rafferman v. Carnival Cruise Lines, Inc.*, 659 So. 2d 1271 (Fla. 3d DCA 1995) (holding that absence of evidence that plaintiff would harm himself was fatal to existence of a duty).

Therefore, where a physician is alleged to be professionally negligent in failing to control harm caused by an outpatient to herself, the correct Florida law is set forth in *Lawlor* and requires the judiciary to conduct an independent foreseeability analysis, considering all of the evidence, to determine the existence of a duty. Contrary to the Second District's implication below, this Court's holding in *McCain v. Florida Power Corp.*, 593 So. 2d 500 (Fla. 1992), does not require a different result based on its directive that courts to look to whether negligence created a "foreseeable zone of risk" rather than whether a "specific injury" was foreseeable. *Granicz*, 147 So. 3d at 548. In *McCain*, this Court had no reason to opine on the different rules that apply in the distinguishable situation where a defendant is alleged to be liable for another's intentional infliction of death outside of his or her custody.

Here, the undisputed facts established that Mrs. Granicz had never expressed any suicidal ideations to Dr. Chirillo, Mr. Granicz, or their registered nurse daughter Renee. As there was no summary judgment evidence tending to establish that Mrs. Granicz intended to harm herself, this Court should reinstate the trial court's entry of summary judgment in favor of Petitioners.

Therefore, alone or in combination with the fact of Mrs. Granicz's status as an outpatient, Petitioners request that this Court quash *Granicz*, approve *Lawlor*, and

remand for entry of judgment on the basis that Mrs. Granicz's suicide was not foreseeable to Dr. Chirillo. Alternatively, and only in the event this Court rejects Petitioners' argument in Issue 1, Petitioners request that this Court remand to the Second District for it to apply an independent analysis of the foreseeability of Mrs. Granicz's suicide, based on all of the evidence, without deferring to the testimony of Mr. Granicz's experts.

ARGUMENT

I. *GRANICZ* MUST BE QUASHED BECAUSE THE SECOND DISTRICT ERRED IN REJECTING FLORIDA LAW HOLDING THAT A PHYSICIAN'S DUTY TO PREVENT A MENTALLY ILL PATIENT'S SUICIDE DOES NOT EXTEND TO A NON-CUSTODIAL RELATIONSHIP

The Second District erred in incorrectly ignoring Florida law, including *Lawlor*, recognizing that the duty of care of a physician treating a patient for mental illness ordinarily does not extend to require a physician to prevent the suicide of an outpatient. Thus, in cases where damages are sought based on alleged medical malpractice for an outpatient's suicide, the Second District incorrectly held that the scope of a physician's duty should not be described as a duty to prevent suicide. *Granicz*, 147 So. 3d at 548-49. Florida courts have consistently emphasized the problems inherent in imposing liability on physicians for the unique, self-inflicted injury of suicide (especially where no suicidal tendencies have been expressed),

based on the unpredictability of mental illness and the limits of medical treatment to predicting whether another will harm himself. The Second District's holding, therefore conflicts with both *Lawlor*, cases from other district courts of appeal, and the broader weight of authority in the country, limiting (or eliminating) the scope of a physician's duty in the case of outpatient suicide. Because Dr. Chirillo did not owe a legal duty to prevent outpatient Mrs. Granicz's suicide, Petitioners respectfully request this Court to quash *Granicz*, approve *Lawlor*, and remand for entry of judgment in favor of Petitioners.

This first conflict issue is a question of law that this Court reviews *de novo*. *See generally Delva v. Cont'l Grp.*, 137 So. 3d 371, 374 (Fla. 2014).

"Suicide has long been the subject of intense religious, ethical, legal and medical debate." *Brandvain v. Ridgeview Institute, Inc.*, 372 S.E.2d 265, 271 (Ga. Ct. App. 1988).[6] In determining whether to impose a duty to prevent suicide, courts

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[6] "At common law, [suicide] was a felony, resulting in the forfeiture to the crown of the deceased's property and an ignominious burial in the highway with a stake driven through his heart." *Brandvain*, 372 S.E.2d at 271-72. *See also State v. Eitel*, 227 So. 2d 489, 491 (Fla. 1969) ("Suicide, for example, has been a common-law crime for centuries."). While no longer the case, the legal history of the phenomenon of suicide is undoubtedly relevant to why it should be subject to a different set of legal rules than those applicable to physical injuries caused by medical malpractice. "An historical overview of the cases reveals an early refusal to recognize suicide as a consequence of a defendant's wrongful act, followed by a later acceptance of the cause of action tempered by the imposition of exacting requirements as a foundation

should consider relevant societal effects, including the chilling effect that may ensue in the medical community in the treatment of outpatients with mental illness. *See Lee v. Corregedore*, 925 P.2d 324, 337 (Haw. 1996) ("Public policy considerations weigh against imposing a duty on all counselors to prevent the suicides of noncustodial clients, because the imposition of such a broad duty could have deleterious effect on counseling in general."); *Adams v. City of Fremont*, 80 Cal. Rptr. 2d 196, 214-16 (Cal. Ct. App. 1998); *Moore v. W. Forge Corp.*, 192 P.3d 427, 438 (Colo. Ct. App. 2007) ("The legal formulation must strike the balance between defendant's responsibility for the consequences of its acts and the consensual societal value that requires life-affirming conduct") (citation omitted).

In Florida, generally, "a doctor is not liable for the suicide of a patient." *Garcia v. Lifemark Hosps. of Fla.*, 754 So. 2d 48, 49 (Fla. 3d DCA 1999). "As a general rule, 'there is no liability for the suicide of another . . . in the absence of a specific duty of care.'" *Kelley v. Beverly Hills Club Apartments*, 68 So. 3d 954, 957 (Fla. 3d DCA 2011) (quoting *Paddock v. Chacko*, 522 So. 2d 410, 416 (Fla. 5th DCA 1988)). Florida's general rule is consistent with a "considerable body of state law" standing for the proposition that there is no affirmative duty to prevent suicide with

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for the claim." *Jamison v. Storer Broadcasting Co.*, 511 F. Supp. 1286, 1291 (E.D. Mich. 1981) (citations omitted).

respect to patients being treated on an outpatient basis. *Farwell v. Un*, 902 F.2d 282, 289 n.6 (4th Cir. 1990). *See Trapnell v. United States*, 926 F. Supp. 534 (D. Md. 1996); *Lee*, 925 P.2d at 332; *Maloney v. Badman*, 938 A.2d 883 (N.H. 2007); *Estate of Eric S. Haar v. Ulwelling*, 154 P.3d 67 (N.M. Ct. App. 2007); *King v. Smith*, 539 So. 2d 262 (Ala. 1989).

Florida courts have been clear that what is meant by "specific duty of care"—i.e., the exception to the general rule that there is no physician liability for patient suicide—is patient confinement or hospitalization. Therefore, a duty of care may exist where a patient surrenders himself to the custody of a psychiatric hospital and the hospital fails to take protective measures to prevent the patient from injuring himself. *See Garcia*, 754 So. 2d at 49 ("An exception to this general rule exists when the patient is confined to a hospital."); *Paddock*, 522 So. 2d at 416 ("The [exception] is based *solely* on the fact of the patient's confinement in the hospital, and the hospital's ability to supervise, monitor and restrain the patient."); *Kelley*, 68 So. 3d at 957 (emphasis added) (quoting *Paddock*); *Lawlor*, 795 So. 2d at 147 ("[N]o Florida cases extend the duty of custodial supervision and care to the outpatient relationship between a psychotherapist and a patient."); *see also, e.g.*, *Santa Cruz v. Nw. Dade Cmty. Health Ctr.*, 590 So. 2d 444 (Fla. 3d DCA 1991). *Cf. Brown v. Kaufman*, 792 So. 2d 502 (Fla. 4th DCA 2001) (reversing directed verdict and

permitting chief psychiatrist to be held liable for patient's suicide in hospital room). Absent confinement, "it seems elementary" that a physician should not be held liable for a patient's suicide. *Garcia*, 754 So. 2d at 49.

The rule originated in *Paddock*, where the Fifth District held that a psychiatrist does not owe a legal duty to hospitalize his patient for the benefit of the patient's own safety. *Id.* at 414. In *Paddock*, in affirming the entry of judgment notwithstanding the verdict in favor of the defendant psychiatrist who was alleged to have deviated from the standard of care by not hospitalizing the plaintiff and leaving her in her parents' care, the Fifth District analogized to the weight of authority recognizing that confinement and control is essential to the imposition of a duty on a physician to prevent a patient from injuring herself:

> There is some precedent in Florida law for liability predicated upon the negligent failure to safeguard and protect a psychiatric patient with suicidal tendencies. However, in each of these cases, the patients were already committed to the custody of a hospital or mental institution. These patients had surrendered themselves to the care of others and thus these custodians were in a position to exercise measures to prevent the suicidal patients from inflicting injuries on themselves. In this case, as long as the plaintiff's father and mother exercised control over the plaintiff, [the psychiatrist] was not in a position to do anything, other than offer his professional advice as to what methods of treatment were most suitable to his patient's needs.
>
> Cases from other jurisdictions are consistent with this reasoning. It has been recognized as a general rule that there is no liability for the suicide of another in the absence of a specific duty of care. As an exception to this general rule, it is well established that a hospital or

> sanatorium owes its patients or inmates a specific duty of care. . . . The duty is based solely on the fact of the patient's confinement in the hospital, and the hospital's ability to supervise, monitor, and restrain the patient. Upon release of the patient, this duty ceases. Several cases have recognized the distinction between the doctor's professional duty to treat and diagnose his patient, and the hospital's duty to protect and restrain the patient. . . .
>
> The principle underlying all of these cases is the same. Where a patient has surrendered himself to the custody, care and treatment of a psychiatric hospital and its staff, liability may be predicated upon the hospital's failure to take protective measures to prevent the patient from injuring himself. We have found no case that has held a doctor liable for the failure to take his patient into custody. Under the circumstances and facts of this case, we are unwilling to extend the duty of custodial supervision and care to the out-patient relationship between a psychiatrist and his patient.

Id. at 415-17 (citations and footnotes omitted).[7]

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[7] Mr. Granicz will likely contend that *Paddock* does not apply here because he is not arguing that Dr. Chirillo should have hospitalized Mrs. Granicz—only that he should have seen her, *then* hospitalized her, if appropriate. *Cf. Sweet v. Sheehan*, 932 So. 2d 365, 367 n.1 (Fla. 2d DCA 2006) (noting that plaintiff did not allege psychiatrist should have forced plaintiff's commitment against his will but expressing no further opinion for procedural reasons). This reasoning is flawed. For purposes of whether Florida recognizes physician liability for outpatient suicide, an allegation that a physician should have conducted a "face-to-face" evaluation is analytically indistinct from the allegation that the physician should have involuntarily hospitalized the patient. These are simply different, purely fact-dependent sides of the same coin. Acceptance of this distinction would create legally inconsistent results by actually imposing a higher duty in a case where the patient expresses *lesser* symptoms of suicidal tendencies. For example, if accepted, Dr. Chirillo could not be held liable for declining to hospitalize Mrs. Granicz even if he saw her and she expressed suicidal tendencies. However, if he saw her, she expressed no suicidal ideations, he sent her home, and she committed suicide, Dr. Chirillo could be held liable if found to have breached the prevailing standard of care. These results are facially incompatible. These problems are demonstrated by a review of Dr. Werner's

There are at least two logical, recognized reasons for this rule limiting a physician's legal responsibility for a patient's suicide to situations involving confinement (setting aside, for the moment, a defendant's need for notice of suicidal tendencies). First, courts have recognized the nature of suicide as ordinarily unforeseeable. Second, courts have been loath to impose liability on a defendant-physician in the case of outpatient suicide because of the medical limits of psychiatric foresight to predicting whether a patient will harm himself or others. *Paddock*, 522 So. 2d at 414-16. Together, these factors warrant the need for a "special relationship" to exist in order for a defendant to be held liable for harm caused by another outside of the defendant's control. *See infra*, pp. 28-30. This is consistent with the test used when liability is sought to be imposed for preventing harm caused by a third-party in general.

The initial rationale for limiting liability for suicide to the inpatient relationship "is that in general, suicide is an independent intervening force that is not

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testimony, who could not say what Mrs. Granicz would or would not have said had complied with a request by Dr. Chirillo for her to come in the day of her phone call. (R. V2, 256-57). *See Paddock*, 522 So. 2d at 417 (holding expert testimony that physician should have arranged for face-to-face evaluation of patient was speculative because appropriate next steps such as hospitalization are entirely dependent on what occurred during the evaluation).

foreseeable." *White v. Whiddon*, 670 So. 2d 131, 134 n.2 (Fla. 1st DCA 1996) (quoting 22 Am. Jur. 2d *Death* § 52; 25A C.J.S. *Death* § 25); *Wyke v. Polk Cnty. Sch. Bd.*, 129 F.3d 560, 574 (11th Cir. 1997) (applying Florida law). *See also Truddle v. Baptist Mem. Hosp.—DeSoto, Inc.*, 150 So. 3d 692, 695 (Miss. 2014) (in holding there is no duty in medical negligence arising from an outpatient's suicide under Mississippi law, noting common law rule that "suicide is an 'unforeseeable, intervening cause . . . which breaks the causal connection between the wrongful act and the death'"); *Dux v. United States*, 2014 WL 4748693, at *4-5 (N.D. Ill. Sept. 24, 2014) (noting general rule that suicide is an unforeseeable event to which there are only two exceptions under Illinois law); *Silva v. Lovelace Health Sys., Inc.*, 331 P.3d 958 (N.M. Ct. App. 2014) ("[G]enerally speaking, suicide is an intentional act that is unforeseeable."); *McPeake v. Cannon*, 553 A.2d 439, 440-41 (Pa. Super. Ct. 1989). Simply put, "[w]hether explained by the absence of a duty to prevent an unforeseeable harm or explained by a lack of proximate cause because a suicide is an intervening cause that is unforeseeable, the law protects a person from liability for another's suicide absent a special relation or unless the defendant has facilitated or contributed to the suicidal impulse by some wrongful action." *Estate of Brennan v. Church of Scientology Flag Service Org.*, 832 F. Supp. 2d 1370, 1381-82 (M.D.

Fla. 2011) (applying Florida law, though chronicling authorities in other jurisdictions).

Because suicide—generally speaking—is viewed as an intervening act that breaks a causal chain because of its presumptively unforeseeable nature, the Second District's approach of treating suicide as any other injury for which compensation is sought based on medical malpractice is flawed. Courts have been clear that the categorical element of personal responsibility involved in ending one's own life requires application of a different set of rules.

Second, multiple courts have expressed doubt about the capacity of psychiatric treatment to sustain the legal imposition of a duty on a practitioner to prevent a patient from harming herself or others. When a duty sought to be imposed is dependent upon standards of mental health treatment, courts must "embark upon a journey that 'will take us from the world of reality into the wonderland of clairvoyance.'" *Boynton v. Burglass*, 590 So. 2d 446, 448 (Fla. 3d DCA 1991) (holding that "[t]o impose a duty to warn to protect third parties [from harm caused by a patient] would require the psychiatrist to foresee a harm which may or may not be foreseeable, depending on the clarity of his crystal ball."). "The science of psychiatry represents the penultimate grey area. Numerous cases underscore the inability of psychiatric experts to predict, with any degree of precision, an

individual's propensity to do violence to himself or others." *Paddock*, 522 So. 2d at 414 (quoting *Nesbitt v. Cmty. Health of S. Dade, Inc.*, 467 So. 2d 711 (Fla. 3d DCA 1985) (Jorgensen, J., dissenting)). *See* Phyllis Coleman & Ronald A. Shellow, *Suicide: Unpredictable and Unavoidable—Proposed Guidelines Provide Rational Test for Physician's Liability*, 71 Neb. L. Rev 643, 644, 681 (1992) (describing the dilemmas faced by physicians in treating suicidal patients).

More recently, the limit of mental health treatment as a rationale for limiting the imposition of a duty to prevent patient harm to herself or others was reiterated in *Tuten v. Fariborzian*, 84 So. 2d 1063, 1068 (Fla. 1st DCA 2012). In *Tuten*, the decedent had been a patient of a psychiatric facility on several previous occasions. *Id.* at 1065. While at the facility subsequently, before a scheduled Baker Act hearing, the decedent requested his release and the treating psychiatrist certified he was competent. The day after his release, the decedent shot his wife and committed suicide. *Id.* The trial court dismissed the plaintiff's complaint. In rejecting the plaintiff's argument that a common law duty existed requiring the facility and the psychiatrist to keep the decedent committed, the First District noted that the "internal workings of the human mind remain largely mysterious" and that "to impose a general duty on a psychiatrist would require such doctors to have the gift of 'clarvoyance.'" *Id.* at 1067. After review of *Paddock*, the court held:

> All of these authorities emphasize the unpredictability and inexactness inherent in the practice of psychiatry. Thus, because the future behavior of a psychiatric patient is unknowable, under Florida law risk of harm is not foreseeable and therefore no duty exists to lessen the risk or protect others from the type of risk which a psychiatric patient might pose. As the Florida Supreme Court has explained, the "requirement of reasonable, general foresight is the core of the duty element." *McCain v. Fla. Power Corp.*, 593 So. 2d 500, 503 (Fla. 1992).

Id. at 1068.

Here, therefore, under *Tuten*, Dr. Chirillo had "no duty . . . to lessen the risk or protect [Mrs. Granicz] from the type of risk" that her psychiatric maladies might pose." *Id.* The *Tuten* court further noted that the facts before it did not fall within the confinement exception to the general rule that a doctor is not liable for a patient's suicide: "Tuten was not in the custody of appellees Meridian or Fariborzian when he killed himself and his wife. These acts of violence occurred outside the scope of the facility's range of observation and control." *Id.* Similarly, of course, here, Mrs. Granicz was outside of Dr. Chirillo's custody, and thus, Petitioners' range of observation and control, when she committed suicide. This distinction is both logical and easy to apply. Thus, "it seems elementary" that Dr. Chirillo did not owe a legal duty to prevent Mrs. Granicz from committing suicide because Mrs. Granicz was not in his custody or control. *Garcia*, 754 So. 2d at 49.

Together, the nature of suicide as a generally intervening, unforeseeable injury, and Florida courts' recognized limits of psychiatric treatment to the ability to

know when a patient will harm herself or others warrant adoption of the black-letter law set forth in *Lawlor*, *Garcia*, *Kelley*, and *Paddock*. Indeed, the "confinement exception" is a form of the "special relationship" test that is commonly used to analyze whether a duty to prevent suicide existed in a particular case. "The requirement of a special relation is particularly important in the context of a suicide." *Schwenke v. Outrigger Hotels Hawaii, LLP*, 227 P.3d 555, 558 (Haw. Ct. App. 2010); *See Lee*, 925 P.2d at 336 ("Because Pereira was not in the custody of Corregedore . . . a special relationship did not exist to impose a duty on Corregedore . . . to prevent Pereira's suicide."). *See Knight v. Merhige*, 133 So. 3d 1140, 1145 (Fla. 4th DCA 2014) (describing relationship between hospitals toward their patients as a "special relationship" that could give rise to a duty to control the conduct of a third person to prevent that person from causing harm to another).[8]

The Second District's decision below has already been criticized as failing to take into account the whether a "special relationship" existed between Dr. Chirillo and Mrs. Granicz under the Restatement (Second) of Torts (1965). *Christian v.*

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[8] *See also* Maggie Murray, Note, *Determining a Psychiatrist's Liability When a Patient Commits Suicide: Haar v. Ulwelling*, 39 N.M. L. Rev. 641, 662 (2009) ("Most courts . . . hold that a special relationship is a prerequisite before a duty to prevent self-harm or suicide can be considered."). *See also King v. Smith*, 539 So. 2d 262 (Ala. 1989); *Weiss v. Rush N. Shore Med. Ctr.*, 865 N.E.2d 555 (Ill. Ct. App. 2007).

Counseling Resource Assocs., Inc., 2014 WL 4100681, at *9 n.34 (Del. Super. Ct. July 16, 2014). The need for a "special relationship" before one can be held liable for harm caused by another to herself or others is discussed in sections 314A–319 of the Restatement. *See* Rest. (2d) of Torts § 315. Thus, "[o]ne who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection is under" a duty to protect the other against unreasonable risk of physical harm. *Id.* § 314A(1), (4). *See also Id.* § 319 ("One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."). Courts have recognized the importance of the custody requirement under this section in cases involving alleged liability for suicide. *Christian*, 2014 WL 4100681, at *6-7; *Maloney*, 938 A.2d at 887-88; *Lenoci v. Leonard*, 21 A.3d 694, 699 (Vt. 2011); *Haar*, 154 P.3d at 70. The application of this Restatement section as set forth in the confinement exception in *Paddock*, *Lawlor*, *Tuten*, and *Garcia* is the law this Court should apply to this case. *See also Aguila v. Hilton, Inc.*, 878 So. 2d 392, 398-99 (Fla. 1st DCA 2004) ("Florida has adopted the 'special relationship' test set forth in the Restatement . . . . [I]mplicit in the special relationship exception is

the proposition that the special relationship 'must include the right *or the ability* to control another's conduct.'").

The mere fact that Dr. Chirillo treated Mrs. Granicz for depression, in light of her status as an outpatient, is insufficient to establish the requisite relationship of custody and control. *Granicz* and the Second District's earlier decision, *Sweet v. Sheehan*, 932 So. 2d 365 (Fla. 2d DCA 2006), are simply out-of-step with the weight of authority in Florida and the United States declining to impose liability related to a physician's diagnosis or treatment which preceded outpatient suicide. *See Winger v. Franciscan Med. Ctr.*, 701 N.E.2d 813, 814 (Ill. Ct. App. 1998) (noting that action asserting a failure to properly supervise a suicidal patient is different in kind than an action asserting malpractice in diagnosis or treatment). In light of the foregoing, and contrary to the Second District's holding, the definition of the standard of care set forth in section 766.102, Florida Statutes (2008), does not control whether a physician can be tasked with the legal duty to prevent an outpatient's suicide.

The *Lawlor* court's conclusion that "Florida law has not yet imposed a legal duty on a psychotherapist for the suicide of a client who is being treated in an outpatient situation" remains true. This recognition in *Lawlor*, *Paddock*, *Garcia*, *Kelley*, and *Tuten* is consistent with the weight of authority in the United States and the requirement that a "special relationship"—i.e., patient confinement—exist.

Petitioners respectfully request this Court to confirm that Florida law imposes no duty on a physician for the suicide of an outpatient outside of his custody or control, such as Mrs. Granicz, and, therefore, to remand for entry of judgment in favor of Petitioners.

II. *GRANICZ* MUST BE QUASHED BECAUSE THE SECOND DISTRICT ERRED IN HOLDING THAT THE STANDARD OF CARE IN MEDICAL MALPRACTICE ACTIONS INVOLVING SUICIDE IS DICTATED SOLELY BY EXPERT TESTIMONY

The Second District also erred in deferring to the opinions of Mr. Granicz's experts regarding the standard of care without conducting its own independent analysis of the foreseeability of Mrs. Granicz's suicide.[9] Even if the standard of care in medical malpractice actions is generally set forth by expert testimony, the weight of Florida law is clear that the foreseeability of a decedent's suicide, based specifically on the extent of a defendant's notice of the decedent's suicidal tendencies, is critical to the determination of whether a defendant can be held liable in connection with another's suicide. *See Lawlor*, 795 So. 2d at 148.

The issue of whether, in a medical malpractice action alleging liability for a patient's suicide, a court must defer to the standard of care opinions of the plaintiff's

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[9] If this Court agrees with Petitioners on Issue 1 and remands for entry of judgment in Petitioners' favor, this Court would not need to reach Issue 2.

experts without independently analyzing the foreseeability of the suicide such as to determine the existence of a duty is a question of law to be reviewed *de novo*. *See generally Delva*, 137 So. 3d at 374.

It is true that this Court has stated, "[i]n medical malpractice cases, the standard of care is determined by a consideration of expert testimony." *Pate v. Threlkel*, 661 So. 2d 78, 81 (Fla. 1995). However, in applying this proposition to the patient suicide at issue here, the Second District incorrectly failed to recognize that Florida courts' refusal to impose liability for suicide applies "even in the extreme situation which occurs when a patient of a mental hospital—who by definition is suffering from psychiatric difficulties of some kind—has given no previous indication that his mental illness might lead to suicide." *Rafferman*, 659 So. 2d at 1273.

"Indeed, it seems to be universally held, in a variety of contexts, that there is no liability for a suicide by an entity responsible for the welfare of another in the absence of evidence of 'suicidal tendencies' of which the defendant was or should have been aware and against which it should have guarded." *Id.* (citing Annot., Civil Liability for Death by Suicide, 11 A.L.R.2d 751, 782 (1950)). Thus, in multiple Florida cases to have addressed the potential of imposing liability for suicide, with the sole exceptions of *Sweet* and *Granicz*, the foreseeability of the patient's suicide

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to the defendant, based specifically on whether the defendant had notice of the patient's suicidal tendencies, was a vital consideration. *See Tuten*, 84 So. 3d at 1068 ("[B]ecause the future behavior of a psychiatric patient is unknowable, under Florida law risk of harm is not foreseeable"); *Kelley*, 68 So. 3d 958 ("[B]ecause . . . Beverly Hills Club . . . had no knowledge regarding Kelly's condition, treatment, or suicidal tendencies, Beverly Hills Club's conduct . . . did not 'create a foreseeable zone of risk'"); *Boynton*, 590 So. 2d at 449-50; *Lawlor*, 795 So. 2d at 148 (stating "Dr. Wood showed no indication of suicidal tendencies; there is no evidence of suicide attempts, threats of suicide, nor any mention of suicide" in affirming entry of summary judgment).

In *Lawlor*, the former patient of a psychotherapist committed suicide. *Id.* at 147-48. The trial court granted summary judgment in favor of the psychotherapist on the ground that "the suicide of a former patient was not sufficiently foreseeable to impose a duty under the circumstances." *Id.* at 147.

On appeal, the First District affirmed, finding the psychotherapist owed "no legal duty under the facts of [the] case." *Id.* at 148. The First District explained, "[t]he necessary examination of facts, which the supreme court recognizes may be essential in determining whether or not a legal duty exists, does not make any part of the duty analysis of a jury question." *Id.* (discussing *McCain*, 593 So. 2d at 502).

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The court expressly approved of the trial court's "review[] of *all the supporting materials,* including the deposition and affidavit of plaintiff's expert." *Id.* (emphasis added). It continued, "[u]nder *McCain*, the trial court correctly considered all of the factual allegations in performing the foreseeability analysis as to the duty element. While there is a foreseeability analysis that would be performed by the trier of fact in regard to proximate causation, the duty analysis of the trial court must result in a finding of duty as a matter of law before the issue of proximate causation becomes relevant." *Id.* Notwithstanding the opinion of the plaintiff's expert, the First District recited that the testimonies of the patient's ex-wife and others, demonstrating a lack of any indication that the patient had suicidal tendencies, in support of its holding that the psychotherapist's alleged conduct did not "create a foreseeable zone of risk of suicide." *Id.*

Where liability is sought to be imposed for the suicide of another, *Lawlor* is consistent with the weight of authority requiring assessment of the decedent's suicidal tendencies in order to resolve the question of duty. One early case, *Guice v. Enfinger*, 389 So. 2d 270, 271 (Fla. 1st DCA 1980), demonstrates that the foreseeability of a suicide as it pertains to a defendant's duty, with reference to a defendant's knowledge of suicidal tendencies, is a question of law for the court:

> Under the circumstances of this case, the deceased's suicide was not sufficiently foreseeable to impose upon the Sheriff's employees the

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> duty to remove the deceased's belt. He had never threatened or attempted suicide in the past, had demonstrated no overt suicidal tendencies, and was expected to bond out the next morning. Under these facts, although the deceased's act of hanging himself was a possible consequence of the failure to remove his belt, it was not a probable consequence and therefore not foreseeable.

Id. See also Hammonds v. United States, 418 F. App'x 853, 856 (11th Cir. 2011) (noting that under Alabama law "a physician's duty to guard against his patient's committing suicide depends upon the foreseeability of the suicide.").

Here, the Second District below held that the standard of care owed by Petitioners was established by Respondent's experts, and that the trial court therefore erred "[b]y focusing on whether [Mrs. Granicz's] suicide was foreseeable" with reference to the record evidence. But Florida law is clear: Even in cases where a duty could conceivably arise (i.e., based on confinement), a patient's expression of suicidal ideations is critical to the foreseeability determination. "[I]t is the suicidal tendencies of a specific person—not an undifferentiated knowledge about a group of individuals . . . which is determinative *of the existence of a duty* owed to that person." *Kelley*, 68 So. 3d at 958. The effect of the Second District's holding that the trial court analyzed Mrs. Granicz's suicide "under the standard for proximate cause," and its exclusive adherence to the statutory definition of a physician's standard of care, was to ignore the importance of a judicial assessment of whether a defendant has notice of a decedent's suicidal tendencies to the duty question.

The Second District agreed with Mr. Granicz that this analysis is inconsistent with *McCain* on the ground that suicide is a "specific injury," rather than a "zone of risk" created by a defendant's conduct. *Cf. Granicz*, 147 So. 2d at 548 ("The proper inquiry that the court should have made to determine the legal issue of duty 'is whether the defendant's conduct created a foreseeable zone of risk, *not* whether the defendant could foresee the specific injury that actually occurred.'"). But this holding ignores 1) other courts' emphasis on the foreseeability of suicide itself after *McCain*, 2), that in *McCain*, this Court had no occasion to opine on the scope of the "zone of risk" where a plaintiff intentionally harms herself, and 3) alleging liability for suicide seeks to hold a defendant liable for harm caused by another on oneself, implicating alternate standards of conduct. In *McCain*, the plaintiff was injured when the blade of a mechanical trencher he was operating struck an underground electrical cable controlled by the defendant. 593 So. 2d at 501. Neither confirming the rule that a physician is not liable for the suicide of a patient absent confinement, nor confirming the requirement of foreseeability to the potential for liability for patient suicide, would detract from *McCain*'s viability as to an ordinary negligence case that does not involve the commission of harm by the plaintiff to oneself or others.

In *Aguila*, the First District explained the interplay between *McCain*'s "zone of risk" formulation and a party's allegation that a defendant is responsible for controlling harm to another:

> One important attribute of a legal duty that is assumed in many cases but not expressed is that the defendant must have had the ability to avoid the risk. This point is made in the *McCain* opinion by implication. Quoting its earlier opinion in *Kaisner v. Kolb*, 543 So. 2d 732 (Fla. 1989), the court said that a defendant who creates a foreseeable zone of risk has a duty "either to lessen the risk or see that sufficient precautions are taken to protect others from the harm that the risk poses." In this part of the opinion, the court clearly implied that the defendant must be in a position to control the risk. That was certainly the case in the controversy then before the court.
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> [I]t is clear from *McCain* that the defendant's conduct must "create" the risk. With this in mind, we can safely conclude that a legal duty is not established by evidence of foreseeability alone. There must also be some evidence that the risk was created by the alleged negligence of the defendant.

878 So. 2d at 396-97 (citations and footnote omitted). Accordingly, the *Lawlor* court's search for foreseeability of whether there was a "zone of risk *of suicide*" is not inconsistent with *McCain*. 795 So. 2d at 148. When suicide is properly viewed as a harm inflicted on oneself, it becomes clear that it is legally insufficient to ask only whether Dr. Chirillo's alleged negligence created a "zone of risk" of harm. Petitioners must have "created the risk" that Mrs. Granicz would harm herself. Therefore, at the least, judicial consideration of the foreseeability of a plaintiff's

suicide itself to a defendant as it pertains to the extent of a defendant's duty is required, as properly assessed in *Lawlor*.

In the present case, the trial court thoroughly pointed out the absence of any evidence that Mrs. Granicz's suicide was foreseeable to her family members or Dr. Chirillo. (R. V3, 464). It also referenced the testimony of Drs. Yaffe and Werner that there was no way to know of her suicide was planned and that she had never previously expressed suicidal ideations to Mr. Granicz or Dr. Chirillo. (R. V3, 464). It then found "that prior to her passing and during Dr. Chirillo's treatment of her, Mrs. Granicz had not shown any indication of suicidal tendencies, there was no evidence of suicidal attempts, no evidence of threats of suicide and never any mention of suicide to her family or Dr. Chirillo." (R. V3, 467). The trial court had correctly applied Florida law by analyzing the foreseeability of Mrs. Granicz's suicide as it related to whether Petitioners owed her a legal duty to prevent it. (R. V3, 463-67).[10]

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[10] Mr. Granicz may assert that Mrs. Granicz's suicide was foreseeable because Dr. Chirillo knew that patients who stopped taking Effexor abruptly had an increased risk of suicide. (I.B. at 2). However, even setting aside Mrs. Granicz's status as an outpatient, this mere point of medical knowledge is insufficient to impose a legal duty on Dr. Chirillo under the facts of this case. Knowledge of the *suicidal tendencies* of a specific person is required to even potentially impose a legal duty in the context of a plaintiff's suicide. *Lawlor*, 795 So. 2d at 148; *Tuten*, 84 So. 3d at 1068; *Kelley*, 68 So. 3d at 958; *Rafferman*, 659 So. 2d at 1273. Dr. Chirillo only learned she had stopped taking the Effexor in the October 8, 2008, phone call; the

The sum and substance of Florida law—with the sole exceptions of the decision below and *Sweet*—dictates the conclusion that suicide is a unique injury, requiring an analysis that looks beyond the basic "zone of risk" formulation of *McCain* and the statutory definition of standard of care. Here, given the clear lack of control of Dr. Chirillo over outpatient's Mrs. Granicz's ability to harm herself, or, at a minimum, her lack of expressions of suicidal ideations such as to potentially trigger an affirmative duty to act on Petitioners' part, it was not sufficient for the Second District to cite to the statutory definition of standard of care in section 766.102, Florida Statutes, find that Mr. Granicz's paid experts stated that Dr. Chirillo failed to act within that standard, and simply leave the issue for a jury.

Therefore, either alone or in combination with Mrs. Granicz's status as an outpatient, Petitioners request this Court to remand for entry of judgment in favor of Petitioners on the basis that Mrs. Granicz's suicide was not foreseeable to Dr. Chirillo. Alternatively, and only if this Court disagrees with Petitioners' argument in Issue 1, Petitioners request this Court to remand to the Second District for that court to conduct an independent analysis of the foreseeability of Mrs. Granicz's

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fact that she stopped taking it and thus may have had an abstract "increased risk" does not equate to knowledge of a suicidal ideation.

suicide as it pertained to Petitioners' duty, without deferring to the testimonies of Mr. Granicz's experts.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that this Court quash the decision of the Second District below in *Granicz*, approve *Lawlor*, and remand for entry of judgment in favor of Petitioners, or alternatively, remand to the Second District for further proceedings.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was furnished via electronic mail on this 6th day of February, 2015, to: **James B. Tilghman, Jr.,** (emailservice@stfblaw.com) Stewart, Tilghman, Fox, Bianchi & Cain, P.A., One S.E. Third Avenue, Suite 3000, Miami, Florida 33131.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 9.210(a), Fla. R. App. P., undersigned counsel hereby certifies that this brief is submitted in Times New Roman 14-point font.

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