IN THE SUPREME COURT OF FLORIDA

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

Petitioners,

v.

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

Respondent.
_____/

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

RESPONDENT'S ANSWER BRIEF ON THE MERITS

On Review from the District Court of Appeal, Second District 2D12-5244

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STATEMENT OF THE CASE AND FACTS

The Facts

Jacqueline Granicz was a fifty-five year old mother of two and the wife of Respondent Robert Granicz, the Plaintiff and Appellant below. (RI, 16-17; RII, 364-366, 370).[1] Joseph S. Chirillo, Jr., M.D., is a board certified family practitioner who is trained and experienced in treating patients with depression. It is a significant part of his practice, and he has treated hundreds, maybe thousands of patients for the condition (RI, 123-125) – a common scenario given that most patients are treated for depression by their primary care physician. (RII, 306-307).

Dr. Chirillo began treating Jacqueline Granicz for depression in 2005, when he prescribed an antidepressant known as Effexor. (RI, 131-132). She had a history of depression and had previously taken Prozac. (RI, 135). On October 8, 2008, Mrs. Granicz called Dr. Chirillo and spoke to his medical assistant. According to the note the medical assistant left for Dr. Chirillo, Mrs. Granicz had stopped taking Effexor, had not "felt right since late June-July," cried easily, was under mental strain, was not sleeping well, was taking more sleeping pills, and was experiencing gastrointestinal problems. (RII, 217).

[1] The parties will be referred to by name or as they appeared in the trial court. References to the record on appeal will be designated by "R" followed by volume and page number(s), with the volume in roman numerals. Deposition and hearing transcripts are incorporated in the pagination of the record on appeal and will not be designated separately.

Dr. Chirillo knew that patients who stopped taking Effexor abruptly had an increased risk of suicide – indeed, he ultimately opinioned that it was "a contributing factor" in Jacqueline's suicide – and he knew that Jacqueline's complaints about crying, mental strain and insomnia were new signs of worsening depression. (RI, 164, 170-171, 174-175, 178). Yet despite this knowledge he made no attempt to see or talk to her. Instead, without counseling her about the drug, and in particular about the fact that it would have no therapeutic effect for weeks and might itself produce suicidal ideations, he prescribed Lexapro, a different antidepressant. (RII, 326-330).

Jacqueline Granicz overdosed on Lexapro and hanged herself the following afternoon. (RII, 329).

The Case

Robert Granicz, as Personal Representative of his wife's estate, filed suit against Dr. Chirillo, his professional association and his employer, Defendant Millennium Physician Group, LLC, in September of 2010. (RI, 1-8). An amended complaint was filed in November of 2010 (RI, 16-22), the parties engaged in discovery, and the Defendants moved for summary judgment in August of 2012 on the grounds that Dr. Chirillo owed no duty to Jacqueline as a matter of law. (RI,

84-95).[2] The factual predicate for the Defendants' "no duty" argument was that Jacqueline's suicide was unforeseeable – in particular because her family members, untrained though they were, did not pick up on any warning signs or see it coming. (RI, 87-92).

The only expert testimony before the trial court was provided by the Plaintiff in the form of the depositions of Tonia Werner, M.D., a board certified psychiatrist and assistant professor at the University of Florida who had treated patients for depression for fifteen years (RII, 222-229), and Michael Yaffe, M.D., a board certified internist and clinical assistant professor at Ohio State University who had treated more than a thousand patients for depression over the last thirty years. (RII, 291, 295, 304-305).

Both experts testified that, given Jacqueline's history and the information she conveyed in her October 8th phone call, the standard of care required Dr. Chirillo to see her and assess her condition to determine if she was having thoughts of suicide, and to counsel her about the effects and side effects of Lexapro before prescribing it. (RII, 240-241, 248-249, 251-252, 275, 324-325). They also testified that Dr. Chirillo's failure to do so was a cause of Jacqueline's death – that,

[2] Defendants also argued that the expert testimony needed to support the Plaintiff's claim violated the rule against stacking inferences and was inadmissible. (RII, 92-95). The Second District rejected this as a ground for summary judgment, *Granicz v. Chirillo*, 147 So. 3d 544, 547 n.1 (Fla. 2d DCA 2014), and the argument has been abandoned before this Court.

more likely than not, he would have been able to discern that she had suicidal ideations and ward it off. (RII, 252-253, 263, 334-336, 345). As Dr. Yaffe explained, "patients who are, indeed, suicidal are more likely than not to confess those symptoms when confronted directly by the healthcare professional;" the reason examining them is "the standard of care is because it's been shown to be effective in warding off and identifying patients who are at risk to take their own life." (RII, 336, 345). Per Dr. Werner:

> [T]his was a lady who was seeking help, who was asking for help, who was complaining of symptoms, and if he had seen her as open and honest, as he said that she was with him, he would have been able to diagnose her and treat her and offer her a treatment plan which she would have, you know, been acceptable of. He didn't offer her anything. She called there and all she got was a pill. Nobody saw her. He didn't even talk to her.

(RII, 263).

The trial court heard the argument on the motion on September 24, 2012 (RIII, 502). Believing that it was the court's role to determine whether Jacqueline's particular suicide was foreseeable before imposing a duty on Dr. Chirillo, the trial court focused on the various indicia of suicide she did or did not exhibit – and in particular on the fact that she never expressed suicidal ideations to anyone – and concluded that it could not impose "a duty to prevent the suicide of an outpatient which … was not foreseeable." (RIII, 463-467). Ignored was the

duty physicians owe to treat their patients according to the prevailing standard of care, and the expert testimony that Jacqueline's suicide was both foreseeable and preventable, that it was Dr. Chirillo's job to find out if she was contemplating suicide, not wait to be told.

The trial court's final summary judgment was entered on October 2, 2012, and Robert Granicz filed his notice of appeal on October 15, 2012. (RIII, 486-492). The Second District reversed, taking issue with the trial court's characterization of Dr. Chirillo's duty as one "to prevent Jacqueline's suicide" rather than to treat her according to the prevailing standard of care, *Granicz v. Chirillo*, 147 So.3d 544, 546 (Fla. 2d DCA 2014), and with its focus on whether Jacqueline's particular suicide was foreseeable – a causation question for the jury to decide, and one on which the Plaintiff presented the only expert testimony – rather than on the foreseeable zone of risk that exists when a doctor treats a patient for depression:

> By focusing on whether Jacqueline's suicide was foreseeable, the trial court analyzed Dr. Chirillo's duty under the standard for proximate cause. 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.'

Id. at 548 (quoting *McCain v. Florida Power Corp.*, 593 So.2d 500, 504 (Fla.

1992)) (emphasis in original).

The Second District also certified that its "decision appears to conflict with that of the First District in *Lawlor v. Orlando*, 795 So.2d 147 (Fla. 1st DCA 2001)." Defendants filed their Notice to Invoke Discretionary Jurisdiction on May 6, 2014, and the Court accepted jurisdiction on December 17, 2014.

SUMMARY OF ARGUMENT

I

The Second District's decision in *Granicz* recognized Dr. Chirillo's duty to treat Jacqueline Granicz according to the prevailing standard of care, a duty that arises from Florida precedent, from section 766.102(1) of the Florida Statutes, and from the general zone of risk analysis prescribed by the Court in *McCain v. Florida Power Corp.*, 593 So.2d 500 (Fla. 1992). It reversed the trial court for failing to recognize that duty, for confusing it with a broader duty to prevent suicide, and for rejecting the existence of any duty based on a specific, proximate cause foreseeability analysis rather than the foreseeable zone of risk analysis prescribed in *McCain.* In doing so the Second District followed its prior decision in *Sweet v. Sheenan*, 932 So.2d 365 (Fla. 2d DCA 2006), and the federal district court decision in *Perez v. United Sates*, 883 F. Supp. 2d 1257 (S.D. Fla. 2012).

In point I of the brief, Defendants incorrectly argue that the decision is at

odds with other Florida case law holding that, absent a custodial relationship, physicians have no duty to prevent a patient's suicide. Their mistake is two-fold. First, they fail to differentiate between the duty a physician owes to treat a patient at risk for suicide according to the standard of care – your basic malpractice, misfeasance duty – and the duty to prevent suicide – a duty to prevent harm to another that addresses nonfeasance and is controlled by a different set of rules, including the requirement of "special relationships" like a custodial relationship. *United States v. Stevens,* 994 So.2d 1062, 1068 (Fla. 2008); RESTATEMENT (SECOND) OF TORTS §§ 314 *et seq.* (1965). The distinction between these two duties is recognized by numerous cases cited in point I of the argument.

Defendants' second mistake is a cursory reading of the remaining Florida cases addressing the suicide of an outpatient – *Paddock v. Chacko*, 522 So.2d 410 (Fla. 5th DCA 1988); *Garcia v. Lifemark Hosps. of Fla.,* 754 So.2d 48 (Fla. 3d DCA 1999), and *Lawlor v. Orlando,* 795 So.2d 147 (Fla. 1st DCA 2001). The principal duty addressed in each is the duty to prevent suicide, not the duty to treat a patient according to the standard of care. In *Paddock* it was the duty to commit or involuntarily hospitalize a patient, in *Garcia* the duty to protect a patient in custody, and in *Lawlor* the duty to provide custodial supervision to a patient. None of these are the duty underlying Mr. Granicz's claim. On the other hand, Defendants miss the fact that, embedded in each of these cases was a malpractice

claim, *i.e.*, one for misfeasance that was disposed of on the facts rather than on the absence of a duty – an implicit recognition of the difference and viability of the claim Mr. Granicz asserts here.

Defendants also survey the law of suicide in other contexts and states – guided, frankly, more by the ring of the quote than its relevance or context. But when the cases are analyzed, the same dichotomy between the duty to treat and the duty to prevent suicide appears, and, as with the Florida outpatient cases, Defendants look for the applicable duty in the wrong place. The end result is that, while there may be no duty to take affirmative action to prevent suicide absent a custodial or other special relationship, there is indeed a duty to provide standard of care treatment to outpatients at risk for suicide, and the contours of the former do not govern the latter. As such, the Second District correctly decided *Granicz,* and there is no conflict.

Finally, Defendants suggest that suicide can act as an independent, intervening cause, and thus undercuts the District Court's treatment of *Granicz* as an ordinary malpractice case. How so is not made clear, but in Florida intervening causes which are themselves foreseeable, including those involving criminal acts, do not break the chain of causation and are handled by the jury as part of the issue of proximate cause, not by courts as part of their duty analysis.

II

In point II of its brief Defendants argue that the Second District erred in its duty analysis by "deferring" to the opinions of Granicz's experts rather than making its own independent determination of whether Jacqueline's particular suicide was foreseeable. There are two principal flaws in the argument. First, the duty Dr. Chirillo owed to Jacqueline Granicz arose from the relationship itself, and from the foreseeable zone of risk created when a doctor treats a patient for depression. That is the foreseeability needed to create a duty and open the courthouse doors under *McCain*. The question Defendants wanted the Second District to focus on – whether Jacqueline's particular suicide was foreseeable – is a question of proximate cause and for the jury to decide.

Defendants argue that the *McCain* analysis is out-of-place in a case involving suicide, but it has never been questioned or distinguished in that context, and certainly not by a case involving the duty of a physician to provide proper treatment to a patient at risk for suicide. The suicide cases Defendants cite to support their argument all involve the duty to prevent suicide and the accompanying special relationship analysis, a context in which foreseeability of the specific suicide in question can, or at least historically has played a different role.

Second, the idea that the Second District deferred to Granicz' experts on the real foreseeability issue is fanciful. The Second District hardly needed to rely on

expert testimony to determine that suicide is within foreseeable zone of risk created by treating patients for depression. It is common knowledge. Rather, the court looked to the expert testimony *Granicz* provided to determine what the standard of care required to fulfill the obvious duty, and whether there was evidence of its breach and of proximate cause before reversing the trial court – just what it was supposed to do. *See Pate v. Threlkel*, 661 So.2d 278 (Fla. 1995).

ARGUMENT

I

THE SECOND DISTRICT CORRECTLY HELD THAT DOCTORS HAVE A DUTY TO TREAT OUTPATIENTS AT RISK FOR SUICIDE ACCORDING TO THE PREVAILING STANDARD OF CARE

Both because the trial court determined the existence of duty as a matter of law and granted summary judgment, review is *de novo*. *Volusia County v. Aberdeen at Ormond Beach, L.P.*, 760 So.2d 126, 130 (Fla. 2000); *Estate of Rotell ex rel. Rotell v. Kuehnle*, 38 So.3d 783, 785 (Fla. DCA 2010).

A. THE SOURCES OF DR. CHIRILLO'S DUTY

Duty is "defined as an obligation, to which the law will give recognition and effect, to conform to a particular standard of conduct toward another." W. PAGE KEETON, PROSSER AND KEETON ON TORTS §53, p. 356 (5th ed. 1984). That obligation, as the Court observed in *McCain v. Florida Power Corp.*, 593 So.2d

500 (Fla. 1992), may arise from a person's status, from legislative enactments, from judicial precedent, or from the general facts of the case. *Id.* at 503 n. 2. Here, Dr. Chirillo's duty arose from **all of these sources**. The doctor-patient relationship has long been held to give rise to a duty on the part of the doctor to treat his or her patient according to the prevailing standard of care. *E.g.*, *Torres v. Sullivan*, 903 So.2d 1064, 1067 (Fla. 2d DCA 2005) ("As a matter of law, a physician owes a duty to a patient to "use the ordinary skills, means and methods that are recognized as necessary and which are customarily followed in the particular type of case according to the standard of those who are qualified by training and experience to perform similar services in the community or in a similar community.") (quoting *Brooks v. Serrano*, 209 So.2d 279, 280 (Fla. 4th DCA 1968). And the duty has been codified by the Florida Legislature. Fla. Stat. §766.102(1).

The facts of the case and general principles of tort law also gave rise to the same duty. The Court defined a trial court's role in identifying foreseeable zones of risk and making the threshold duty determination in *McCain.* Key here is the Court's admonition that trial courts should not focus on "the specific, narrow factual details of the case," but rather on whether the defendant's conduct foreseeably creates "a broader 'zone of risk that poses a general threat of harm to others." 593 So.2d at 502, 503. Big picture forseeability, and thus the existence of

a duty, was obvious in *McCain*:

> [T]here can be no question but that Florida Power has the ability to foresee a zone of risk. By its very nature, power-generating equipment creates a zone of risk that encompasses all persons who foreseeably may come in contact with that equipment.
>
> * * *
>
> Thus, if there is any general and foreseeable risk of injury …, the courts are not free to relieve the power company of [its] duty.

593 So.2d at 504. The rest – foreseeability of the plaintiff's injury given the specific facts in *McCain* – was a component of proximate cause and a question for the jury.

Big picture foreseeability is equally obvious here. Doctors can foresee that failing to treat their patients in a timely and proper fashion puts them in harm's way. Drilling down further, doctors treating patients for depression can foresee that failing to treat them in a timely and competent manner may result in suicide. The trial court lost its way, though, by putting on its stethoscope and diving into the specific facts, discounting those pointing to the need for Dr. Chirillo to see Jacqueline Granicz – her long history of depression, her crying, her mental strain, her inability to sleep, her abuse of sleeping pills, her physical symptoms, the fact that she was no longer taking her antidepressants, her call for help, and the fact that he was prescribing a new antidepressant that came with its own baggage – in favor

of the fact that Jacqueline, although never asked, had not expressed thoughts of suicide to Dr. Chirillo, her husband or her daughter. (RIII, 463-467). The result, contrary to the Court's warning in *McCain* against relieving a defendant of his or her duty when "there is any general and foreseeable risk of injury," 593 So.2d at 504, was that the trial court took the issue of foreseeability as it relates to proximate cause from the jury and declined to impose a duty on Dr. Chirillo because it did not think Jacqueline's specific suicide was foreseeable – notwithstanding the duty imposed on treating physicians by both case law and statute and the obvious zone of risk inherent in their relationship.

The Second District reversed, holding that, under Florida law, Dr. Chirillo had a duty to exercise reasonable care in treating Jacqueline rather than to "prevent" her suicide, 147 So.3d at 546, and that the trial court misapplied the *McCain* duty/forseeability analysis in determining that no duty existed because it believed Jacqueline's suicide was unforeseeable:

> By focusing on whether Jacqueline's suicide was foreseeable, the trial court analyzed Dr. Chirillo's duty under the standard for proximate cause. 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 occurred.'

147 So.3d at 548 (quoting *McCain*, 593 So.2d at 504) (emphasis in original).

The Defendants argue that the trial court was right and the Second District

was wrong because physicians owe no duty of care to outpatients at risk for suicide absent a custodial relationship, and that the *McCain* foreseeable zone of risk analysis is supplanted by the specific foreseeability analysis used to determine proximate cause when a suicide is involved. The flaws in this argument are addressed below, but the short answer is that physicians owe a different (as opposed to no) duty to outpatients than they do to those in a custodial relationship, and that the *McCain* foreseeable zone of risk analysis is alive and well when it comes to treating them.

B. FLORIDA LAW SUPPORTS RATHER THAN CONFLICTS WITH THE SECOND DISTRICT'S DECISION

Three Florida cases expressly address whether a physician owes a duty to treat an outpatient at risk for suicide according to the standard of care, and each holds that they do. Before *Granicz*, there was *Sweet v. Sheenan*, 932 So.2d 365 (Fla. 2d DCA 2006), where an outpatient who was injured in a failed suicide attempt sued his treating psychiatrist for malpractice and the trial court entered summary judgment in the psychiatrist's favor based on its conclusions that the doctor owed no duty to his patient and there was no causal connection between his negligence and the suicide attempt. The Second District reversed, holding that there was indeed a duty, and that the issue of proximate cause was for the jury:

> Sweet first contends that the trial court erred when it determined that Dr. Sheehan owed no duty to Sweet. We

> agree. Florida law unquestionably recognizes that physicians owe their patients a duty to 'use the ordinary skills, means and methods that are recognized as necessary and which are customarily followed in the particular type of case according to the standard of those who are qualified by training and experience to perform similar services in the community or in a similar community.' Section 766.102(1), Florida Statutes (2004), codifies this duty, stating that a health care provider has a duty to act in accordance with the prevailing professional standard of care for that health care provider. Thus, the relevant inquiry is not whether Dr. Sheehan had a duty, but whether Dr. Sheehan breached that duty by failing to treat Sweet in accordance with the standard of care required of him, and if so, whether this failure resulted in Sweet's injuries.

Id. at 368 (citations omitted). And between *Granicz* and *Sweet* there was *Perez v. United States*, 883 F. Supp 2d 1257 (S.D. Fla. 2012), where the federal district court agreed with *Sweet* that, under Florida law, physicians have a duty to treat potentially suicidal outpatients according to the prevailing standard of care. *Id.* at 1259.

Three additional cases, relied upon by the Defendants, implicitly address the issue – *Lawlor v. Orlando*, 795 So.2d 147 (Fla. 1st DCA 2001); *Garcia v. Lifemark Hosps. of Fla.*, 754 So.2d 48 (Fla. 3d DCA 1999); and *Paddock v. Chacko*, 522 So.2d 410 (Fla. 5th DCA 1988). None of them hold, or support a holding that doctors treating outpatients at risk for suicide owe them no duty of care. To the contrary, reading them more carefully than Defendants have done reveals that each

recognizes the same duty the Second District found controlling here, and supports rather than conflicts with its decision.

Paddock involved a malpractice claim for injuries suffered by a plaintiff who was visiting from North Carolina and saw Dr. Chacko, the defendant psychiatrist, once as an outpatient before she attempted to commit suicide. The thrust of the claim was that Dr. Chacko failed to involuntarily hospitalize her, and both the trial court and the Fifth District rejected the existence of such a duty. Per the trial court, "the law [does] not impose a legal duty on [a] psychiatrist to involuntarily take a patient into custody," 522 So.2d at 412, and per the Fifth District:

> [N]o case… has held a doctor liable for the failure to take his patient into custody [and] we are unwilling to extend the duty of custodial supervision and care to the outpatient relationship between a psychiatrist and a patient.

522 So.2d at 417.

Granicz has no quarrel with the holding, but does not allege that Dr. Chirillo had a duty to involuntarily hospitalize Jacqueline. (RI, 18-19). Rather, the claim is that Dr. Chirillo failed to do all of the things the standard of care requires short of that drastic step: talk to Jacqueline; examine her; learn if she was having suicidal thoughts; gauge the severity of her condition; offer counsel and guidance; get her family involved; recommend/arrange for psychiatric care if needed;

recommend/arrange for voluntary hospitalization if needed; explain the effect stopping her medication was having on her; and explain that the new medication he was about to prescribe might make her feel suicidal before it began to work. Instead, nothing.[3]

What the Defendants miss or ignore is that there was also a claim for misfeasance in *Paddock* – a claim that Dr. Chacko failed to treat the plaintiff according to the prevailing standard of care. And that claim was rejected based on the evidence adduced at trial, not because there was no duty:

> There was testimony that the failure to arrange a face-to-face interview with plaintiff was negligent.... However, since Dr. Chacko had already recommended hospitalization, we fail to see how an in person meeting would have changed anything. There was testimony that the increased dosage of Navane was inadequate, and thus a deviation from the standard of care, but there was no testimony that this failure, by itself, was a proximate cause of the plaintiff's injuries."

522 So.2d at 413. So the take away from *Paddock* is that there is no duty to prevent suicide by involuntarily commitment, but there is duty to treat outpatients according to the standard of care, and its breach, if a proximate cause of the

[3] Defendants suggest in footnote 7 of their initial brief that this was just a slippery slope to involuntary commitment. But the suggestion is a red herring, both medically and legally. Medically, Jacqueline's history says otherwise, and, as Dr. Werner explained, "we don't just hospitalize people because of suicidal ideations…." (RII, 257). Legally, whether a doctor's duty runs to involuntary hospitalization is ultimately a question of its scope, not its existence, and can be handled by instructions to the jury if need be.

plaintiff's suicide, will support liability.[4]

In *Garcia*, the deceased was treated in the defendant's emergency room twice – once for what was believed to be an accidental overdose of post- surgical pain medication, and two days later for injuries suffered in a car accident. After he was released the second time, Garcia committed suicide. Since Garcia was never confined in the hospital, the Third District noted that there was no duty to take protective measures to prevent him from injuring himself – again, a claim Granicz does not make – and went on to address the malpractice claim and reject it for reasons that have no bearing here:

> However, the appellants argue that although Mr. Garcia was not confined, the doctors still had a duty to properly diagnose and treat all of his ailments, including his suicidal tendencies. We disagree.
>
> * * *
>
> Doctors Fernandez and Alonso each treated Mr. Garcia in an emergency room setting, where the fast paced atmosphere does not lend itself to the establishment of a close, personal relationship between patient and physician. The nature of an emergency room physician's job is to treat the patient for the medical emergency

[4] In *Santa Cruz v. Northwest Dade Cmty. Health Ctr.*, 590 So.2d 444 (Fla. 3d DCA 1992), the Third District extended *Paddock* to hold that psychiatrists have no duty to third persons to detain or involuntarily hospitalize a patient. The First District relied in turn on both *Paddock* and *Santa Cruz* to reiterate that neither the common law nor the Baker Act, section 394.451 et. seq., Florida Statutes, imposes a duty on a physician to involuntarily hospitalize or detain a patient against his will. *Tuten v. Fariborzian*, 84 So.3d 1063, 1067-68 (Fla.1st DCA 2012). Neither case addressed a physician's duty to treat an outpatient according to the standard of care.

> which brought them there, and move on.
>
> * * *
>
> Doctors do not have a duty to treat each of their patients for every conceivable medical condition that they might have. For example, if a person goes to an ophthalmologist because they have an eye infection, one could hardly contend that there is a duty to treat that patient for hemorrhoids.

754 So.2d at 49.

Again, Granicz has no quarrel with the holding, but the duty limitation *Garcia* turned on is neither part of the duty matrix in suicide cases nor otherwise relevant here since Dr. Chirillo was actively treating Jacqueline for depression, not some unrelated condition. And, again, there was no holding that doctors treating outpatients at risk for suicide have no duty to treat them according to the standard of care. To the contrary, *Garcia* implicitly recognized the duty and supports the Second District's decision in this case.

Finally, the First District's decision in *Lawlor* involved the suicide of a "former patient" who had not seen the defendant in more than three months and had experienced a number of significant life events in the interim. 795 So.2d at 147, 149. The trial court acknowledged that the defendant had a duty to treat the plaintiff according to the standard of care, but found that the duty had "lapsed at the time of the suicide":

> Even if Dr. Orlando's treatment was found to be

> substandard, she did not have a continuing duty toward the patient who committed suicide more than three months after the last visit and who experienced a number of intervening life circumstances following the last visit to Dr. Orlando.

795 So.2d at 149. The majority opinion did not address the duty to treat issue, affirming instead on the basis that "no Florida cases extend the duty of custodial supervision and care to the outpatient relationship between a psychotherapist and a patient." *Id*. In a dissent, Justice Benton returned to the duty to treat issue, pointing out that physicians treating patients at risk for suicide did have a duty to do so according to the standard of care, and that he could not "agree that, as a matter of law, [the defendant] had no duty to provide 'appropriate psychotherapy.'" 795 So. 2d at 149-150.

The trial court's analysis and the dissenting opinion in *Paddock* support the Second District's opinion here. The fact that the majority rejected a duty of custodial supervision is of no consequence as Granicz does not assert such a duty and there was nothing "lapsed" about the relationship between Dr. Chirillo and Jacqueline Granicz.[5]

Granicz, *Sweet*, *Perez*, *Paddock*, *Garcia* and *Lawlor* comprise the universe of Florida cases (or federal cases applying Florida law) that involve/address the duty owed by a doctor or psychiatrist to an outpatient at risk for suicide. Three of

[5] The First District also engaged in a foreseeabilty analysis which is discussed in point II below.

them (and the dissent in *Lawlor*) expressly recognize that doctors have a duty to treat potentially suicidal patients according to the standard of care, and the other three implicitly recognize the duty. None, some loose language notwithstanding, reject it.[6]

The same discrete duty is also recognized by numerous decisions in other states. *See, e.g.*, *Kockelman v. Segal*, 71 Cal.Rptr.2d 552, 558 (Cal. Ct. App. 1998) ("…California courts have recognized that psychiatrists owe a duty of care, consistent with standards in the professional community, to provide appropriate treatment for potentially suicidal patients, whether the patient is hospitalized or not…."); *Edwards v. Tardiff*, 692 A.2d 1266, 1270 (Conn. 1997) ("Physicians have a duty to exercise the degree of care that physicians in that particular field would exercise in similar circumstances. If the physician's treatment falls below the relevant standard of care, liability may be imposed if it is reasonably foreseeable that suicide will result…."); *Farwell v. Un*, 902 F.2d 282, 288 (4th Cir. 1990)

[6] The soundbites that get most of the play in Defendants' brief and elsewhere start in *Paddock*, with the court's pronouncement that "[i]t 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." 522 So.2d at 416. Of course, there is no liability for anything absent a duty, and the only duty *Paddock* addressed was the duty to involuntarily commit or hospitalize. In *Garcia*, the *Paddock* pronouncement becomes "[g]enerally, a doctor is not liable for the suicide of a patient." About as broad as you can get, and a huge leap from the real *Garcia* holdings – that being treated in the emergency room is not the same as being in custodial confinement, and that emergency room doctors are only required to treat what brought you there, not look for anything else that might be wrong with you.

("Maryland and Delaware law, in line with principles generally applied, define a physician's duty to his patient as that of exercising the care and skill of a reasonably competent practitioner under the circumstances presented by particular patients' conditions. Obviously this duty could run wider in a particular case than the duty … not to commit involuntarily.…"); *Seastrunk v. United States*, 25 F.Supp.3d 812, 815 (D.S.C. 2014) ("The South Carolina Supreme Court has explained that the inquiry is the same in the context of a suicide. '[A] professional's duty to prevent suicide requires the exercise of that degree of skill and care … ordinarily employed by members of the profession under similar conditions and circumstances.'") (quoting *Hoeffner v. The Citadel*, 429 S.E.2d 190, 194 (S.C. 1993) (citation omitted).

C. THE DUTY TO PREVENT HARM TO ANOTHER – IN THIS CASE TO PREVENT SUICIDE – IS A DIFFERENT DUTY

In point I of their brief Defendants argue that a physician's duty in suicide cases is limited to custodial relationships. The argument, however, conflates a physicians' duty to exercise reasonable care when treating a patient at risk for suicide with the broader duty to prevent suicide through custodial supervision or involuntary hospitalization – the duties *Paddock* and *Lawlor* declined to impose. The duties are materially different. The former involves a physician's misfeasance or negligence in treating a patient, and arises from Florida case law, from section

766.102(1) of the Florida Statutes, and from the *McCain* foreseeable zone of risk analysis discussed in section A above. The latter involves nonfeasance. The basic nonfeasance rule is that, absent a "special relationship" or other special circumstance, one does not have a duty to take affirmative action to protect others from harm, even when it is foreseeable. *See* RESTATEMENT (SECOND) OF TORTS, §314-324A (1965); *United States v. Stevens*, 994 So.2d 1062, 1068 (Fla. 2008).

The nonfeasance rule often applies in suicide cases, including those involving outpatients where the plaintiff attempts to impose a duty to supervise, control or commit on the mental health care provider. It is not, however, the operative duty here, which is the reason the Second District made a point of differentiating between Dr. Chirillo's "duty to prevent Jacqueline's suicide" and his duty "to exercise reasonable care" in treating her. 147 So.3d at 546.

The distinction between the duty to treat according to the standard of care and the duty to prevent suicide has been recognized in numerous cases, both in Florida and elsewhere. *See, e.g., Kockelman*, 71 Cal.Rptr.2d at 560 ("Rather than create a duty to prevent suicide, [California cases] recognized that a cause of action may exist for professional malpractice when a psychiatrist's (or hospital's) treatment of a suicidal patient falls below the standard of care for the profession, thus giving rise to a traditional malpractice action.") (quoting *Nally v. Grace Cmty, Church*, 763 P.2d 948, 958 (Cal. 1988) (citations omitted); *Edwards*, 692 A.2d at

1270 n.7 ("[W]e disagree with the defendants characterization with respect to whether a physician has a duty to *prevent* suicide." We merely recognize that a cause of action exists for malpractice.); *Estate of Rotell ex rel. Rotell v. Kuehnle*, 38 So.3d 783, 789 (Fla. 2d DCA 2010) (The…complaint does not assert a duty on the part of [the doctor] to predict, control, or prevent the actions of the mother. The …complaint alleges that [the doctor] was a licensed psychologist, [and] that she owed a duty to treat … under the standard of care owed by licensed psychologists…. When a negligent party is a professional, the law imposes a duty to perform the requested services in accordance with the standard of care….") (quoting *Moransais v. Heathman*, 744 So.2d 973, 975-76 (Fla. 1999)); *Winger v. Franciscan Med. Ctr.*, 701 N.E.2d 813, 818 (Ill.App.Ct. 1998) ("This is an action asserting psychiatric malpractice and the failure to supervise; it is different from general malpractice because the negligence is not in the diagnosis or treatment, but rather, it is in the failure to carefully protect a patient from inflicting self-harm."); *Lee v. Corregedore*, 925 P.2d 324, 332 (Haw. 1996) (noting the difference between physician's misfeasance in the form of malpractice and nonfeasance in failing to supervise or control patients, with the latter but not the former limited to a special custodial relationship).

Missing the distinction, Defendants end up relying on a bevy of cases and quotations that do not address the duty to treat issue in this case. One group of

cases does not involve physicians or mental health providers, but rather a disparate group of actors and the nonfeasance issue of whether a special relationship exists so as to give rise to a duty to protect or control the conduct of another. *See*, *e.g.*, *Knight v. Merhige*, 133 So.3d 1140, 1145-46 (Fla. 4th DCA 2014) (family of murderer and murder victims did not have a special relationship giving rise to a duty to control the former or protect the latter); *Kelley v. Beverly Hills Club Apts.*, 68 So.3d 954, 957 (Fla. 3d DCA 2011) (special duty of care exists in custodial relationships, but landlord renting rooms to extended care healthcare provider, who in turn place clients there, did not have a custodial relationship); *Aguila v. Hilton, Inc.*, 878 So.2d 392, 398-399 (Fla. 1st DCA 2004) (no special relationship existed which would give rise to a duty on behalf of motel owner to control the conduct of a non-guest for the protection of a passing motorist); *Schwenke v. Outrigger Hotels Hawaii, LLP*, 227 P.3d 555, 557-558 (Haw. Ct. App. 2010) (absent custody or control, there was no special relationship between hotel and a non-guest that would give rise to a duty to prevent suicide); *Lee*, 925 P.2d at 329-330 (veterans counselor with no medical training and no custody or control did not have a special relationship that gave rise to a duty to prevent suicide); *Lenoci v. Leonard*, 21 A.3d 694, 699 (Vt. 2011) (18 year old friend who took a 15 year old to a party did not have a special relationship that gave rise to a duty to protect her from suicide).

The suicide cases Defendants cite that involve mental healthcare providers

ask whether they have a duty to prevent the suicide of an outpatient and answer "no" absent a special relationship characterized by custody or control – the same kind of determination *Paddock* and *Lawlor* made but not the issue here. *See, e.g.*, *King v. Smith*, 539 So.2d 262, 264 (Ala.1989) (minimal contact between physician and patient did not demonstrate "the special relationship or circumstance" needed to give rise to a duty to prevent suicide or protect others); *Christian v. Counseling Resource Assocs., Inc.*, 2014 WL 4100681, *6-7 (Del. Super. Ct. July 16, 2014) (family practitioner had no affirmative duty to prevent suicide absent custody or control of patient)[7]; *Boynton v. Burglass*, 590 So.2d 446, 448-449 (Fla. 3d DCA 1991) (duty to warn is the equivalent of a duty to prevent harm to or control another; outpatient relationship lacked sufficient elements of control to create special relationship and impose such a duty); *Weiss v. Rush North Shore Med. Ctr.*, 865 N.E.2d 555 (Ill. App. Ct. 2007) (limited contact between psychiatrist and patient did not give rise to a special relationship or a duty to manage future care); *Maloney v. Badman*, 938 A.2d 883, 887, 890 (N.H. 2007) (doctor treating decedent for Crohn's disease did not have a special relationship giving rise to a duty to

[7] The point of decision in *Christian* was that "there [was] no basis to find that [the defendants] had a special relationship with Mr. Christian as required by the Restatement regarding actions based on nonfeasance." 2014 WL 4100681 at *9. The court distinguished *Granicz*, among other cases, as not involving "any application of the Restatement or discussion of [a] special relationship." 2014 WL 4100681 at *9n.34. Defendants suggest this was criticism, but it was merely recognition that different duty analyses were involved in the two cases.

prevent suicide); *Estate of Haar v. Ulwelling*, 154 P.3d 67, (N.M. Ct. App. 2007) (psychiatrist of patient who discontinued treatment had no special relationship giving rise to duty to prevent suicide).

In short, Defendants are looking for Dr. Chirillo's duty in the wrong place. The duty he owed Jacqueline to diagnose and treat her according to the standard of care is a creature of misfeasance and arises from Florida case law, the Florida statutes and the *McCain* foreseeable zone of risk analysis. Granicz does not contend that Dr. Chirillo had a duty to prevent his wife's suicide, by custodial supervision, involuntary hospitalization or the like. That would be a duty to prevent harm to another, and only then would Defendants' special relationship cases and analysis be relevant.

D. WHETHER JACQUELINE'S SUICIDE WAS AN INDEPENDENT INTERVENING CAUSE IS A QUESTION OF PROXIMATE CAUSE FOR THE JURY

Defendants also argue in point I of their brief that suicide may be regarded as an independent intervening cause, although to what end is not clear. The phenomenon is first cited as one of the reasons a special relationship is required before a duty to prevent suicide can be imposed, and there are cases saying as much. *See, e.g.*, *Wyke v. Polk County School Bd.*, 129 F.3d 560, 574-75 (11th Cir. 1997); *White v. Whiddon*, 670 So.2d 131, 134n.2 (Fla. 1st DCA 1996); *Schwenke*, 227 P.2d at 558. The point, however, is not relevant here because Granicz does not

assert a duty to prevent suicide, and the special relationship analysis does not apply to his claim. Defendants go on, however, to argue that this causation issue means that "the Second District's approach of treating suicide as any other injury for which compensation is sought based on medical malpractice is flawed." (Defendants' brief, p.25). Not so. None of the Florida cases addressing the duty owed by a doctor or psychiatrist to an outpatient at risk for suicide even mention suicide as an independent intervening cause, and Defendants did not move on for summary judgment on that basis. This is presumably so because proximate cause is generally a question for the jury, *McCain*, 593 So.2d at 502, and because Florida law treats the subsumed questions of whether a potential intervening or superseding cause is itself foreseeable, and thus does not break the chain of causation, in the same way – as a question of fact for the jury. *Goldberg v. FPL*, 899 So.2d 1105, 1116 (Fla. 2005); *Gibson v. Avis Rent-A-Car Sys., Inc.*, 386 So.2d 520, 522 (Fla. 1980). And the same rule applies to intervening criminal acts, as Defendants sometimes characterize suicide. *Vining v. Avis Rent-A-Car Sys., Inc.*, 354 So.2d 54, 55-56 (Fla. 1977).

The result is that the question of whether suicide is an independent intervening cause is one for the jury in Florida. *E.g., Wyke*, 129 F.3d at 574-575; *Kirkman Rd. Sports Pub & Restaurant, Inc. v. Dempsey*, 723 So.2d 384 (Fla. 5th DCA 1998); *White*, 670 So.2d at 134 n.2; *Schmelz v. Sheriff of Monroe County*,

624 So.2d 298, 298-299 (Fla.3d DCA 1993); *Sogo v. Garcia's Nat'l Gun, Inc.*, 615 So.2d 184, 186 (Fla. 3d DCA 1993). *But see Guice v. Enfinger*, 382 So.2d 270, 271-272 (Fla. 1st DCA 1980) (deciding that the facts permitted a determination that suicide of prisoner was an unforeseeable intervening cause as a matter of law).[8]

In short, the argument that suicide is an independent, intervening cause does not change the fact that the Second District correctly followed *McCain* by leaving the question of whether Jacqueline's particular suicide was foreseeable for the jury to determine as a matter of proximate cause rather than doing so as part of its duty analysis.

II

THE SECOND DISTRICT CORRECTLY HELD THAT THE FORSEEABILITY OF JACQUELINE'S SUICIDE WAS A QUESTION OF PROXIMATE CAUSE FOR THE JURY

The Defendants also believe the Second District erred by "deferring" to the opinions of Granicz's experts rather than making its own independent determination of whether Jacqueline's particular suicide was foreseeable as part of

[8] Nor is Florida law an outlier here. Numerous decisions in other states, including in the context of physicians treating patients at risk for suicide, handle a claim that the suicide was an independent intervening cause in the same way. *See, e.g., Brandvain v. Ridgeview Inst., Inc.* 372 S.E.2d 265, 273 (Ga. Ct. App. 1988); *Muse v. Charter Hosp. of Winston-Salem, Inc.*, 452 S.E.2d 589, 596 (N.C. Ct. App. 1995); *White v. Lawrence*, 975 S.W.2d 525, 529 (Tenn. 1998); *Wilson v. Brister*, 982 S.W.2d 42, 44-45 (Tex. Ct. App. 1998).

the duty analysis. Defendants are wrong for several reasons.

First, as discussed in point I above, a physician's duty to treat his or her patients according to the standard of care is imposed by both case law and statute. Fla.Stat. §766.102(1); *Torres,* 903 So. 2d at 1067. At least where the subject of the treatment relates to the injury, foreseeability is not a condition precedent to this duty.[9] Rather, what is medically foreseeable determines what the standard of care requires and ultimately proximate cause.

Second, in terms of duties that arise out of the relationships and facts involved in a given case, this Court has made it clear that the foreseeability analysis which informs the question of duty has to do with broad "zones of risk," not "the specific, narrow factual details of the case" or "the precise manner in which the injury occurred." *McCain*, 593 So.2d at 502, 503. The viability of this analysis has repeatedly (and recently) been confirmed. *E.g.*, *Dorsey v. Reider,* 139 So.2d 860, 863-64 (Fla. 2014); *United States v. Stevens*, 994 So.2d 1062, 1067 (Fla. 2008).

Third, Defendants' suggestion that only *Granicz* and *Sweet* have applied the *McCain* analysis in suicide cases is incorrect. *Perez* did as well:

> The existence of a duty is a legal question determined by

[9] The caveat acknowledges that there would be a foreseeable zone of risk/duty issue if, for example, one sued a dermatologist for failing to detect pancreatic cancer – the point made in *Garcia* and by the Second District in *Granicz*. 147 So.3d at 548 n.2.

> whether a general zone of foreseeable danger was created, as compared to the factual question of whether a defendant's activity foreseeably caused a specific harm.

883 F.Supp.2d at 1284 n.82. And in *Estate of Rotell*, where a psychologist was sued for a murder rather than a suicide, the analysis was the same:

> Florida, like other jurisdictions, recognizes that a legal duty will arise whenever a human endeavor creates a generalized and foreseeable risk of harming others.
>
> * * *
>
> Dr. Knehnle need not have been able to foresee the precise injury….

38 So.3d at 788-789, 790. Further, as pointed out in point IB above, the cases Defendants rely on, *Paddock*, *Garcia* and *Lawlor*, disposed of the embedded misfeasance claims on the facts, not on the absence of foreseeability or duty.

Fourth, Defendants acknowledge that the Second District's duty analysis was correct under *McCain*, but suggest that *McCain* is out-of-date or out-of-touch when it comes to suicide cases. To the contrary, no Florida court has called *McCain's* relevance into question in the context of the duty to diagnose and treat a patient as risk for suicide, and it has been cited in numerous suicide cases. In each, the court professed to apply it rather than attempt to distinguish it. *See, e.g.*, *Granicz*, 147 So.3d at 547-48; *Tuten*, 84 So.3d at 1068; *Kelley*, 68 So.3d at 957; *Lawlor*, 795 So.2d at 147; *White v. Whiddon*, 670 So.2d 131, 134 (Fla. 1st DCA

1996).

Fifth, the notion that the Second District shirked its responsibility to conduct a duty analysis by "deferring" to the opinions of Granicz' experts is fanciful. It did not need expert testimony to know that suicide is within the foreseeable zone of risk when a doctor treats a patient for depression, which was the foreseeability issue as far as duty is concerned. And the foreseeability of Jacqueline's suicide, including the implications of what Defendants claim were no apparent suicidal tendencies, remains in the case as part of the issue of causation, which will no doubt be hotly contested before the jury. But when the time comes the issue will not be whether a family member, a friend, a motel owner, a ship's captain or a landlord could have reasonably foreseen it. The issue will be whether a doctor trained and experienced in treatment of depression could have. So it was appropriate for the District Court to consider the opinions of similarly trained and experienced doctors on both the causation as well as the standard of care issues before reversing the trial court. And the evidence they provided was that, given her symptoms, Dr. Chirillo needed to see Jacqeuline and find out if she was having suicidal ideations – "the standard of care because it has been shown to be effective in warding off and identifying patients who are at risk to take their own life." (RII, 336, 345). So the Second District did not abdicate its responsibility by "deferring" to experts, it just understood how the process works. *See Pate v. Threlkel*, 661

So.2d 278 (Fla.1995).

Finally, Defendants cite several Florida cases in which courts have looked at the foreseeability of the specific suicide in question to determine whether a duty to prevent harm existed. As in previous contexts, they are nonfeasance cases where the issue was whether a duty to prevent suicide should be imposed – not misfeasance cases dealing with the duty to treat and diagnose a patient who may be at risk for suicide in accordance with the standard of care. *Tuten,* 84 So.3d 1063 (duty to commit or detain patient); *Kelley,*68 So.3d 954 (landlord's duty to prevent suicide); *Lawlor* (physician's duty to provide custodial supervision); *Rafferman v. Carnival Cruise Lines, Inc.*, 659 So.2d 1271 (Fla. 3d DCA 1995) (ship captain's duty to prevent suicide of crew member); *Boynton,* 590 So2d 446 (psychiatrist's duty to warn third parties); *Guice,* 382 So. 2d 270 (jailor's duty to prevent prisoner's suicide). And again, the difference is a material one.

Foreseeability plays a different role in nonfeasance cases where the duty in play is one to take affirmative action to prevent harm to another. Indeed, unlike in a *McCain* misfeasance analysis, foreseeability is not enough. As section 314 of the Restatement (Second) of Torts put it:

> The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.

There must also be a special relationship between the defendant and the victim – one in which some kind of custody or control or supervisory role exists.

Once a special relationship is found, however, foreseeability reenters the picture as a predicate for duty. And the foreseeability tends to focus on the suicide or actions of the person with whom the special relationship exists, i.e. specific rather than general or categorical foreseeability. For example, comment i to section 314A of the Restatement (Second) of Torts, which deals with the duties arising in the context of several common special relationships, provides that a duty to prevent harm only exists when the defendant "knows [or] should know of the unreasonable risk, or of the illness or injury."

The phenomenon is explained in greater detail in comment f to section 37 of the Restatement (Third) of Torts (2012):

> By contrast to categorical foreseeability, courts sometimes inquire about the *specific* foreseeability of harm based on the facts of the *individual* case in determining whether an affirmative duty exists. Judicial reliance on foreseeability under specific facts occurs more frequently and aggressively in cases involving the allegation that an affirmative duty exists than in other cases. This suggests that courts more carefully supervise affirmative-duty cases than cases in which the actor's conduct creates a risk of harm. This tendency is even more pronounced when the alleged duty is to protect the plaintiff from third parties, especially the criminal acts of third parties. Sometimes, courts develop specific rules or balancing tests about the quantity, quality, and similarly of prior episodes required to satisfy foreseeability. **Many**

> **courts use similar techniques to limit liability for failing to protect a plaintiff from self-inflicted harms.**

(italic emphasis in original; bold emphasis added).

So the response to the Defendants' protest that there are cases looking at the specifics of a particular suicide in determining duty is that those cases are looking at a different duty – one in which, historically at least, foreseeability has played a different role. Conversely, no Florida case has used specific foreseeability in determining whether a doctor has a duty to properly treat patients at risk for suicide; nor can they under *McCain*.[10]

This last point brings us full circle to the perceived conflict with *Lawlor*. As discussed in point IB, the case acknowledges that the defendant had a "lapsed" duty to treat the plaintiff according to the standard of care, but decided the case based on the absence of a continuing duty to provide custodial supervision for a patient that had not been seen in three plus months – a nonfeasance duty to prevent harm. It was in that context that *Lawlor* delved into the specific forseeability of

[10] The Court's decision in *Dorsey v. Reider*, 139 So.2d 860, may provide another response. The case involved a claim by one participant in a fight against another for injuries inflicted by a third with a tomahawk he unexpectedly retrieved from a truck – a nonfeasance claim based in part on a duty to prevent the misconduct of a third party. The Third District reversed a plaintiff's verdict, finding no duty on the basis that the defendant could not have foreseen the tomahawk attack. The Court reversed the Third District, pointing out that the *McCain* duty analysis involves foreseeable zones of risk, not the forseeability of the specific incident. The decision would seem to undercut the practice of looking at specific foreseeability in duty to prevent harm cases.

Mr. Lawlor's suicide – what other cases have done in the context of a duty to prevent suicide, and not at odds with what the Second District did here.

CONCLUSION

For the above reasons, it is respectfully submitted that the writ of certiorari should be discharged or the Second District's decision in *Granicz* affirmed.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was furnished via electronic mail to: Scott A. Cole, scott.cole@csklegal.com, Daniel M. Schwarz, Daniel.schwarz@csklegal.com, Cole Scott & Kissane, P.A., Counsel for Petitioners, Dadeland Centre II, Suite 1400, 9150 South Dadeland Boulevard, Miami, FL 33156 this 17th day of March, 2015.

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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 Time New Roman 14 point font.

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