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TAKING A CHANCE ON PATIENT LIFE: SUICIDAL PATIENTS, INVOLUNTARY ADMISSIONS, AND PHYSICIAN IMMUNITY IN MARYLAND

Lauren Miller*

According to the most recent government data, suicide is the tenth leading cause of death in the United States and the fourth leading cause of death for people ages ten to thirty-four.¹ In 2015 alone, almost ten million adults contemplated suicide.² Attempting to address this tragedy, a majority of states authorize involuntary civil commitment³ for mentally ill persons and “more than one million patients per year” are involuntarily committed.⁴ *Parens patriae* and state police powers authorize involuntary commitments,⁵ but the Supreme Court of the United States qualifies this treatment as a “massive curtailment of liberty.”⁶ States implement procedural and substantive safeguards to counterbalance the Fourteenth Amendment liberty interest that protects patients from being forcibly admitted for mental health treatment.⁷

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¹ U.S. DEP’T OF HEALTH & HUM. SERVS., Results from the 2015 National Survey on Drug Use and Health: Mental Health Findings, 1, 2 (Sept. 2016), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR3-2015/NSDUH-DR-FFR3-2015.htm>.

² *Id.* at 3.

³ The Department of the Treasury’s Bureau of Alcohol, Tobacco, and Firearms defines hospital commitments as “[a] formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. . . . The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.” 27 C.F.R. § 478.11 (2017). This article uses “commitment” and “admission” interchangeably. For a description on the parallel uses of commitment and admission, see *Furda v. State*, 193 Md. App. 371, 410, 997 A.2d 856, 879 (Md. Ct. Spec. App. 2010) (stating that “‘commit[ment]’ [applies] to situations in which, at the very least, the patient has been afforded an evidentiary hearing, held either by a court or a hearing officer; the patient or the defendant has a right to appear and has the right to counsel; and findings are made by the factfinder, based on competent medical evidence.”).

⁴ See SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 101–05 (3d ed. 1985) (describing the medical certification for involuntary hospitalizations in the majority of states); William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 261 (2010).

⁵ John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL’Y & L. 377, 377 (1998).

⁶ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

⁷ See *infra*, Part I.A.

Before applying to commit a mentally ill individual, a physician must perform an evaluation that allows the physician to determine if the patient meets all required admission criteria. The evaluation questions whether the patient is mentally ill, requires treatment, poses a danger to self or others, refuses voluntary commitment, and is unable to be treated in a less restrictive environment.⁸ If the individual meets the required criteria, the individual is then committed until the physician releases the patient due to improvement of their condition or, in the absence of improvement, continued treatment to the extent permitted by state statute.⁹ If a patient suffering from suicidal ideation is turned away from initial hospitalization or released early without receiving sufficient treatment, it is possible that the patient may make additional suicide attempts, as was the case with Charlie Williams in *Williams v. Peninsula Regional Medical Center*¹⁰ and Brandon Mackey in *Chance v. Bon Secours Hospital*.¹¹

Jurisdictions differ on whether a physician may be held liable for failing to prevent a mentally ill individual from committing suicide.¹² Some states predicate liability on the foreseeability of self-harm and incorporate that into the proximate cause analysis for medical malpractice claims.¹³ Other states refuse to find liability if the physician did not have custody of the patient, or because suicide is considered an intervening act that breaks the causal link between the physician's negligent conduct and death.¹⁴ Maryland provides immunity from civil and criminal liability to individuals who in good faith apply to involuntarily admit a potentially suicidal individual and to physicians who eschew involuntary admission.¹⁵ This article posits that physicians should have an affirmative duty to involuntarily commit and treat foreseeably suicidal patients. Additionally, physicians failing to comply with the duty should not be insulated from liability; instead, the physicians' potential liability should be evaluated under a reckless failure to act standard.¹⁶

I. BACKGROUND

When an individual exhibits signs of mental illness (*e.g.* suicidal thoughts or tendencies), and the severity of the illness appears to warrant inpatient treatment, physicians may

⁸ See *e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016). See generally, Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. 657 (2016) (asserting that the dangerousness requirement for civil commitment insufficiently helps to serve mentally ill patients).

⁹ See *e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-632(b) (West 2016) (mandating that a hearing is held "within 10 days of the date of the initial confinement").

¹⁰ 440 Md. 573, 103 A.3d 658 (Md. 2014).

¹¹ No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017).

¹² See *infra*, Part II.A.

¹³ See *infra*, Part II.A.2.

¹⁴ See *infra*, Part II.A.1 & II.A.2.

¹⁵ See *infra*, Part I.C.

¹⁶ A patient may voluntarily admit herself into treatment but this Comment explores only the involuntary admission of patients already brought to a hospital.

elect to apply for involuntary civil commitment (“involuntary commitment”).¹⁷ Part A of this Section traces the history of involuntary commitments and examines how potential infringements of the Fourteenth Amendment liberty interest are forestalled by dangerousness and due process requirements.¹⁸ Part B explores jurisdictional differences, contemplating whether physicians owe (1) a general duty to prevent suicide deaths of their patients and, if so, (2) if that duty can be discharged by involuntarily committing these patients.¹⁹ Finally, Part C details physician immunity in Maryland for the choice to apply for or eschew involuntary commitments of foreseeably suicidal patients.²⁰

A. Deinstitutionalization, Dangerousness, and Due Process

Between the 1960s and 1970s, the general physician approach to involuntary commitments shifted from forcibly treating individuals as a societal prophylactic to prioritizing the individual’s liberty interest.²¹ The landmark involuntary commitment cases, *Wyatt v. Stickney*²² and *Lessard v. Schmidt*,²³ brought forth the federal courts’ deinstitutionalization of mentally ill patients. Shortly thereafter, the United States Supreme Court followed suit in *Specht v. Patterson*²⁴ and *Jackson v. Indiana*.²⁵ Since the early 1970s, however, the Supreme Court has held that involuntarily committing mentally ill patients to hospitals for psychiatric treatment is constitutional, provided that

¹⁷ MD. CODE ANN., HEALTH-GEN. § 10-614(a) (West 2016) (authorizing applications for involuntary admissions by any interested party); MD. CODE ANN., HEALTH-GEN. § 10-616(a) (West 2016) (requiring application materials to include a physician evaluation and mental illness diagnosis of the patient); MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016) (enumerating the qualifications for involuntary admission).

¹⁸ See *infra*, Part I.A.

¹⁹ See *infra*, Part I.B.

²⁰ See *infra*, Part I.C.

²¹ J.H. v. Prince George’s Hosp. Ctr., 233 Md. App. 549, 570, 165 A.3d 664, 677 (Md. Ct. Spec. App. 2017) (quoting Donald H. J. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 83, 85 (1986)).

²² 325 F. Supp. 781, 784, 785 (M.D. Ala. 1971) (holding that the treatment given to involuntarily committed patients at Bryce Hospital in Alabama was “scientifically and medically inadequate” and remarking that “depriv[ing] any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail[ing] to provide adequate treatment violates the very fundamentals of due process.”).

²³ 349 F. Supp. 1078, 1084 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976) (holding Wisconsin involuntary commitment procedures deficient given that the “[s]tate commitment procedures have not ... traditionally assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of crime.”).

²⁴ 386 U.S. 605 (1967).

²⁵ 406 U.S. 715, 737, n.22 (1972). Justice Blackmun commented that “[c]onsidering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.” *Id.* (citing a Congressional report “estimate[ing] that 90% of the approximately 800,000 patients in mental hospitals in this country had been involuntarily committed.”).

certain procedural requirements are met.²⁶ When a state places a patient in involuntary civil commitment without meeting procedural or substantive due process requirements, the patient's Fourteenth Amendment liberty interest is unjustly infringed.²⁷

Nonetheless, the state's *parens patriae*²⁸ role and inherent police power permit the state to act despite the patient's liberty interests. In *Addington v. Texas*,²⁹ Justice Burger explained that:

The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.³⁰

In the *parens patriae* context, the state steps in as guardian and seeks to protect mentally ill individuals that cannot care for themselves.³¹ State police powers, on the other hand, authorize state action to protect the health, safety, and morals of its residents.³² By permitting involuntary commitment, the state quarantines mentally ill patients that may inflict harm on other people or themselves and places them in a treatment-oriented facility.³³

²⁶ *Kansas v. Hendricks*, 521 U.S. 346, 356 (1997) (remarking that “[the Supreme] Court has consistently upheld involuntary commitment statutes that detain people who are unable to control their behavior and thereby pose a danger to the public health and safety, provided the confinement takes place pursuant to proper procedures and evidentiary standards.” (citing *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992))).

²⁷ U.S. CONST. amend. XIV, § 1. See *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (remarking “[t]here can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law.”); *Anderson v. Dep't of Health and Mental Hygiene*, 310 Md. 217, 228, 528 A.2d 904, 910 (Md. 1987) (holding that “civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”).

²⁸ *Parens patriae* is “used to describe the power of the state to act in loco parentis for the purpose of protecting the property interests and the person of [residents] ...” *In re Gault*, 387 U.S. 1, 16 (1967).

²⁹ 441 U.S. 418 (1979).

³⁰ *Id.* at 426.

³¹ *In re Gault*, 387 U.S. 1, 16–18 (describing the historical developments of the *parens patriae* doctrine).

³² *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (“According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.”) (citations omitted). See also *Crowley v. Christensen*, 137 U.S. 86, 89–90 (1890) (averring that “the possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to be equal enjoyment of the same right by others.”).

³³ See, e.g., MD. CODE ANN., HEALTH-GEN. § 10-614(a) (West 2016) (permitting “application for involuntary admission of an individual to a facility or Veterans' Administration hospital ... under this part by any person who has a legitimate interest in the welfare of the individual.”).

Prior to admission, an evaluating physician must conduct an evaluation and deem the patient dangerous.³⁴ The Massachusetts Supreme Court explained: “The right to restrain an insane person of his liberty, is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others.”³⁵ In 1975, the Supreme Court held that “a State cannot constitutionally confine without more a nondangerous individual.”³⁶ The Supreme Court’s holding signifies that, absent a showing of dangerousness, an involuntary commitment is an unconstitutional deprivation of liberty.³⁷

Kenneth Donaldson was involuntarily committed to a Florida hospital for fifteen years despite Donaldson’s repeated assertions that he was not dangerous and did not require treatment.³⁸ Though it was plausible that Donaldson suffered from a mental illness, the Court stated that this alone was insufficient to deprive an individual of liberty and “there is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.”³⁹ Only where an individual presents a danger to self or others may they be committed because, although “the State has a proper interest in providing [treatment]” to its mentally ill residents, “the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution.”⁴⁰ Jurisdictions differ on the threshold of dangerousness required to meet the involuntary admission criteria.⁴¹ The higher the threshold, the less likely a

³⁴ See *infra*, notes 36–37, and accompanying text.

³⁵ In re Josiah Oakes, 8 Law Rep. 123, 4–5 (Mass. 1845). The court further explained that “[t]he question must then arise in each particular case, whether a person’s own safety or that of others requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restraint can continue as long as the necessity continues.” *Id.* at 6–7.

³⁶ O’Connor v. Donaldson, 422 U.S. 563, 576 (1975).

³⁷ See also *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (noting that states, when statutorily permitting involuntary commitment, base this choice “not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.”) (dictum). See also *People v. Stevens*, 761 P.2d 768, 772–73 nn. 4–9 (Colo. 1988) (listing the degree of dangerousness required by statute across a majority of jurisdictions).

³⁸ *O’Connor*, 422 U.S. at 564–63. The hospital provided Donaldson with custodial care rather than mental health treatment and refused to release him despite offers from a half-way house and from a friend to provide Donaldson with the care required upon discharge. *Id.* at 569.

³⁹ *Id.* at 574.

⁴⁰ *Id.*

⁴¹ See e.g., Md. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016) (requiring that an individual “presents a danger” to self or others); ALA. CODE § 22-52-37 (1975) (requiring an overt act); CAL. WELF. & INST. CODE § 5300(a) (West 1983) (requiring threats, attempts, or infliction of “substantial physical harm”); DEL. CODE ANN. tit. 16, § 5013 (West 2014) (requiring that the individual is “reasonably expected to become dangerous to self” or others, and either (1) a documented history of nonadherence to treatment, or (2) an “extreme threat of danger to self” or others, evidenced by an observation of danger or imminent danger).

patient will be involuntarily committed, and most states require that there be no less restrictive alternative treatment available prior to involuntarily committing a patient.⁴²

Following admission, the patient is afforded procedural protections. Federal courts have contemplated the constitutionality of these protections on several occasions.⁴³ *Vitek v. Jones*⁴⁴ identified these safeguards as: (1) notice of transfer to a mental health facility; (2) a hearing with an opportunity to contest evidence; (3) presentation and cross-examination of witnesses; (4) an independent decision-maker; (5) disclosure of the evidence relied on by the decision-maker; and (6) “effective and timely notice of all foregoing rights.”⁴⁵ When a patient challenges their involuntary commitment, courts do not apply a specific test to decide if the patient was denied procedural due process. Instead, the courts apply the balancing standard⁴⁶ set forth in *Mathews v. Eldridge*,⁴⁷ wherein the Supreme Court outlined the interest considerations as follows:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the

⁴² See e.g., DEL. CODE ANN. tit. 16, § 5002 (West 2014); D.C. CODE ANN. § 21-545(b)(2) (West 2004); MISS. CODE ANN. § 41-21-73(4) (West 2010); N.J. STAT. ANN. § 30:4-24.2(d)(3) (West 2013); OKLA. STAT. ANN. tit. 43A, § 4-102(5) (West 2005); and WASH. REV. CODE ANN. § 71.05.230 (West 2016).

⁴³ See e.g., *Vitek v. Jones*, 445 U.S. 480 (1980); *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (holding “due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed”); *In re Joseph P.*, 943 N.E. 2d 715 (Ill. 2010) (finding potential prejudice to individual where police officer did not identify himself on emergency petition); *Rueda v. Charmaine*, 906 N.Y.S. 2d 246 (N.Y. 2010) (allowing emergency room psychiatrists to petition for non-emergency involuntary commitment); *Kootenai Med. Ctr. v. Bonner Cty. Comm’rs*, 105 P.3d 667 (Idaho 2004) (precluding hospital from petitioning for involuntary commitment where patient has not requested to leave facility); *In re Miller*, 585 N.E.2d 396 (Ohio 1992) (precluding social worker from filing affidavit initiating commitment in lieu of hospital’s chief clinical officer).

⁴⁴ 445 U.S. 480 (1980).

⁴⁵ *Id.* at 494–95 (citing *Miller v. Vitek*, 437 F. Supp. 569, 575 (D. Neb. 1977), *vacated sub nom. Vitek v. Jones*, 436 U.S. 407 (1978)). The plurality, led by Justice White, also found that state-funded legal counsel should be provided to “prisoners who are illiterate and uneducated” or suffering from “mental disease or defect” because they are unlikely to comprehend their rights. *Id.* at 496–97 (Powell, J., concurring).

⁴⁶ *Wilkinson v. Austin*, 545 U.S. 209, 224 (2005) (stating that “[b]ecause the requirements of due process are ‘flexible and cal[li] for such procedural protections as the particular situation demands,’ we generally have declined to establish rigid rules and instead have embraced a framework to evaluate the sufficiency of particular procedures.” (quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972))). See also *Addington v. Texas*, 441 U.S. 418, 425 (1979) (holding that “[i]n considering what standard should govern in a civil commitment proceeding, we must assess both the extent of the individual’s interest in not being involuntarily confined indefinitely and the state’s interest in committing the emotionally disturbed under a particular standard of proof.”).

⁴⁷ 424 U.S. 319 (1976).

fiscal and administrative burdens that the additional or substitute procedural requirement would entail.⁴⁸

The Supreme Court of Alaska recently applied this test in *Matter of Jacob S.*⁴⁹ where an involuntarily committed patient challenged the use of telephonic testimony at his commitment hearing.⁵⁰ The patient's domestic partner filed for an emergency evaluation after the patient ceased taking his medication, exhibited violent behavior, and appeared to suffer from paranoid delusions.⁵¹ The evaluating physician applied for an involuntary admission and "approval to administer psychotropic medication because [the patient] lacked capacity to give informed consent."⁵² The court held a hearing on both petitions wherein the patient's domestic partner and neighbor testified via telephone. The patient argued that this testimony violated his due process rights.⁵³ In balancing the interests of the parties, the court recognized that the patient's commitment severely limited his liberty interest.⁵⁴ Despite this recognition, the court found that the risk of erroneous commitment in light of the telephonic testimony was minimal because the patient had an opportunity to cross-examine the witnesses at his hearing and did not attack their credibility.⁵⁵ The court also recognized the state's interest in quickly gathering evidence; the involuntary commitment hearing was held less than seventy-two hours after the initial detention since a potentially dangerous individual may be discharged and harm the community if fact-finding is not done expeditiously.⁵⁶ In weighing these interests, "the low erroneous deprivation risk and the State's great health and public safety interest tip[ped] the scale in the State's favor—even when balanced against [the patient's] significant liberty interest."⁵⁷

B. Physician Liability for Failure to Protect Foreseeably Suicidal Patients

Furthermore, if a physician declines to commit, or prematurely releases, a patient in need of additional treatment, the physician exposes themselves and others to liability for future harm caused by the patient.⁵⁸ While a person ordinarily owes no duty to protect

⁴⁸ *Id.* at 335.

⁴⁹ 384 P.3d 758 (Alaska 2016).

⁵⁰ *Id.* at 764.

⁵¹ *Id.* at 762.

⁵² *Id.* at 764.

⁵³ *Id.* at 762.

⁵⁴ *Id.* at 764.

⁵⁵ *Id.*

⁵⁶ *Id.* at 765.

⁵⁷ *Id.*

⁵⁸ See e.g., *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App. 2012) (holding that where physician failed to involuntarily commit his foreseeably suicidal patient, he may be liable for her subsequent suicide attempt because "while [physician] had no duty to guarantee that [patient] did not attempt suicide, he had a long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of ... his patient."); and *Foster v. Charter Med. Corp.*, 601 So. 2d 435, 440 (Ala. 1992) (reversing grant of summary judgment in favor of defendant doctor where patient was released from treatment and foreseeably committed suicide afterwards).

someone else from harm, certain special relationships impose such an affirmative duty. For example, psychiatrists have an affirmative duty to protect patients suffering from suicidal ideations.⁵⁹ In *Tabor v. Doctors Memorial Hospital*,⁶⁰ decedent Andy Tabor was quickly transported to the emergency room⁶¹ after attempting to commit suicide by consuming thirteen Quaaludes.⁶² The treating physician diagnosed Andy with depression and recommended that he be placed in the psychiatric ward for seventy-two hours.⁶³ The physician later learned that Andy's insurance would not cover the psychiatric treatment and released him—despite his ability to waive the payment requirement—because he did not believe Andy's condition was an emergency.⁶⁴ Andy shot himself in the heart the next day.⁶⁵ The Supreme Court of Louisiana ultimately held the physician liable because his failure to commit Andy into psychiatric treatment, while not guaranteed to prevent Andy's suicide, “was a substantial factor in the cause of Andy's death.”⁶⁶

In addition to the psychiatrist-patient relationship, foreseeability of suicide further establishes the duty to protect another from self-harm. For example, in *Wyke v. Polk Country School Board*,⁶⁷ a middle-school aged boy twice attempted to commit suicide at school and neither attempt was reported to his mother.⁶⁸ The adolescent took his life shortly after the second suicide attempt, for which the Eleventh Circuit held the school liable because the special relationship between schools and children, coupled with the foreseeability of death in this case, imposed an obligation to inform the decedent's mother about his condition.⁶⁹

Alternatively, many jurisdictions do not recognize physician liability for the failure to commit and treat foreseeably suicidal patients. These jurisdictions utilize various lines of reasoning to excuse physician liability, including: no special relationship exists;⁷⁰

⁵⁹ See *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334, 340 (Cal. 1976) (holding that mental health physicians have a duty to protect intended victims of violent patients). In situations involving patients with suicidal ideation, the intended victim would be the patient herself. Suicidal ideation is either passive or active, wherein “passive suicidal ideation entails thoughts such as wishing that you were dead, while active suicidal ideation entails thoughts of self-directed violence and death.” *Bankhead v. Shulkin*, 29 Vet. App. 10, 20 (Vet. App. 2017).

⁶⁰ 563 So.2d 233 (La. 1990).

⁶¹ *Id.* at 235.

⁶² *Mendoza v. Sec'y, Florida Dep't of Corr.*, 761 F.3d 1213, 1217 n.3 (11th Cir. 2014) (explaining that “‘Quaalude’ is the brand name for the drug Methaqualone, ‘a non-barbiturate sedative-hypnotic that is a general depressant of the central nervous system.’” (citing *Hardwick v. Crosby*, 320 F.3d 1127, 1168 n. 159 (11th Cir.2003))).

⁶³ *Id.*

⁶⁴ *Id.* Three members of the nursing staff attending to Andy also approached the physician and voiced their opinion “that Andy's condition presented an emergency.” *Id.*

⁶⁵ *Id.* at 236.

⁶⁶ *Id.* at 238.

⁶⁷ 129 F.3d 560 (11th Cir. 1997), *certified question withdrawn*, 137 F.3d 1292 (11th Cir. 1998).

⁶⁸ *Id.* at 563–65.

⁶⁹ *Id.* at 574.

⁷⁰ See, e.g., *Weiss v. Rush North Shore Medical Center*, 865 N.E.2d 555 (Ill. App. Ct. 1st Dist. 2007).

suicide is construed as an intervening act;⁷¹ death by suicide constitutes contributory fault;⁷² the exercise of professional medical judgment precludes liability;⁷³ or the state offers statutory immunity.⁷⁴

C. Maryland: Physician Immunity for Involuntary Admission Applications

In Maryland, a physician is immune from civil and criminal liability when they “in good faith and with reasonable grounds apply for involuntary admission.”⁷⁵ In *Williams v. Peninsula Regional Medical Center*, the Court of Appeals construed Courts and Judicial Proceedings Article § 5-623 (“CJP § 5-623”) and Health-General Article § 10-618 as granting immunity to physicians that elect to commit a mentally ill individual as well as those physicians that elect *not* to commit and treat the individual.⁷⁶ In 2009, decedent Charlie Williams (“Charlie”) arrived in an emergency room exhibiting signs of suicidal ideation and auditory and visual hallucinations.⁷⁷ Health care providers elected not to admit Charlie, released him into the custody of his mother and “advis[ed] her to remove any firearms from the home.”⁷⁸ Charlie immediately escaped his mother’s custody and broke into a Salisbury, MD residence later that evening.⁷⁹ When police arrived, he brandished a knife and exclaimed that he wanted to be shot. Charlie then rushed the officers, who opened fire on Charlie and killed him.⁸⁰ The Court of Appeals of Maryland exempted the physician from liability after comparing CJP § 5-623 to the entirety of the involuntary admissions part of the Maryland mental health laws.⁸¹ Based

⁷¹ See, e.g., *Johnson v. Wal-Mart Stores, Inc.*, 588 F.3d 439 (7th Cir. 2009) (affirming Illinois law “describing suicides as intervening acts that break the causal chain because of their presumptively unforeseeable nature”); but see also *Edwards v. Tardif*, 692 A.2d 1266 (Conn. 1997) (recognizing that suicide is ordinarily considered an intervening act but finding an exception where the physician’s conduct fell below the standard of care when treating a foreseeably suicidal patient).

⁷² See, e.g., *Skar v. City of Lincoln, Neb.*, 599 F.2d 253 (8th Cir. 1979) (permitting defense of contributory fault under Nebraska law); but see also *McNamara v. Honeyman*, 46 N.E.2d 139, 146 (Mass. 1989) (stating that “there can be no comparative negligence where the defendant’s duty of care includes preventing the self-abusive or self-destructive acts that caused the plaintiff’s injury.”).

⁷³ See, e.g., *Topel v. Long Island Jewish Medical Center*, 431 N.E.2d 293, 294–95 (N.Y. 1981) (refusing to hold physician liable for patient’s suicide because physician’s choice to forgo continuous observation was an exercise of his professional medical judgment).

⁷⁴ See, e.g., GA. CODE ANN. § 37–3–4 (West 2011).

⁷⁵ MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 1997); MD. CODE ANN., HEALTH-GEN. § 10-618 (West 2016) (granting immunity to anyone that “applies for involuntary admission of an individual ... under § 5-623(b) of the Courts and Judicial Proceedings Article”).

⁷⁶ 440 Md. 573, 587, 103 A.3d 658, 666–67 (Md. 2014) (holding that “[t]he immunity conferred by HG § 10–618 and CJP § 5–623 protects the discretion of health care providers, which in turn safeguards the liberties of those subject to evaluation and possible involuntary admission.”).

⁷⁷ *Id.* at 576, 660.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.* at 576–77, 660. Charlie’s actions constitute what is known as “suicide by cop.” *United States v. List*, 200 F. App’x 535, 544 n.2 (6th Cir. 2006) (defining suicide by cop as “act[ing] in a way that would require law enforcement officers to respond with lethal force.”).

⁸¹ *Williams*, 440 Md. at 583, 664 (Md. 2014). The involuntary admissions part of the Maryland mental health laws is referred to as “Part III” by the Court of Appeals and this Comment.

on this comparison, the court construed the Maryland General Assembly's purpose as conferring immunity on the physician since the physician complied with the other health articles by electing not to admit.⁸²

The Court of Appeals will have an opportunity to revisit this issue in an appeal from *Chance v. Bon Secours Hospital*.⁸³ On March 13, 2011, Dr. Leroy M. Bell ("Dr. Bell") at Bon Secours Hospital gained care of twenty-three-year-old Brandon Mackey ("Brandon") after a suicide attempt in which Brandon slit his wrists.⁸⁴ Dr. Bell diagnosed Brandon with major depressive disorder and released him from voluntary commitment eight days later (March 21).⁸⁵ Brandon made a second suicide attempt ten days after his release (April 1), and Dr. Bell again gained care of Brandon via involuntary commitment to Bon Secours Hospital.⁸⁶ Dr. Bell diagnosed Brandon with "schizoaffective disorder, bipolar type," and administered the drug Risperdal (April 6).⁸⁷ Brandon was released three days later (April 9), and tragically died after jumping in front of a metro train the next day.⁸⁸ Patricia Chance, Brandon's mother, filed suit against Dr. Bell and Bon Secours Hospital Baltimore, Inc., alleging that Brandon's negligent release from involuntary commitment led to his suicide.⁸⁹ At trial, Dr. Nicola G. Cascella ("Dr. Cascella"), certified as an expert in schizophrenic psychiatry, testified that "Bell breached the applicable standard of care by discharging Mackey before confirming that the prescribed medication was showing adequate impact, and that the premature release proximately caused Mackey's suicide the day after his release."⁹⁰ The jury awarded Patricia Chance \$6,112 in economic damages and \$2,300,000 in non-economic damages, but the court granted the defendants' motion

⁸² *Id.*

⁸³ No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017); *Bell & Bon Secours Hosp. v. Chance*, 170 A.3d 289 (Table) (Md. 2017).

⁸⁴ *Id.* at *1.

⁸⁵ *Chance*, slip op. at *1. The Mayo Clinic defines major depressive disorder (depression) as "a mood disorder that causes a persistent feeling of sadness and loss of interest. ... [I]t affects how you feel, think and behave and can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and sometimes you may feel as if life isn't worth living." *Depression (major depressive disorder)*, MAYO CLINIC (last visited October 2, 2017), <http://www.mayoclinic.org/diseases-conditions/depression/home/ovc-20321449>.

⁸⁶ *Chance*, slip op. at *1.

⁸⁷ *Id.* at *1–2. Schizoaffective disorder is defined as "a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression." *Schizoaffective Disorder*, NATIONAL ALLIANCE ON MENTAL ILLNESS (last visited Oct. 24, 2017), <https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizoaffective-Disorder>. Risperdal is a second-generation antipsychotic medication used to treat conditions such as schizophrenia and, if administered via injection, can take up to three weeks before it begins treating symptoms and two to three months before full benefits are realized. College of Psychiatric and Neurologic Pharmacists, *Risperidone (Risperdal)*, NATIONAL ALLIANCE ON MENTAL ILLNESS (June 2016), [https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Risperidone-\(Risperdal\)](https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Risperidone-(Risperdal)).

⁸⁸ *Chance*, 2017 WL 1716258 at *1.

⁸⁹ *Id.*

⁹⁰ *Id.* at *2 (citing *Chance v. Bell, Jr., M.D.*, 2014 WL 4401077 (Md. Cir. Ct.) (Trial Order)).

for judgment notwithstanding the verdict.⁹¹ On appeal, the Maryland Court of Special Appeals questioned whether the release was a proximate cause of his Mackey's suicide and whether there was sufficient evidence for the jury to conclude that Dr. Bell breached the standard of care by releasing Brandon on April 9.⁹² The court stated:

[W]e conclude that sufficient evidence was presented at trial for the jury to find, based upon the testimony of Dr. Cascella: (1) that the standard of care required Dr. Bell not to discharge Mackey until his symptoms of psychosis were significantly reduced by Risperdal, (2) that, at the time Dr. Bell discharged Mackey, the patient continued to present symptoms of responding to internal stimuli, as well as poor insight and poor judgment, indicating that Mackey's symptoms had not yet been significantly reduced by the Risperdal, and (3) that Mackey's premature discharge from Bon Secours was a proximate cause of his death. There was sufficient evidence to support the jury's finding of liability. Therefore, the motion for judgment notwithstanding verdict should not have been granted.⁹³

In addition to reversing the verdict, the court ordered a remand because the circuit court did not rule on the appellee's alternative motion for a new trial.⁹⁴ Interestingly, the only mention of Health-General Article § 10-618 appeared in Judge Dan Friedman's dissent.⁹⁵ He concluded the only way for Dr. Bell to meet the standard of care opined by Dr. Cascella would be to involuntarily commit Brandon, and therefore Dr. Bell would enjoy immunity conferred under *Williams*.⁹⁶ The Court of Appeals' upcoming review of the case will provide the court with the ability to reevaluate *Williams* and further shape how physicians treat foreseeably suicidal patients.⁹⁷

II. ANALYSIS

Maryland should recognize that physicians have an affirmative duty to prevent the foreseeable suicide of their patients (potentially through the use of involuntary admissions) and eliminate the current provision of statutory immunity that is provided when this duty is breached. Part II.A of this Comment explores jurisdictional differences in liability for the failure to prevent an individual's suicide from a judicial perspective and posits that the Maryland judiciary should recognize a physician duty to prevent self-harm which, under some circumstances, must be discharged by involuntarily admitting and treating a patient.⁹⁸ The Maryland legislature could reduce medical malpractice litigation, protect patients' right to liberty, and combat unsound involuntary admissions through the adoption of several procedural and substantive safeguards, such as

⁹¹ *Id.* at *3–4. The non-economic damages were reduced to \$695,000 in accordance with the statutory limit. *Id.* The appellees also alternatively motioned for a new trial. *Id.* at *4.

⁹² *Id.* at *5.

⁹³ *Id.*

⁹⁴ *Id.* at *6.

⁹⁵ *Id.* at *6–7.

⁹⁶ *Id.* See *supra*, notes 48–53, and accompanying text.

⁹⁷ 456 Md. 52, 170 A.3d 289 (Table) (Md. 2017).

⁹⁸ See *infra*, Part II.A.

buttressing the dangerousness requirement with a showing of an overt act and narrowing the establishment of proximate cause with a definitive temporal element.⁹⁹ Part II.B then applies this paradigm to *Chance v. Bon Secours Hospital* and proposes setting aside *Williams v. Peninsula Regional Medical Center* to ultimately hold Dr. Bell liable and prevent further expansion of physician immunity following the death of a foreseeably suicidal patient.¹⁰⁰ Part II.C advocates that the Maryland legislature amend the health articles to clearly remove physician immunity following a reckless breach of the duty explored in Part II.A.¹⁰¹ Finally, Part II.D examines the benefits and harms of the standard and changes advocated throughout this analysis and finds that jurisprudence favors saving potential lives over the potentially implicating liberty interests.

A. Preventing Patient Suicide: Foreseeability Creates Liability

When suing for medical malpractice based on the suicide of a patient, the decedent's estate must establish that the physician (1) owed a duty of care to the patient, (2) breached the duty, (3) the breach of duty was the legal and proximate cause of the patient's death.¹⁰² Patients and physicians are parties to a "special relationship" that creates an affirmative duty of care.¹⁰³ Physicians may be found liable for the suicide of their patients where the harm was foreseeable, even if the patient was not in the custody of a treatment facility at the time of death.¹⁰⁴ This attendant liability, however, may encourage physicians to petition for substantially more involuntary admissions than they would otherwise, therefore unnecessarily infringing on preeminent liberty interests.¹⁰⁵ Part II.A.1 surveys how different courts treat the duty owed by physicians to their suicidal patients and Part II.A.2 explores how foreseeability impacts this duty. Finally, Part II.A.3 discusses procedural changes to the involuntary admission process that may reduce unnecessary admissions.

1. Physicians Owe a Duty of Care to Their Patients to Prevent Self-Harm

The special relationship between physicians and their patients is one of the few relationships that create a duty to take affirmative action, which some jurisdictions find includes the duty to protect patients from self-harm.¹⁰⁶ The Sixth Circuit, applying

⁹⁹ See *infra*, Part II.A.3.

¹⁰⁰ See *infra*, Part II.B.

¹⁰¹ See *infra*, Part II.C.

¹⁰² *Crise v. Maryland Gen. Hosp., Inc.*, 212 Md. App. 492, 520–21, 69 A.3d 536, 553 (Md. Ct. Spec. App. 2013) (citing *Sterling v. Johns Hopkins Hosp.*, 145 Md.App. 161, 802 A.2d 440 (Md. Ct. Spec. App. 2002)); *Jacobs v. Flynn*, 131 Md. App. 342, 749 A.2d 174 (Md. Ct. Spec. App. 2000)). The standard of care in Maryland is "the degree of care or skill expected of a reasonably competent health care provider in the same or similar circumstances." *Id.* at 521 (citing *Shilkret v. Annapolis Emergency Hosp. Assoc.*, 276 Md. 187, 349 A.2d 245 (Md. 1975)).

¹⁰³ See *infra*, Part II.A.1.

¹⁰⁴ See *infra*, Part II.A.2.

¹⁰⁵ See *infra*, Part II.A.3.

¹⁰⁶ See *supra*, note 59, and accompanying text.

Tennessee law, in *MacDermid v. Discover Financial Services*,¹⁰⁷ held that there are three scenarios where a wrongful death action following suicide is permitted:

(1) where defendant's negligence causes 'delirium' or 'insanity' that results in self-destructive acts; (2) where defendant is the decedent's custodian, and defendant knows or has reason to know that the decedent might engage in self-destructive acts; [or] (3) where defendant and decedent have a legally recognized 'special relationship,' such as a physician-patient relationship, and defendant knows or has reason to know that the decedent might engage in self-destructive acts.¹⁰⁸

For patients suffering from suicidal thoughts or tendencies, the physician must take appropriate steps to prevent the impending self-harm or risk incurring liability.¹⁰⁹ While this article focuses on involuntary admissions, where appropriate, as one such step in protecting patients, "[t]he duty at issue is not, properly speaking, a duty to involuntarily commit. It is a much broader duty, which may, in particular cases, entail a duty to commit."¹¹⁰

The duty of physicians to protect others is so paramount that the Supreme Court of California extended this duty beyond patients to foreseeable victims of their patients' violence in *Tarasoff v. Regents of University of California*.¹¹¹ This holding indicates that not only is a physician's duty to protect others clearly recognized, but that the action required to protect others in the face of anticipated human-inflicted violence must be a real and calculated attempt to prevent danger. The physicians in *Tarasoff* notified police when the outpatient indicated his desire to kill the decedent, but the court suggested that this action was insufficient and the physicians should have warned the decedent directly.¹¹²

Applying this paradigm to patients suffering from suicidal ideation, the victim would be the patient herself.¹¹³ If the treating physician determines through patient evaluation that the patient exhibits a high likelihood of suicide and the patient meets all statutory

¹⁰⁷ 488 F.3d 721 (6th Cir. 2007).

¹⁰⁸ *Id.* at 736 (citing *Rains v. Rains v. Bend of the River*, 124 S.W.3d 580, 593–94 (Tenn. Ct. App. 2003)). *See also* *Stevens v. MTR Gaming Group, Inc.*, 788 S.E.2d 59, 67 (W. Va. 2016) (“[A]bsent a special relationship between the parties giving rise to a specific duty to prevent the decedent’s suicide, the act of taking one’s own life is generally regarded as a supervening act that breaks the chain of causation”).

¹⁰⁹ *See* *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App. 2012) (holding that “while [the physician had no duty to guarantee that [his patient] did not attempt suicide, he had a long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of ... his patient.”).

¹¹⁰ *Id.*

¹¹¹ 551 P.2d 334, 340 (Cal. 1976) (holding “[w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”).

¹¹² *Id.* at 341.

¹¹³ *See supra*, note 60.

requirements for involuntary commitment, the physician must apply for a commitment to discharge the duty to prevent self-harm.¹¹⁴ The court recognized the inherent privacy concerns that exist when psychiatrists are required to disclose conversations with patients, but found that “public interest in safety from violent assault” outweighed the preservation of “the open and confidential character of psychotherapeutic dialogue.”¹¹⁵ The California Supreme Court, while essentially mandating that physicians take steps to protect even non-patients, noted that this duty should be limited to instances where it is “necessary to avert danger to *others*.”¹¹⁶ However, a patient’s display of suicidal behavior and conduct meeting the requirements for involuntary commitment should outweigh privacy concerns and trigger the duty to prevent the foreseeable suicide.¹¹⁷

Physician liability, like that exhibited in *Tarasoff*, may not be solely predicated on whether the patient was in the custody of a treatment facility.¹¹⁸ Rather than focusing on custody, the analysis should question whether the physician failed to provide the requisite standard of care and whether that breach was a proximate cause of the patient’s suicide.¹¹⁹ California law “recognize[s] 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. . . . Indeed, it would seem almost self-evident that doctors must use reasonable care with *all* of their patients in diagnosing suicidal intent and implementing treatment plans.”¹²⁰ Other jurisdictions, such as Illinois and Hawaii, refuse to find liability in the absence of custody.¹²¹

¹¹⁴ *Tarasoff*, 551 P.2d at 345.

¹¹⁵ *Id.* at 346–47.

¹¹⁶ *Id.* at 346 (emphasis added).

¹¹⁷ *Id.* at 347 (citing CAL. EVID. CODE § 1024 (West 1967)) (finding a statutory exception to the confidentiality privilege where “the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”).

¹¹⁸ Prosenjit Poddar, as an outpatient, was never in civil commitment; he was briefly detained by police and then released from custody. *Id.* at 339.

¹¹⁹ *Edwards v. Tardif*, 692 A.2d 1266, 1270 n.7 (Conn. 1997).

¹²⁰ *Kockelman v. Segal*, 61 Cal. App. 4th 491, 501 (Cal. Ct. App. 1998). However, the court noted it does not “endorse a rule which imposes an absolute duty on a psychiatrist to prevent a patient’s suicide. . . . [O]nly that a psychiatrist’s duty of care to a patient, which may include taking appropriate suicide prevention measures if warranted by all of the circumstances, is not negated by the patient’s status as an outpatient.” *Id.* at 503.

¹²¹ See e.g., *Winger v. Franciscan Med. Ctr.*, 701 N.E.2d 813, 820 (Ill. App. 3d. 1998) (finding liability only where “the [suicide] arose from the plaintiff’s mental state (e.g., severe depression), the act of suicide was foreseeable, and the plaintiff was in the custody or control of the physician or hospital at the time he acted.”); *Lee v. Corregedore*, 925 P.2d 324, 337 (Haw. 1996) (refusing to hold state veterans’ services counselor liable for suicide of outpatient as “[p]ublic 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 a deleterious effect on counseling in general.”).

2. Foreseeability May Require Involuntarily Admission as a Means of Discharging the Duty to Protect Against Self-Harm

When coupled with the special physician-patient relationship, foreseeability of self-harm is the most significant factor in establishing the duty to prevent a patient's suicide and whether the physician's obligation to apply for involuntary commitment is triggered.¹²² Similar to the dangerousness evaluation upon admission, the patient must show signs of suicidal thoughts or tendencies in order for the physician to effectively appreciate her condition and (1) treat her, or (2) unreasonably fail to treat her and be susceptible to liability.¹²³ Where the patient is not exhibiting signs of suicidal thoughts or tendencies, courts are rightfully reluctant to impose liability.¹²⁴

Conversely, where a patient suffers from suicidal ideation or previously attempted suicide, courts may choose to impose liability. One example of the judiciary's willingness to impose physician liability for suicide cases is *Wyke v. Polk County School Board*.¹²⁵ In *Wyke*, a thirteen year old boy twice attempted to commit suicide at school, and his school was aware of the attempts.¹²⁶ After the first attempt, the Dean of Students called the child into his office and recited Bible verses for the student.¹²⁷ The school did nothing after the second attempt.¹²⁸ Unfortunately, no representative of the school system informed the child's mother of the suicide attempts, and he later hanged himself from a tree in the backyard of his home.¹²⁹ The Eleventh Circuit held the school liable for its failure to warn the child's mother, stating:

[The child] did not merely seem unhappy. [He] did not merely talk about committing suicide. He twice tried to hang himself from the rafters in the school's restroom. The workings of the human mind are truly an enigma, but we do not believe ... that a prudent person would have needed a crystal ball

¹²² *Edwards v. Tardif*, 692 A.2d 1266, 1269 (Conn. 1997) (holding "suicide will not break the chain of causation if it was a foreseeable result of defendant's tortious act.").

¹²³ *Jacoves v. United Merch. Corp.*, 11 Cal. Rptr. 2d 468, 478 (Cal. Ct. App. 1992) (stating that "[i]f those who are caring for and treating mentally disturbed patients know of facts from which they could reasonably conclude that the patient would be likely to self-inflict harm in the absence of preventative measures, then those caretakers must use reasonable care under the circumstances to prevent such harm from occurring."); *Runyon v. Reid*, 510 P.2d 943 (Okla. 1973) (holding pharmacist not liable for refilling a non-refillable prescription used by decedent to commit suicide because there was nothing to make the pharmacist aware of the intended use).

¹²⁴ *Fleming v. HCA Health Services of Louisiana, Inc.*, 691 So.2d 1216, 1219 (La. 1997) (holding that where no parties in contact with decedent perceived that he was suicidal, hospital was not liable for his death by suicide where the circumstances did not appear to warrant providing "emergency medical services").

¹²⁵ *Wyke v. Polk Cty. Sch. Bd.*, 129 F.3d 560 (11th Cir. 1997), *certified question withdrawn*, 137 F.3d 1292 (11th Cir. 1998).

¹²⁶ *Id.* at 564–65.

¹²⁷ *Id.* at 564.

¹²⁸ *Id.* at 565.

¹²⁹ *Id.*

to see that [he] needed help and that if he didn't get it soon, he might attempt suicide again.¹³⁰

The *Wyke* court described the special relationship between schools and children, noting that this relationship imposed a supervisory duty.¹³¹ The court further reasoned that the school's duty created an obligation to warn parents whose children experience emergency health problems such as suicidal ideation, explaining that "[t]he failure to discharge those obligations can subject the school to possible liability for reasonably foreseeable injuries."¹³² Notably, the Maryland Court of Appeals came to the same conclusion when it addressed the foreseeability of student suicide: "[f]oreseeability is the most important variable in the duty calculus and without it there can be no duty to prevent suicide."¹³³

The Maryland judiciary should adopt the position taken by jurisdictions that impose liability on a physician who failed to treat a patient with reasonable care when it was foreseeable that the patient would attempt to commit suicide.¹³⁴ Some jurisdictions impose liability even where the state generally treats suicide as an intervening act that breaks the chain of causation. *Edwards v. Tardif* is illustrative.¹³⁵ The Supreme Court of Connecticut noted the common law rule that death by suicide is an unforeseeable act that supersedes a defendant's liability in a wrongful death action.¹³⁶ The court then noted that many jurisdictions do not consider suicide a superseding act "if it was a foreseeable result of the defendant's tortious act" or if "suicide was one of the foreseeable risks that made the physician's antecedent conduct negligent."¹³⁷

Some courts even go so far as to impose liability for a breach of duty in instances where suicide is foreseeable irrespective of the individual's behavior.¹³⁸ For example, the Supreme Court of Idaho imposed physician liability when a patient committed suicide after he was "negligently misinformed...that he was HIV negative and subsequently subjected to the medical negligence of [another doctor]."¹³⁹ Such cases indicate that where self-harm is foreseeable, courts will recognize that affirmatively taking action to

¹³⁰ *Id.* at 574.

¹³¹ *Id.* at 572–73.

¹³² *Id.* at 574.

¹³³ *Eisel v. Bd. of Educ. of Montgomery Cty.*, 324 Md. 376, 386, 597 A.2d 447, 452 (Md. 1991). This case involved a school counselor failing to protect a student from self-harm despite the foreseeability of suicide, and the court ultimately held that "school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent student's suicidal intent." *Id.* at 393.

¹³⁴ See e.g., *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App 2012) (holding physician liable for the failure to involuntarily commit his foreseeably suicidal patient).

¹³⁵ 692 A.2d 1266, 1270 (Conn. 1997).

¹³⁶ *Id.* at 1269.

¹³⁷ *Id.* at 1269–70.

¹³⁸ I.e., where circumstances objectively would create a foreseeable likelihood of suicide, regardless of how the patient subjectively feels or behaves.

¹³⁹ *Cramer v. Slater*, 204 P.3d 508, 516 (Idaho 2009) (applying the Restatement (Second) of Torts § 457 where "subsequent medical negligence is generally foreseeable, including instances where the injury complained of stems from an original negligent act failing to properly diagnose and treat").

protect the patient from suicide is the reasonable course of action and the absence of such action will make the physician susceptible to liability.¹⁴⁰ Circumstances may arise where involuntary commitment is the most reasonable response to foreseeable patient suicide.¹⁴¹ However, across-the-board assignment of liability to physicians who fail to act is undermined by the amorphous and sometimes inaccurate task of diagnosing a potential suicide.¹⁴²

3. Procedural Changes to Balance the Increased Liability Which may Lead to Over-Commitments

The possibility of liability for not treating a patient that subsequently commits suicide may incentivize healthcare providers to unnecessarily commit patients arriving in the hospital on emergency petitions or other seemingly exigent circumstances.¹⁴³ As indicated by the shift to deinstitutionalization in the 1960s and 1970s, the constitutional right to liberty trounces attempts to palliate mental illness with involuntary commitments.¹⁴⁴ The Maryland courts and legislature rightfully emphasized the importance of this right and established procedural safeguards to protect it.¹⁴⁵

Any increase in medical malpractice litigation that has the potential to unnecessarily deprive individuals of their right to liberty warrants a change in procedural due process to counterbalance the harm. Instating a stricter dangerousness requirement is one

¹⁴⁰ See e.g., *Keeton v. Fayette County*, 558 So.2d 884, 887 (Ala. 1989) (explaining that where the “[c]ounty voluntarily undertook a duty beyond that which the law imposed,” it became obligated to act with due care, and therefore was susceptible to liability for the foreseeable suicide of a juvenile in its custody. The court explained that “foreseeability of a decedent’s suicide is legally sufficient ... if the deceased had a history of suicidal proclivities, or manifested suicidal proclivities in the presence of the defendant, or was admitted to the facility of the defendant because of a suicide attempt.”).

¹⁴¹ See *supra*, note 60.

¹⁴² *Maggie Murray, Determining A Psychiatrist’s Liability When A Patient Commits Suicide: Haar v. Ulwelling*, 39 N.M. L. REV. 641, 659 (2009).

¹⁴³ Emergency petitions are the procedural vehicle by which the involuntary admission process begins. See e.g., MD. CODE ANN., HEALTH-GEN. § 10-622(b) (West 2016) (permitting health care professionals that have examined the person, peace officers that have observed the person’s behavior, or “any other interest person” to file an emergency petition for the evaluation of an individual the petitioner believes is mentally ill and poses a danger to self or others); MD. CODE ANN., HEALTH-GEN. § 10-625(a) (West 2016) (mandating that “[i]f an emergency evaluatee meets the requirements for an involuntary admission and is unable or unwilling to agree to a voluntary admission ... the examining physician shall take the steps needed for involuntary admission of the emergency evaluatee to an appropriate facility, which may be a general hospital with a licensed inpatient psychiatric unit.”). For a brief discussion on applications for involuntary admission and petitions for emergency evaluations in Maryland, see *J.H. v. Prince George’s Hosp. Ctr.*, 233 Md. App. 549, 582, 165 A.3d 664, 684 (Md. Ct. Spec. App. 2017).

¹⁴⁴ See *supra*, notes 21–27, and accompanying text.

¹⁴⁵ *Anderson v. Solomon*, 315 F.Supp. 1192 (D. Md. 1970) (identifying procedural deficiencies prior to the adoption of Maryland’s current involuntary admission procedures). These included the lack of: (1) a hearing “at a reasonable point in time;” (2) involvement of an independent agency to look out for the individual’s interests; and (3) physician certification regarding the need for treatment. *Id.* at 1194–95. Following the *Anderson* case, the Maryland legislature implemented new involuntary admission procedures that became effective in 1973. MARR 10.04.03.03G (1974).

such check on erroneous involuntary admissions. Currently, under § 10-617(a) of the Health—General Article, a physician may only involuntarily admit a patient if the patient fulfills five criteria. For example, “the individual [must] present[] a danger to the life or safety of the individual or of others.”¹⁴⁶ The statutes governing involuntary admissions, however, are silent as to the degree of dangerousness required.¹⁴⁷ As a counterbalance, Maryland could adopt the overt act requirement as evidence that the individual poses a danger to self or others, or heighten the evidentiary standard to clear and convincing.¹⁴⁸ Requiring a clearer showing of dangerous behavior or intentions reduces the risk that a physician will unnecessarily commit patients on an involuntary basis.¹⁴⁹ For example, under Alabama law, a physician must present clear and convincing evidence to support an involuntary commitment, or “conclud[e] that continued custody is necessary.”¹⁵⁰

If the dangerousness requirement were to be narrowed so far as to only be satisfied by an executed violent act, involuntary admissions may become under inclusive and inadvertently “superimpos[e] criminal concepts into the civil commitment proceedings.”¹⁵¹ In an amicus brief for *Addington v. Texas*¹⁵² the American Psychiatry Association (“Association”) advocated against tightening the dangerousness requirement.¹⁵³ The Association asserted that “one dramatic result of [narrowing the dangerousness standard] has been that many seriously mentally ill people have ‘escaped’ civil commitment only to find themselves abandoned by society,” and that this could be

¹⁴⁶ MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016). The other four criteria are: “(1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; [3] the individual is unable or unwilling to be admitted voluntarily; [and (4)] there is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.” *Id.* This must also be certified by one physician and either a psychologist or psychiatric nurse practitioner, or two physicians, and then later reviewed at a hearing before an administrative law judge if the patient remains in treatment for ten days. MD. CODE ANN., HEALTH-GEN. § 10-615 (West Supp. 2015).

¹⁴⁷ *In re J.C.N.*, No. 1021, 2017 WL 3634282, at *5 (Md. Ct. Spec. App. Aug. 24, 2017) (remarking that since the type of harm required to satisfy the dangerousness requirement is unspecified, the standard of proof during an administrative hearing is substantial evidence, rather than clear and convincing evidence).

¹⁴⁸ See e.g., CAL. WELF. & INST. CODE § 5300(c) (West Supp. 1983); MINN. STAT. ANN. § 253B.02 (West Supp. 2017). See also Zachary Groendyk, “It Takes A Lot to Get into Bellevue”: A Pro-Rights Critique of New York’s Involuntary Commitment Law, 40 FORDHAM URB. L.J. 549, 576–78 (2012) (surveying Circuit court differences on the degree of dangerousness required to involuntarily commit mentally ill individuals).

¹⁴⁹ David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 247 (1984) (analyzing jurisdictional differences in the dangerousness requirement and finding that most “have a more relaxed standard which merely requires evidence that the individual poses a substantial risk of harm to himself or others.”).

¹⁵⁰ ALA. CODE § 22-52-37 (West 1975).

¹⁵¹ *Project Release v. Prevost*, 551 F. Supp. 1298, 1305 (E.D.N.Y. 1982), *aff’d*, 722 F.2d 960 (2d Cir. 1983).

¹⁵² *Addington v. Texas*, 441 U.S. 418 (1979).

¹⁵³ Brief for American Psychiatry Ass’n as Amici Curiae Supporting Respondents at 8, *Addington v. Texas*, 441 U.S. 418 (1979) (No. 77-5992).

lessened by relaxing the standard of proof to prevent “effectively shut[ting] the door on the sensible application of *parens patriae* civil commitment.”¹⁵⁴ In *Addington*, the Supreme Court ultimately held that “given the uncertainties of psychiatric diagnosis,” the constitutional minimum is a “greater than the preponderance-of-the-evidence standard” because a higher standard may prevent states from providing their residents with crucial mental health treatment.¹⁵⁵ Additionally, studies indicate that physicians often fail to honestly adhere to the dangerousness requirement and “will use an assessment of dangerousness as a post-hoc justification for treatment.”¹⁵⁶

Calls for increased medical malpractice litigation are further tempered by the challenge of establishing proximate cause between failure to involuntarily commit a patient and the subsequent suicide. The Maryland judiciary may elect to impose liability only if a short period of time passes between the patient’s release and suicide (for example, forty-eight hours).¹⁵⁷ Where the time frame is longer, the link between the release and death would be attenuated and unlikely to establish liability.¹⁵⁸

Furthermore, Maryland requires expert testimony by other physicians when assessing duty breaches in medical malpractice actions, which are currently based on a negligence standard.¹⁵⁹ By requiring expert testimony, the physician’s actions are less likely to be inadvertently scrutinized by the jury based on a reasonable person standard. Instead, the expert clarifies whether the conduct was appropriate given “the degree of care or skill expected of a reasonably competent health care provider in the same or similar circumstances.”¹⁶⁰

¹⁵⁴ *Id.* at 8–9.

¹⁵⁵ *Addington*, 441 U.S. at 432–33.

¹⁵⁶ William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 279–80 (2010).

¹⁵⁷ *Chance v. Bon Secours Hospital*, No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017) (death occurred the day after release); *Williams v. Peninsula Reg’l Med. Ctr.*, 440 Md. 573, 103 A.3d 658 (Md. 2014) (death occurred the same day as release); *Foster v. Charter Med. Corp.*, 601 So. 2d 435, 438 (Ala. 1992) (death occurred hours after release); *Tabor v. Doctors Memorial Hosp.*, 563 So.2d 233 (La. 1990) (death occurred the day after release).

¹⁵⁸ *Farwell v. Un*, 902 F.2d 282, 290 (4th Cir. 1990) (refusing to find proximate cause for a physician’s failure to prevent a patient’s suicide that occurred nine days after the physician originally treated him).

¹⁵⁹ *See supra*, note 102.

¹⁶⁰ *See supra*, note 102. *See also* *Almonte v. Kurl*, 46 A.3d 1, 19 (R.I. 2012) (stating that “expert testimony was necessary to inform the fact-finder as to an expert’s opinion concerning whether or not [the physician’s] failure to commit [the patient] was a proximate cause of his death by suicide.”); *Thompson v. Patton*, 6 So.3d 1129, 1141–42 (Ala. 2008) (remarking that “proximate causation in this case was not an issue that could be determined without expert testimony.”); *Wilkins v. Lamoille County Mental Health Services, Inc.*, A.2d 245, 252 (Vt. 2005) (holding “that the standard-of-care and causation elements of professional negligence claims . . . be proved by expert testimony, and this is no less true of claims relating to the negligent treatment or assessment of patients at risk of committing suicide.” (citation and internal quotation marks omitted)); *Estate of Joshua T. v. State*, 840 A.2d 768, 772 (N.H. 2003) (“Assessing the causal link between [negligence] and [an adolescent patient’s] death, without the assistance of expert testimony, is simply beyond the capacity of an average juror and would amount to speculation, especially considering [the patient’s] self-destructive behavior and suicide attempts”); *Moats v. Preston County Commission*, 521 S.E.2d 180,

The failure to involuntarily admit a foreseeably suicidal individual should be adjudicated based on a reckless failure to act standard rather than a negligence or gross negligence standard. Physicians cannot be expected to prevent all patients' suicide attempts; they must retain the leeway to make decisions based on their best medical judgment without pressure to involuntarily commit a patient solely to avoid liability.¹⁶¹ By requiring a higher level of injurious conduct to predicate fault, a physician is less likely to be found liable for merely misdiagnosing the patient or releasing the patient based on a spurious belief that the patient's condition sufficiently improved.¹⁶²

B. Application to Chance and Inapplicability of Williams

1. Dr. Bell Breached the Duty of Care Owed to Brandon When He Released Him and Therefore Chance v. Bon Secours Hospital Should Be Affirmed

The Court of Appeals should affirm *Chance v. Bon Secours Hospital* and find that Dr. Bell's failure to keep decedent Brandon Mackey in treatment was a breach of duty, significantly contributing to his death.¹⁶³ Dr. Bell was the primary physician treating Brandon each time he was committed to Bon Secours Hospital; he diagnosed Brandon with two different mental illnesses and prescribed an antipsychotic medication that takes weeks to become effective.¹⁶⁴ Dr. Bell was aware of Brandon's condition and, as Dr. Cascella testified, it was likely that Brandon still suffered from suicidal ideation after only three days on the medication Risperdal.¹⁶⁵ Given Brandon's history of mental illness and the unreasonably short amount of time that Brandon was committed, it was foreseeable that he would once again attempt to commit suicide after being released.¹⁶⁶ Even if Maryland adopted the overt act requirement, Brandon's case still warranted

188 (W. Va. 1999) (remarking that "[t]his case involves complicated medical issues, specifically, the manner and method of protecting someone who is suicidal. While there may be some circumstances where an expert is not needed, such as where a loaded gun is left in the presence of a mentally-ill person, that is not the case here. [Health center's] potential liability arises from its duties in relation to the involuntary commitment process. Despite the plaintiff's attempt to characterize this case as simply a failure to report [the patient's] suicidal tendencies, we believe that determining whether [health center] deviated from the standard of care involves more complex issues that are not within the common knowledge of lay jurors."); *Edwards v. Tardif*, 692 A.2d 1266, 1269 (1997) (requiring expert testimony to establish medical malpractice following the suicide of a patient); *Kanter v. Metropolitan Medical Center*, 384 N.W.2d 914, 916 (Minn. Ct. App. 1986) (noting "[i]n a psychiatric ward the potential tendencies of patients suffering from mental illness are not so easily determined by one without special training and knowledge.").

¹⁶¹ *Champagne v. United States*, 513 N.W.2d 75, 79 (N.D. 1994) (noting "medical providers are not insurers; their duty is to act reasonably under the circumstances of each case.").

¹⁶² *Chance v. Bon Secours Hospital* was adjudicated on a negligence standard. No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017).

¹⁶³ *Id.* at *6 (reversing trial court grant of motion for judgment notwithstanding the verdict in favor of respondents and remanding "for disposition of the alternative motion for a new trial.").

¹⁶⁴ *Id.* See also, note 88.

¹⁶⁵ *Chance*, slip op. at *3.

¹⁶⁶ *Id.* at *5. Mary C. Barovica, *Fact Sheet*, NATIONAL ALLIANCE ON MENTAL ILLNESS 6 (Feb. 2007), <http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Risperdal.pdf> (estimating that "improvement of some symptoms may be noticed in some patients within a few weeks. The full benefit ... may not be seen for 4–6 weeks.").

involuntary admission because his pre-admission behavior¹⁶⁷ demonstrated that he posed a danger to himself.¹⁶⁸ Brandon's suicide a day after discharge, combined with Dr. Cascella's expert testimony, established that Brandon's early release from treatment caused his death and indicated that Dr. Bell's conduct did not meet the standard of care owed to his patient.¹⁶⁹

2. *Williams Should Be Overruled or Differentiated from Chance*

Williams v. Peninsula Regional Medical Center should be overruled because the Maryland General Assembly only intended to provide a liability exemption to physicians making an affirmative decision to involuntarily admit a patient; thus, Dr. Bell is not immune. The *Williams* court instructed that "[t]he cardinal rule of statutory interpretation is to ascertain and effectuate the intent of the Legislature." Following this analysis, the court determined that the legislature intended physician immunity to "extend beyond a decision to admit" and also encompassed the decision not to admit.¹⁷⁰ In analyzing the legislative intent, the court read the relevant provisions in conjunction with the entire involuntary admissions section of the Maryland mental health laws, concluding "that the General Assembly referred to all of Part III, including restrictions on admittance [in § 10–617], when establishing the prerequisites to qualifying for immunity, demonstrates its intent that the immunity extend beyond a decision to admit."¹⁷¹

The court's analysis, however, fails to address a significant dissimilarity between CJP § 5-623(b) and subsections (c) and (d). Subsection (b), plainly and in conjunction with subparts (c) and (d), indicates that the Maryland General Assembly intended for physician immunity to exclude actions beyond a physician's affirmative choice to involuntarily admit a patient.¹⁷² CJP § 5-623 states, in part:

(b) A person who in good faith and with reasonable grounds applies for involuntary admission of an individual is not civilly or criminally liable

¹⁶⁷ Brandon slit his wrists prior to his first admission and made another suicide attempt that led to his second admission. *Chance*, slip op. at *1.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at *5.

¹⁷⁰ *Id.* at 580, 583 (quoting *Kushell v. Dep't of Natural Res.*, 385 Md. 563, 576, 870 A.2d 186, 193 (2005)). First, the court looked to the canons of statutory construction and stated: "[W]e begin with the normal, plain meaning of the language of the statute. If the language of the statute is unambiguous and clearly consistent with the statute's apparent purpose, our inquiry as to legislative intent ends ordinarily and we apply the statute as written, without resort to other rules of construction.... We, however, do not read statutory language in a vacuum, nor do we confine strictly our interpretation of a statute's plain language to the isolated section alone. Rather, the plain language must be viewed within the context of the statutory scheme to which it belongs, considering the purpose, aim, or policy of the Legislature in enacting the statute." *Id.* at 580–81 (quoting *Lockshin v. Semsler*, 412 Md. 257, 275–76, 987 A.2d 18, 28–29 (Md. 2010)).

¹⁷¹ *Id.* at 582–83.

¹⁷² MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014). *See also* MD. CODE ANN., HEALTH-GEN. § 10-618 (West 2016) (granting immunity to anyone that "applies for involuntary admission of an individual ... under § 5-623(b) of the Courts and Judicial Proceedings Article").

for making the application under Title 10, Subtitle 6, Part III of the Health-General Article.

(c) A facility or veterans' administration hospital that, in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action.

(d) An agent or employee of a facility or veterans' administration hospital who, in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action.¹⁷³

Subsection (b) specifically addresses any individual that applies to involuntarily admit a patient into treatment. The legislature intended to insulate applications for involuntary admission from legal consequences. If, as the Court of Appeals held, subsection (b) should be interpreted in light of subsections (c) and (d), and thus provide immunity for the same actions, then subsection (b) effectually would provide immunity for "compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article."¹⁷⁴ The *Williams* court stated that "a health care provider acts in compliance with Part III when a good faith evaluation leads to commitment, but it also acts in compliance with Part III when the conclusion of a good faith evaluation is that a less restrictive form of intervention than commitment is warranted."¹⁷⁵ If compliance with Part III is the decisive factor in determining physician liability, then the legislature would have worded subsection (b) to contain the "who acts in compliance with...Part III" language found in the other provisions instead of singling out the affirmative choice to seek an involuntary commitment. If subsection (b) was intended to grant immunity to anyone "who acts in compliance with...Part III," the legislature would not have differentiated the choice to apply for an involuntary admission from all other involuntary admission provisions. Rather, the legislature could have simply written a single subsection that states: "Any party, including a facility or veterans' administration hospital and their agents and employees, who in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action."

By adding subsection (b), the choice to apply for involuntary admission was removed from subsections (c) and (d); otherwise physicians would receive immunity under the Court of Appeals determination that subsection (d) protects physician discretion as in compliance with Part III.¹⁷⁶ The rationale that they are differentiated in order to sever the parties—hospitals and their agents/employees from public actors—also fails.¹⁷⁷ If

¹⁷³ MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014).

¹⁷⁴ *Id.*

¹⁷⁵ *Williams*, 440 Md. at 583 (quoting *Williams v. Peninsula Reg'l Med. Ctr*, 213 Md.App. 644, 75 A.3d 359 (Md. Ct. Spec. App. 2013)).

¹⁷⁶ *Id.* at 584.

¹⁷⁷ Subpart (b) addresses "anyone" while (c) and (d) address facilities, veterans' administration hospitals, and their agents and employees.

the legislature meant to separate physician actors from public actors, physician actions would receive immunity under subsection (d), not subsection (b). It is highly unlikely that the General Assembly contemplated this distinction because subsection (d) exempts agents and employees of mental health facilities and veterans' administration hospitals from liability. If lawmakers meant to make the hospital personnel–public distinction, contractor physicians would fall on the public side since they are independent actors (not agents or employees).¹⁷⁸ By separating “any party” in subsection (b) from “facilities” in subsection (c) and “medical personnel” in subsection (d), lawmakers intended to provide immunity to all actors with an interest in applying for an involuntary admission. The legislature denied physicians broad immunity under subsection (d), leaving the door open for medical malpractice suits based on the failure to admit a patient. The General Assembly could have insulated physician discretion several ways if it intended to do so by including language in subsection (b) that indicated the choice to not admit was likewise protected, using the familiar “acts in compliance with...Part III” language, stating in subsection (d) that compliance with Part III includes discretion on admission determinations, or creating one all-encompassing provision whereby everyone is immune. The Assembly's failure to do so demonstrates intent to expose admission denials amounting to a breach of care to liability.

Rather than overrule *Williams*, the Court of Appeals may elect to distinguish it from *Chance*. In *Williams*, the court extended immunity to the physician based on the apparent purpose of CJP § 5-623. The court stated that CJP § 5-623 protects physician discretion to involuntarily admit mentally ill patients.¹⁷⁹ However, *Chance* did not involve Dr. Bell's choice to admit Brandon. *Williams* differs because Brandon was already in treatment, but received an early release despite a new diagnosis and medication regimen.¹⁸⁰ The physician in *Williams* evaluated the decedent in a triage setting, failing to fully appreciate the seriousness of his patient's condition. His decision against admittance was nonetheless protected because, per the Court of Appeals, shielding physician discretion is a critical matter of public policy and the apparent intent behind CJP § 5-623.¹⁸¹ In contrast, Brandon was already involuntarily admitted when Dr. Bell evaluated him outside of an emergency room or any other exigent circumstances such as in *Williams*.¹⁸² Dr. Bell's breach of duty did not arise in relation to Brandon's admittance into treatment. Instead, the breach occurred in relation to Brandon's discharge; the Court of Appeals may find this factor dispositive in the inapplicability of *Williams* and, therefore, choose to not further extend immunity.¹⁸³ The provision plainly confers immunity for the affirmative decision to involuntarily admit mentally ill patients and *Williams* protects the decision not to admit them. If *Williams* were applied here, *Chance* would stand for an entirely different protected action not contemplated by the legislature—the choice to release

¹⁷⁸ MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014).

¹⁷⁹ 440 Md. 573, 584, 103 A.3d 658, 665 (Md. 2014).

¹⁸⁰ See *supra*, notes 167 and 168.

¹⁸¹ *Williams*, 440 Md. at 584.

¹⁸² See *supra*, note 167.

¹⁸³ See *supra*, note 171.

a patient prematurely.¹⁸⁴ As such, Dr. Bell's conduct should be susceptible to liability because *Williams* is not applicable when determining liability for a physician's decision to prematurely release patients from treatment.

C. Prioritize Patient Life and Amend CJP § 5-623

Amending CJP § 5-623 to clearly withhold immunity from physicians that breach the standard of care owed to foreseeably suicidal patients will likely preserve the lives of Maryland residents suffering from suicidal ideation. While the liability attendant to stripping this immunity creates an increased risk of erroneously involuntarily admitting patients, changes to the front end of mental health treatment and services will reduce this potential for error.¹⁸⁵ By adopting a clear position on involuntary admissions, the Maryland legislature would save the judiciary from having to balance the benefits and harms of such treatment.¹⁸⁶ This, in turn, would provide definite expectations in the standard of care that physicians owe Maryland residents suffering from suicidal ideation and provide recourse to decedents' families when this duty is breached.¹⁸⁷

1. Legislative Over-Commitment Concerns Should be Resolved with Increased Community Mental Health Resources

Endeavoring to ward off medical malpractice suits, the legislative change suggested above may make physicians more susceptible to liability and compel them to more frequently apply for involuntary admissions.¹⁸⁸ Adopting changes to outpatient care may prevent a spike in involuntary admission applications and reduce the number of mentally ill individuals arriving in the emergency room. The Maryland Department of Health offers several community services for mental health, including group homes, psychiatric rehabilitation services, and outpatient mental health clinics.¹⁸⁹ By increasing the availability of community based treatment centers, mentally ill individuals can seek help in unrestricted environments.¹⁹⁰ In particular, additional group homes would significantly reduce the number of involuntary commitments. Homeless mentally ill individuals are repeatedly cycled through commitment—known as the revolving door

¹⁸⁴ MD. CODE ANN., CTS. & JUD. PROC. § 5-623(b) (West 2014). *See supra*, notes 174–180, and accompanying text.

¹⁸⁵ *See infra*, Part II.C.1.

¹⁸⁶ *See infra*, Part II.C.2. *See also* David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 242 (1984) (advocating that the legislature, not the judiciary, is the appropriate party to address “existing overinclusiveness and underinclusiveness problems.”).

¹⁸⁷ *Id.*

¹⁸⁸ *See supra*, notes 142–144, and accompanying text.

¹⁸⁹ *Mental Health*, MD DEP'T OF HEALTH, MARYLAND.GOV (last visited Nov 4, 2017), <https://health.maryland.gov/ohcq/mh/Pages/home.aspx>.

¹⁹⁰ The importance of available outpatient care and alternative treatment options is reflected in the statutory mandate that a mentally ill patient be involuntarily admitted only if there is not available less restrictive alternative. *See supra*, note 43.

problem—and are often unable to find placement in assisted living units due to lack of funding, forcing hospitals to temporarily provide for their care.¹⁹¹

Alternative options include moving the administrative hearing up from ten days, or implementing an administrative review very early in the hospitalization process.¹⁹² Another way to stave off unnecessary involuntary admissions is through the adoption of a case management system. The system would ensure the availability of an impartial third party during a suicidal patient's hospital stay, providing an administrative party that could help locate less restrictive environments or other treatment resources if the patient's condition progresses to no longer warrant involuntary admission.¹⁹³ Because Maryland permits an emergency facility to hold an emergency evaluatee for up to thirty hours, the provision of a case manager could significantly reduce involuntary admissions by readily providing administrative intervention and easing the search for alternative resources prior to the patient's formal involuntary admission.¹⁹⁴ This would decrease the likelihood of litigation because (1) accessible treatment creates less need for involuntary commitment, and (2) Maryland courts are highly unlikely to impose liability on a physician following the death of an outpatient.¹⁹⁵

2. The Maryland Legislature Should Adopt a Clear Position on Involuntary Admissions Because Deprivation of Liberty and Potential for Death are Issues Too Sensitive to be Decided by the Court System

Relying on the judicial system to determine the obligations and immunities of health care professionals when treating suicidal patients impermissibly threatens the lives of Maryland residents by establishing the standard of care post-hoc and failing to strike the balance desired by the Maryland General Assembly and Maryland residents.¹⁹⁶ Similar

¹⁹¹ Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 48–49 (2014) (noting that “the revolving door problem” is the result of a lack of funding and “resources in state mental health systems [that cannot] support the needs of an expanding population of deinstitutionalized outpatients.”); U.S. DEP’T OF HOUS. AND URBAN DEV., OFF. OF CMTY. PLANNING AND DEV., THE 2010 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS 18 (2011), <https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf> (estimating that over a quarter of people living in homeless shelters suffer from serious mental illnesses).

¹⁹² MD. CODE ANN., HEALTH-GEN. § 10-615 (West Supp. 2016).

¹⁹³ This would particularly suit the homeless, non-dangerous population that routinely gets cycled through the hospital rather than placed in an environment that treats not only their mental health but also meets their housing needs. Boldt, *supra* note 191, at 48–49.

¹⁹⁴ MD. CODE ANN., HEALTH-GEN. § 10-624(b)(4) (West 2014).

¹⁹⁵ MD. CODE ANN., HEALTH-GEN. § 10-617(a)(5) (West 2016) (forbidding the involuntary admission of a mentally ill individual if there is a less restrictive alternative treatment available); *Eisel v. Bd. of Educ. of Montgomery Cty.*, 324 Md. 376, 382, 384 (Md. 1991) (stating “[l]iability against therapists for outpatient suicides is rarely imposed ... and some commentators have suggested that liability under these circumstances should never be imposed.” While the counselor in this case was found liable, the court distinguished this scenario from cases where a patient commits suicide while in the custody of a treatment facility, and found dispositive that the victim was an adolescent and had her father been warned, “he could have exercised his custody and control, as parent,” and prevented her death).

¹⁹⁶ This is particularly evidenced in *Williams* where the Court of Appeals based part of its reasoning on a historical analysis of the legislative proposals to the involuntary admission process. 440 Md.

to the concern in three New Jersey companion cases addressing the constitutionality of forced life-sustaining medical care, Maryland's General Assembly should address the use of involuntary admissions in an attempt to preserve the lives of suicidal patients.¹⁹⁷ In *Matter of Farrell*,¹⁹⁸ the Supreme Court of New Jersey was reluctant to address the delicate issue sub judice and aptly stated:

Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law,...medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.¹⁹⁹

The serious consequences associated with involuntary admissions include shifting mentally ill people into the criminal justice system, forcing physicians to experience cognitive dissonance, and harrowing the boundary between autonomy and life. Instead of allowing the court to scrutinize these factors in an ad hoc court setting, the Maryland legislature must examine and factor these concerns into a scrupulous law that establishes a set of expectations for both physicians and patients.²⁰⁰

D. The Balance Between the Competing Interests and Harms Favors Physician Liability for The Failure to Not Utilize Involuntary Admissions to Treat Foreseeably Suicidal Patients

The current statutory scheme, combined with the physician immunity conferred under *Williams v. Peninsula Regional Medical Center*, fails suicidal patients and their families because it results in higher rates of suicide and bars families from bringing wrongful death claims. When a family member suffers from a severe mental illness that perverts their cognizance of reality and impedes their ability to seek help, available treatment options are limited to: (1) persuading the sick family member to voluntarily admit themselves into inpatient treatment; (2) filing an emergency petition to get the sick family member evaluated at a hospital and applying for involuntary admission if the sick family member meets admission criteria; (3) attempting to cajole the sick

573, 584–86 (Md. 2014).

¹⁹⁷ *Matter of Farrell*, 529 A.2d 404 (N.J. 1987); *Matter of Peter*, 529 A.2d 419 (N.J. 1987); *Matter of Jobe*, 529 A.2d 434 (N.J. 1987).

¹⁹⁸ *Matter of Farrell*, 529 A.2d 404 (N.J. 1987).

¹⁹⁹ 529 A.2d 404, 408 (N.J. 1987) (quoting *In re Conroy*, 486 A.2d 1209 (1985) (alteration in original)). The court ultimately held that the right to self-determination is paramount when the patient is competent and informed. *Id.* at 412.

²⁰⁰ Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 *PSYCHIATRY* 30, 31, 38 (2010) (asserting that psychiatrists, when contemplating involuntarily committing their patients, must balance beneficence with nonmaleficence, including respect for autonomy on one hand and the “grave need of treatment” on the other, whereby repercussions arise such as “a shift of people with mental illness from asylums to prisons, and creation of an epidemic of homelessness among persons with mental disorders” when civil commitments give way to deinstitutionalization).

family member into outpatient care; or (4) doing nothing.²⁰¹ However, convincing an individual suffering from depression and suicidal ideation to voluntarily seek inpatient or outpatient treatment becomes less likely as the mental illness becomes more profound.²⁰² When a foreseeably suicidal patient commits suicide shortly following discharge, in addition to the devastating loss of life, the family is unlikely to recover through litigation or insurance because suicide typically renders an insurance contract void.²⁰³

On the other hand, liberty should not be casually implicated because it is a fundamental constitutional right.²⁰⁴ The liberty interest includes freedom from custody, freedom from “stigmatizing consequences” and freedom from “mandatory behavior modification as a treatment for mental illness.”²⁰⁵ Jurisprudence demands use of involuntary commitments only where the interest of the state in preserving life outweighs the individual’s right to freedom and self-determination.²⁰⁶ The state, however, has an interest in also *reducing* the number of hospital admissions in order to curtail Medicaid spending, limit medical malpractice insurance payouts, and preserve judicial and mental health resources for “cases of genuine need.”²⁰⁷ Moreover, insulating physician discretion—and reducing the risk of unnecessary involuntary admissions—allows physicians to work without making decisions based solely on the desire to avoid liability.²⁰⁸ Notably, there are large discrepancies in the accuracy of psychiatric dangerousness predictions; physicians are

²⁰¹ *Id.* at 31 (observing that “[w]hen an individual is suffering from a severe mental illness that grossly distorts his perception of reality, it is often clear that he or she has lost the usual capacity for making decisions in his or her best interest.”). Maryland is one of few states that does not offer outpatient commitment as a treatment option. Boldt, *supra* note 191, at 81.

²⁰² See *infra*, text accompanying note 86. This is increasingly less likely to be successful if the individual is homeless, lacking a familial support system, and without means to afford care or transportation to treatment facilities. See *supra*, Boldt, note 191.

²⁰³ *Williams*, 440 Md. at 584; *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 286 (1876) (holding that “[i]f [insurance companies] are at liberty to stipulate against hazardous occupations, unhealthy climates, or death by the hands of the law, or in consequence of injuries received when intoxicated, surely it is competent for them to stipulate against intentional self-destruction, whether it be the voluntary act of an accountable moral agent or not.”); *Fister ex rel. v. Allstate Life Ins. Co.*, 366 Md. 201, 211, 783 A.2d 194, 200 (Md. 2001) (stating “[t]he Maryland Legislature enacted a provision which forbids insurance companies from excluding policy coverage for deaths caused in a specified manner except under five specific circumstances, of which suicide is one.”).

²⁰⁴ *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972) (vacated on other grounds) (holding “[t]he power of the state to deprive a person of the fundamental liberty to go unimpeded about his or her affairs must rest on a consideration that society has a compelling interest in such deprivation.”).

²⁰⁵ *Vitek v. Jones*, 445 U.S. 480, 494 (1980).

²⁰⁶ See *supra*, notes 21–32, and accompanying text.

²⁰⁷ *Parham v. J. R.*, 442 U.S. 584, 604 (1979); Cynthia Shirk, *Medicaid and Mental Health Services* 3 (Nat’l Health Policy Forum, Background Paper No. 66, 2008), https://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf (“Medicaid is the largest payer of mental health services in the United States”).

²⁰⁸ *Williams v. Peninsula Reg’l Med. Ctr.*, 440 Md. 573, 584, 103 A.3d 658, 665 (Md. 2014) (“Cloaking health care providers in immunity both when they decide in favor of and when they decide against admittance amounts to sound public policy, consistent with the General Assembly’s intent.”).

not insurers of an individual's behavior.²⁰⁹ As the *Williams* court aptly pointed out, the involuntary commitment process would not have rigorous requirements if physicians were encouraged "to err on the side of involuntary admittance in order to receive statutory immunity and avoid liability."²¹⁰

Implication of the liberty interest, however, is protected with "layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected."²¹¹ Even when the state has an interest in civilly committing a mentally ill individual, the state must nonetheless protect the patient's due process rights. In *Addington v. Texas*²¹² the Supreme Court recognized that:

One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed.²¹³

By providing physicians who fail to involuntarily commit foreseeably suicidal patients with a liability exemption, Maryland falls short in protecting its mentally ill population.²¹⁴ While freedom from restraint should be safeguarded, the countervailing interests in preserving life and providing mental health treatment are paramount.²¹⁵ Adoption of robust procedural safeguards will protect patients' liberty interests while providing physicians the necessary flexibility to involuntarily commit suicidal patients.²¹⁶ Under the protection of these procedural safeguards, the reckless failure to use involuntary admissions as a treatment option, where reasonably required, should qualify as a breach of physician duty of care.

III. CONCLUSION

Physicians have a special relationship with their patients that create a duty to protect them from self-harm. Physicians may discharge this duty by applying suicidal patients for involuntary admission.²¹⁷ Foreseeability of suicide is the strongest factor triggering use

²⁰⁹ Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 21–22 (1999).

²¹⁰ *Williams*, 440 Md. at 587, 103 A.3d at 666 (Md. 2014).

²¹¹ *Addington v. Texas*, 441 U.S. 418, 428–29 (1976).

²¹² *Id.*

²¹³ *Id.* at 429 (internal citations omitted).

²¹⁴ Some commentators argue that not imposing the duty advocated throughout this article "would be 'tantamount to strict non-liability.' ... [whereby a physician] could intentionally fail to treat the [patient] without any legal consequences." See Murray, *supra* note 142, at 661 (internal citations omitted).

²¹⁵ See *supra*, notes 50–58, and accompanying text.

²¹⁶ Additional safeguards than those previously explored throughout this article include "a guardian ad litem appointment, professional recommendations, open hearings, and the usually well-seasoned perspective of the probate judge." Judge Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIAC PROB. L.J. 36, 38 (2006).

²¹⁷ See *supra*, Parts I.A.1.

of involuntary admissions over less restrictive treatment options. Failure to involuntarily admit a suicidal patient, or continue admittance for a patient still at risk of suicide, should result in liability adjudicated under a recklessness standard.²¹⁸ While this duty increases the risk of erroneous involuntary admissions, lawmakers can mitigate this risk by finding proximate cause only in cases where the suicide occurred a short time after the patient's release from care and through the adoption of procedural changes, including quick performance of the patient's administrative hearing and creation of an administrative case manager for each potentially suicidal patient.²¹⁹ The present statutory scheme in Maryland provides liability exemption to anyone that applies for involuntary admission. *Williams v. Peninsula Regional Medical Center* extends the exemption to include physicians that elect not to admit patients.²²⁰ The Court of Appeals, however, should not apply *Williams* to *Chance v. Bon Secours Hospital*. The General Assembly did not intend to create this immunity, and *Williams* applies to the choice not to admit while *Chance* is about early release from admission.²²¹ In *Chance*, the physician violated the standard of care owed to his patient by releasing him after only three days on a new, slow-acting medication regime. Additionally, the physician's decision to release his patient ignored the patient's two recent suicide attempts and new mental illness diagnosis. Considering these facts, the Court of Appeals should affirm the Court of Special Appeals and find that Dr. Bell was negligent.²²²

The Maryland legislature should amend CJP § 5-623 to affirmatively recognize the duty to prevent a patient from foreseeably committing suicide and remove the existing liability exemption for physicians recklessly breaching their duty of care by failing to involuntarily commit a suicidal patient.²²³ This legislative change would prevent further ad hoc judicial influence altering the standard of care owed to mentally ill patients. The legislative modification should be accompanied by improvements to outpatient mental health services in order to offer treatment options better suited to meet the needs of Maryland residents.²²⁴ While the constitutional right to freedom demands preservation, interests in preserving life, providing mental health treatment, and protecting existing procedural safeguards eclipse the risk of erroneous commitments and override the right to self-determination where the patient is foreseeably suicidal.²²⁵

²¹⁸ See *supra*, Parts I.A.2.

²¹⁹ See *supra*, Parts I.A.2.

²²⁰ See *supra*, notes 76–82, and accompanying text.

²²¹ See *supra*, Parts II.B.1 and II.B.2.

²²² See *supra*, Part I.A.3.

²²³ See *supra*, Part II.C.

²²⁴ See *supra*, Parts II.C.1 and II.C.2.

²²⁵ See *supra*, Part II.D.