IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Docket No. 20-0750

CHRISTOPHER MORRIS, individually and as Administrator of the ESTATE OF AMY CHRISTINE WADE,

Plaintiff Below, Petitioner,

v.

Case No. 20-0750
(On Appeal from Circuit Court of Ohio County, Civil Action No. 20-C-140)

STEVEN CORDER, M.D; MELANIE BASSA, M.A.; MARTHA DONAHUE, N.P.; NORTHWOOD HEALTH SYSTEMS, INC.; MID-VALLEY HEALTHCARE SYSTEMS, INC.; and JOHN DOES 1-5,

Defendants Below, Respondents.

PETITIONER'S BRIEF

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INTRODUCTION

Recognizing that West Virginians are entitled to receive quality medical care and facilities, the West Virginia Medical Professional Liability Act ("MPLA") protects those who suffer injury or death from negligent conduct of health care providers. W. Va. Code § 55-7B-1. The circuit court's order in this case strips these critical MPLA entitlements and protections from one particularly vulnerable group, those suffering from mental illness so severe that they are driven to take their own lives.

According to the circuit court's order, the only situation in which a health care provider's negligent act can constitute the proximate cause of a patient's suicide is if: (1) the decedent patient was in the health care provider's custodial care at the time of the suicide, (2) the health care provider knows that the potential for suicide exists, and (3) if the health care provider fails to take measures to prevent the suicide. (JA0212-213) Applying the circuit court's reasoning, health care providers may deviate from even ordinary standards of skill and diligence without consequence if the "only" harm caused is an outpatient's death by suicide. In fact, affirming the circuit court's order sets dangerous precedent whereby it is legally safer for a healthcare provider with a knowingly suicidal outpatient to take no action to protect the patient rather than take steps to intervene for fear of creating a previously non-existent "special relationship" which could result in potential liability for a patient's suicide.

Justification for such a result is found nowhere in the Medical Professional Liability Act, which explicitly requires all health care providers, regardless of whether their patients are inpatients or outpatients, to exercise that degree of care required or expected of reasonable, prudent health care providers in similar circumstances. Such a disregard for patient protection is absent in any other medical situations dealing with more traditional physical ailments. Does the law view those suffering from mental illness less deserving of protection?

The circuit court's deviation from the plain language and requirements of the MPLA is an unintended consequence of the circuit court's reliance on, and misunderstanding of, two factually distinct cases in which this Court reached the correct outcome for different legal reasons.

For these reasons, which are further discussed herein, Petitioner respectfully asks that this Court reverse the circuit court's dismissal, and that Petitioner be given the opportunity to engage in discovery which will either prove or disprove the elements of Petitioner's claims.

ASSIGNMENTS OF ERROR

I. **The Circuit Court Erred by Finding No Special Relationship Leading to a Duty to Prevent Suicide Exists Between a Patient and Her Health Care Providers Despite Over 10 Years of Monthly Treatment Which Continued Until 10 Days Before Patient's Death.**

II. **The Circuit Court Erred by Finding that Health Care Providers of Knowingly Suicidal Outpatients Have No Obligation to Exercise Even Reasonably Ordinary Care.**

III. **The Circuit Court Erred by applying the *Moats/Hull* precedent in a manner that does not treat all persons within the class of medical negligence claimants equally in violation of the Equal Protection guarantee in Article III §17 of the West Virginia Constitution.**

STATEMENT OF THE CASE

I. Procedural History

On June 25, 2020, Christopher Morris, individually and as Administrator of the Estate of Amy Christine Wade, filed a lawsuit in the Circuit Court of Ohio County, West Virginia for the negligent treatment of Amy Christine Wade by: psychiatry specialist Steven Corder, M.D.; psychiatric therapist Melanie Bassa, MA; psychiatric nurse practitioner Martha Donahue, NP; and their employers: Northwood Health Systems, Inc. and Mid-Valley Healthcare, Inc. (collectively referred to herein as "Respondents"). The Complaint alleged that the Respondents' negligent deviation from the required standard of care in the treatment of Amy Christine Wade led to her death on June 30, 2018. (JA0004, 0008, 0010-12) According to the Certificate of Merit issued by David Purselle, M.D., who is certified by the American Board of Psychiatry and Neurology,

Respondents deviated from the national standard of care in the treatment of Ms. Wade and that their failure to attempt any changes to her treatment or medication or to contact her family constituted gross negligence. (JA0157-181)

In July 2020, Respondents filed motions to dismiss, which the circuit court granted on August 26, 2020. Despite the Complaint's allegations that Respondents failed to act in compliance with the applicable standard of care using the appropriate standard of care even though they knew of Ms. Wade's deteriorating mental condition and recently expressed suicidal ideations to the very mental health providers from whom she sought help, the circuit court found that Petitioner failed to assert a claim upon which relief could be granted because the Complaint "fail[ed] to allege that the decedent was in the custody of any Defendant at the time of her suicide." (JA0214)

Specifically, the circuit court made the following relevant findings of fact in its Order at JA0212-13:

(1) Plaintiff's Complaint was brought pursuant to the MPLA;

(2) "Decedent was a long-time patient of the individual Defendants and Defendants Northwood and Mid-Valley Healthcare primarily through periodic office visits with various mental health professionals..."; and

(3) "At no time was Decedent in the voluntary or involuntary custody of any of the Defendants..." and "...all services were rendered on an out-patient basis."

The circuit court also made the following relevant findings as a matter of law in its order dismissing Petitioner's case at JA0211-14:

(1) "...negligence actions seeking damages for the suicide of another have generally been barred because the act of suicide is considered deliberate and intentional, and therefore, an intervening act that precludes a finding that the defendant is responsible..."

(2) "...courts have allowed such [suicide negligence] actions where the defendant is found to have actually caused the suicide or where the defendant is found to have had a duty to prevent the suicide from occurring."

(3) "The Complaint merely alleges that Defendants deviated from the standard of care as healthcare professionals increasing the risk of Decedent's suicide" and "[s]uch allegation is antithetical to the discussion in *Moats*..."

(4) that a health care provider may only be held liable for the suicide of another if "...(1) the health care provider has a duty of custodial care, (2) the health care provider knows that the potential for suicide exists, and (3) the health care provider fails to take measures to prevent the suicide from occurring."

(5) the "...findings in *Hull* are entirely consistent with *Moats*."

(6) "...Plaintiff's Complaint fails to assert a claim upon which relief may be granted because the allegations fail to allege that decedent was in the custody of any Defendant at the time of her suicide on June 30, 2018..."

This appeal timely followed.

II. Statement of Facts

The Complaint further explained that Ms. Wade received treatment from Respondents beginning in January 2008, consisting of monthly scheduled appointments, during which time she was diagnosed by one or more of the Respondents with paranoid schizophrenia, borderline mental functioning, panic disorder agoraphobia, and that she was treated for these conditions with a combination of pharmaceuticals, clinical management, and counseling. (JA0004) According to the Complaint, in the years before her death, Ms. Wade had been admitted to a crisis stabilization unit and Respondents' facilities operated crisis stabilization units. (JA0005)

Beginning on or around February 28, 2018, according to the Complaint, Ms. Wade's condition began to decline and on several occasions in the months that followed she reported auditory hallucinations and threatening visual hallucinations. (JA0005-6) On March 22, 2018, the Complaint alleges that it was noted that Ms. Wade's emotional instability was higher than it had been in a long time and that on April 25, 2018, Ms. Wade made irrational claims about the death of her grandson and reported increased sadness, crying spells, decreased sleep, and increased weepiness. (JA0006) On June 11, 2019, nineteen days before her death, the Complaint alleges that Ms. Wade's condition continued to rapidly decline, she presented with a disheveled appearance, reported that she "doesn't sleep anymore," and that her "life has been hell," and that she had three suicidal ideations the week prior. (JA0006) Finally, according to the Complaint, ten days before

her death, on June 20, 2018, Ms. Wade reported that she had been in "such a state of panic" that she was forced to seek treatment at an Emergency Department. *Id.* During this time, the Complaint alleges that Ms. Wade's medical providers did not attempt to make any changes to her clinical treatment or to her prescription medications, did not investigate the emergency treatment she reported receiving, and did not consult a specialist or Ms. Wade's family to discuss her condition or her need for hospitalization to one of Respondents' crisis stabilization units. (JA0006-7) Ms. Wade followed through on her suicidal threats she had expressed to the mental health care provider Respondents on June 30, 2018.

III. Standard of Review

In West Virginia, "[t]he single purpose of a motion to dismiss under subdivision 12(b)(6) is to seek a determination whether the plaintiff is entitled to offer evidence to support the claims made in the complaint. *Dimon v. Mansy,* 198 W. Va. 40, 479 S.E.2d 339 (1996). "Appellate review of a circuit court's order granting a motion to dismiss a complaint is *de novo." Keith v. Lawrence,* No. 15-0223, 2015 WL 7628691, *3 (2015) ((citing Syllabus Point 2, *State ex rel. McGraw v. Scott Runyan Pontiac-Buick,* 194 W. Va. 770, 461 S.E.2d 516 (1995)). As this Court explained in *Chapman v. Kane Transfer Co., Inc.*, 160 W. Va. 530, 236 S.E.2d 207 (1977), "Rule 12(b)(6) should be granted only if it appears beyond doubt that plaintiff can prove no set of facts in support of his claims which would entitle him to relief."

SUMMARY OF ARGUMENT

In this case, Respondents owed – and breached – two distinct duties to Amy Christine Wade, the Decedent. First, Respondents had a statutory duty under the West Virginia Medical Professional Liability Act ("MPLA") to provide health care exercising "that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which [Respondents] belong[] acting in the same or similar circumstances." W. Va. Code § 55-7B-3. Respondents' failure to fulfill this statutory duty was the proximate cause of Decedent's death and resulted in Respondents' liability under the MPLA. Second, by virtue of the special relationship between Ms. Wade and the mental health care Respondents, Respondents owed Ms. Wade a duty to prevent her foreseeable suicide. *Moats v. Preston County Commission,* 206 W. Va. 8, 521 S.E.2d 180 (1999). Respondents' failure to meet this duty was likewise a proximate cause of her death and a basis for liability.

In consideration of Respondents' motions to dismiss, the circuit court erred, first by wholly bypassing Respondents' general duty under the MPLA to "render reasonable and ordinary care in the diagnosis and treatment of a patient." *Bunner v. Unites States,* No. 613-cv-20655, 2016 WL 1261151 (Mar. 30, 2016 S.D.W. Va.). Instead, the circuit court focused only on whether Respondents had a duty to prevent Decedent's suicide. Second, the circuit court erred in its determination that a duty to prevent a patient's suicide cannot exist when a person receives treatment on an outpatient basis. Such a finding contravenes law and public policy. Third, the circuit court erred by reaching conclusions on issues of disputed fact which must be decided by a jury.

The circuit court's order unjustifiably places unique legal burdens on the families of those bringing medical malpractice claims involving the suicide of a loved one in violation of long-standing Equal Protection guarantees of the West Virginia and United States Constitution. The

wholesale exemption of health care providers from medical malpractice claims when an outpatient commits a foreseeable suicide denies statutory MPLA protection to vulnerable mental health care recipients. Such harsh treatment in suicide cases is rooted in society's medieval views of suicide as "sinful and immoral" carried out by "lunatics" and "madm[e]n" in fits of "raving madness" rather than as a symptom of a valid medical condition. *See* Alex B. Long, *Abolishing the Suicide Rule,* 113 NW. U.L. Rev. 767, 781 (2019). However, as the understanding of suicide by society and modern medicine has evolved, so too has case law on negligence claims related to foreseeable suicide. As discussed herein, this evolution, along with the logical consideration of health care provider responsibility, justify reversal of the circuit court's dismissal of this action.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

This appeal involves issues that have not been authoritatively decided. Petitioner believes the questions presented are therefore appropriate for oral argument in accordance with Rules 18, 19 and 20 of the West Virginia Rules of Appellate Procedure.

ARGUMENT

I. The Circuit Court Erred by Finding No Special Relationship Leading to a Duty to Prevent Suicide Exists Between a Patient and Her Mental Health Care Providers Despite Over 10 Years of Monthly Treatment Which Continued Until 10 Days Before Patient's Death

In support of its determination that custodial care is required for a viable action to exist under the MPLA, the circuit court relied primarily on *Moats v. Preston County Comm'n.* 206 W. Va. 8, 521 S.E.2d 180 (1999) and *Hull v. Dr. Muhammed Samar Nasher-Alneam* No. 18-1028, 2020 WL 882087. In *Moats,* this Court answered affirmatively the question of whether there could be liability for negligence where a detainee in jail committed suicide after a hospital representative dropped the detainee off at jail but failed to advise the jail that the detainee was suicidal. The holding from *Moats* most critical to this case is found in Syllabus Point 6, which states as follows:

> Recovery for wrongful death by suicide may be possible where the defendant had a duty to prevent the suicide from occurring. In order to recover, the plaintiff must show the existence of some relationship between the defendant(s) and the decedent giving rise to a duty to prevent the decedent from committing suicide. *Generally*, such relationship exists if one of the parties, knowing the other is suicidal, is placed in the superior position of caretaker of the other who depends upon that caretaker either entirely or with respect to a particular matter.

Syl. Pt. 6, *Moats v. Preston County Comm'n.* 206 W. Va. 8, 521 S.E.2d 180 (1999) (emphasis added). Interpreting the above *Moats* syllabus point as requiring custodial care for a finding of negligence connected to a foreseeable suicide as opposed to generally describing one such example is a very narrow reading which contravenes the requirement that the MPLA be liberally construed. *See Martin v. Smith,* 190 W. Va. 286, 38 S.E.2d 318, 320 (1993) ("Not only has the Legislature liberalized the wrongful death recovery statute through the years, but this Court has adopted a liberal construction of the statute from our earliest cases."). While *Moats* mentions those situations which "generally" give rise to a duty to prevent suicide, it does not say that custodial care is always required for the successful recovery for wrongful death by suicide. And in fact, courts have permitted recovery in negligence actions absent custodial care in a number of circumstances. *See Martin,* 190 W. Va. 286; *Kockelman v. Segal,* 61 al. App. 4th 491 (Cal. 6th Dist. 1998) (finding that the trial court erred when it determined that, as a matter of law, a psychiatrist owed no duty of care to an outpatient who may be suicidal).

Further, *Moats* was decided on a motion for summary judgment, not a motion to dismiss, and *Moats* did not center on medical malpractice claims. The fact that Petitioner's claims are based on a statutory provision rather than common law negligence removes any custodial requirement as a basis for finding a "special relationship" leading to a duty to prevent Decedent's suicide. The decision to permit liability in such a circumstance was logically explained as follows by the Florida Supreme Court in *Chirillo v. Granicz*:

> Petitioners are correct that Florida law has not extended the duty to prevent suicide to an outpatient scenario, but such fact only highlights why Petitioners' attempt to classify the duty in the instant case as a duty to prevent suicide is incorrect and inappropriate. The decedent in this case was an outpatient of Dr. Chirillo's. Therefore, under Florida law, there was no duty to prevent her suicide. . . . However, the nonexistence of one specific type of duty does not mean that Dr. Chirillo owed the decedent no duty at all. As we plainly stated in *McCain*, there are several sources of duty. Although the inpatient duty to prevent suicide does not apply here, there still existed a statutory duty under section 766.102 to treat the decedent in accordance with the standard of care. We find that the Second District properly evaluated the instant case based on the statutory duty owed to the decedent and also properly classified the foreseeability of the decedent's suicide as a matter of fact for the jury to decide in determining proximate cause.

199 So. 3d 246 (Fla. 2016). Likewise, in *McLaughlin v. Sullivan*, 123 N.H. 335, 461 A2d. 123 (1983), cited with approval in *Moats*, the court clarified that exceptions have evolved from the historical bar on actions seeking damages for the suicide of another. One such exception is the existence of a statutory duty imposed on persons or institutions such as mental hospitals, psychiatrists and other mental-health trained professionals, deemed to have a special training and expertise enabling them to detect mental illness and/or the potential for suicide, and which have the power or control necessary to prevent that suicide. *Id.* at 338, 126. Much like the plaintiff in *Chirillo* and *McLaughlin*, even in the absence of inpatient treatment there still existed a statutory duty to treat the Decedent in this matter in accordance with the standard of care as set forth in W. Va. Code Section 55-7B-3. Here, Respondents had a long-term special physician-patient relationship with Decedent - that of a mental health care provider and patient. The relationship continued for over ten (10) years and treatment occurred on at least a monthly basis during this time. In the days leading to her suicide, Decedent confided in Respondents about matters that would never be discussed outside such a "special relationship," including the fact that she had threatening visual hallucinations, auditory hallucinations, and suicidal ideations shortly before she took her own life. It was in the context of that special relationship between mental health care

providers and a troubled patient that the Respondents had the power or control necessary to prevent that suicide through re-admission to its available crisis stabilization unit, medication adjustments, increased follow-up counseling, etc. Respondents are entitled to retain an expert witness to respond to Petitioner's claims and defend against Petitioner's claims as to breach and causation; however, to deny a special relationship existed in this case is to turn a blind eye to the significant and important relationship health care providers in all fields of medicine have with their patients.

Finally, the circuit court based its dismissal of this case, in part, on its misreading of this Court's ruling in *Hull v. Nasher-Alneam,* a non-published memorandum opinion, No. 18-1028, 2020 WL 882087 (Feb. 24, 2020).[1] Notwithstanding the misapplication discussed below, *Hull* is factually distinguishable from the matter at issue. The distinctions between *Hull* and the matter *sub judice* are substantial serving to distinguish it entirely:

- In *Hull*, the health care providers were orthopedic, not mental health care providers, like the mental health care provider Respondents in the instant matter;
- The health care providers in *Hull* treated the decedent for orthopedic issues, chronic pain and sleeplessness, not for mental health treatment or suicidality like the Respondent mental health care providers in the matter at issue;
- Unlike Ms. Wade, the decedent in *Hull* had not expressed suicidal ideations to the defendant health care providers days before committing suicide;
- The health care providers in *Hull* had not had a physician-patient relationship with the decedent for over a year prior to his suicide whereas Ms. Wade had been treated by the Respondents – and complained of suicidal ideations – only days before her suicide during their continuing care of her.

However, while this Court's *Hull* opinion reiterated the findings of the circuit court, this Court never espoused those findings of requiring custodial care as its own.[2] If *Hull* is to be read as

[1] Petitioner notes that the *Hull* plaintiff filed a motion for writ of certiorari with the United States Supreme Court on December 18, 2020.

[2] "The circuit court further found that petitioners' claims do not fall within the narrow exception to the *Moats* rule, because Mr. Hull was not in the custodial care of respondents . . ." *Hull,* 2020 WL 882087, at *2; "The circuit court further held that this Court has recognized only one narrow exception to the general

requiring custodial care for a finding of health care provider liability of a patient's suicide, even where the patient has disclosed suicidal ideations, then Petitioner asserts that *Hull* is plainly inconsistent with *Moats* and reads into *Moats* a requirement simply does not exist. As such, because this would create a conflict between a published and unpublished decision, *Hull* would be overruled by the more rational approach in *Moats*. Syl. Pt. 5, *State v. Mckinley*, 234 W. Va. 213, 764 W.E.2d 303 (2014). The ultimate decision to deny liability in *Hull* was justified based on the lack of patient and health care provider relationship under the MPLA given that, "respondents had not even had a patient-physician relationship with Mr. Hull for more than one year prior to his suicide." *Hull,* 2020 WL 882087, at *3. As set forth above, the ongoing physician-patient relationship in the matter *sub judice* leading up to Decedent's suicide is starkly different from that in *Hull* where the decedent had not been treated by defendant health care providers in over a year.

II. The Circuit Court Erred by Finding that Health Care Providers of Knowingly Suicidal Outpatients Have No Obligation to Exercise Even Reasonably Ordinary Care

The circuit court's Order improperly side-stepped the well-established framework for analyzing statutory negligence claims. A legal claim rooted in negligence may stem from a common law obligation; a contractual obligation; or, as in this case, a statutory obligation such as a state's medical malpractice statute. While their origins may vary, all negligence claims at their core involve a duty owed, a duty breached, and an injury proximately caused by the breach of the duty owed. Determination on whether a defendant owed a duty to plaintiff is an initial determination made by the court and the answer depends, in part, on the origin of the negligence claim.

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rule 'where the defendant is found to have had a duty to prevent the suicide from occurring' which applies to 'someone who has a duty of custodial care'. . . ." *Id.*

In West Virginia, a *prima facie* case of negligence requires establishing "that the defendant has been guilty of some act or omission in violation of a duty owed to the plaintiff. No action for negligence will lie without a duty broken." Syl. Pt. 1, *Parsley v. General Motors Acceptance Corp.*, 167 W. Va. 866, 280 S.E.2d 703 (1981). A legal duty may arise from a statute, common law, public policy, or a special relationship between the parties. *Daugherty v. Equifax Info. Servs., LLC*, No. 5:14-CV-24506, 2015 WL 6456572, at *9 (S.D.W. Va. Oct. 26, 2015).

i. The Duty Inquiry

Where negligence is alleged outside of a statutory provision, a common law negligence cause of action results. Because it is not found in the law, to determine whether defendant owed plaintiff a legal duty courts ask: "would the ordinary [person] in the defendant's position, knowing what he knew or should have known, anticipate that harm of the general nature of that suffered was likely to result?" Syllabus Point 7, *Lockhart v. Airco Heating & Cooling, Inc.*, 211 W. Va. 609, 610–11, 567 S.E.2d 619, 620–21 (2002); Syllabus Point 3, *Sewell v. Gregory*, 179 W. Va. 585, 371 S.E.2d 82 (1988). An answer in the affirmative establishes the existence of a duty.

While the existence of a duty in a common law negligence action is determined, in part, by considering whether the injury that occurred was foreseeable, this is not the case when determining duty in a statutory negligence action. Instead, in statutory negligence cases, where the duty owed is clearly defined in the statute, determining whether a duty exists requires no more than confirming the plaintiff was in the class of persons for whom the statute was designed to protect. *See Pack v. Van Meter*, 177 W. Va. 485, 494, 354 S.E.2d 581, 590 (1986) (holding that "[t]he problem with this theory is that it attempts to apply common law concepts...to a case where a positive statutory duty exists... [i]n this situation, courts have generally focused on whether the injured party was a member of the protected class...").

The physician-patient relationship is an example of a legal duty and related negligence action deriving from a statute. The MPLA explains that the health care provider's duty is to "exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances." W. Va. Code § 55-7B-3. A duty is established under the MPLA where the parties meet the definitions of: "Health Care Provider"[3] and "Patient"[4] and where the care received – or not received – constituted "Health Care."[5] *Bunner v. United States*, No. 6:13-cv-20655, 6:13-CV-20655, 2016 WL 1261151, at *5 (S.D.W. Va. Mar. 30, 2016) (holding that "[i]n West Virginia, the standard of medical care is a national one. That standard imposes a duty on a physician to render reasonable and ordinary care in the diagnosis and treatment of a patient. A deviation from this duty is malpractice.") (internal citations omitted).

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[3] W. Va. Code § 55-7B-2(g) defines "Health Care Provider" as:

> [A] person, partnership, corporation, professional limited liability company, health care facility, entity or institution licensed by, or certified in, this state or another state, to provide health care or professional health care services, including, but not limited to, a physician, osteopathic physician, physician assistant, advanced practice registered nurse, hospital, health care facility, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, speech-language pathologist, audiologist, occupational therapist, psychologist, pharmacist, technician, certified nursing assistant, emergency medical service personnel, emergency medical services authority or agency, any person supervised by or acting under the direction of a licensed professional, any person taking actions or providing service or treatment pursuant to or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis or treatment; or an officer, employee or agent of a health care provider acting in the course and scope of the officer's, employee's or agent's employment.

[4] W. Va. Code § 55-7B-2(m) defines "Patient" as: "[A] natural person who receives or should have received health care from a licensed health care provider under a contract, expressed or implied."

[5] W. Va. Code § 55-7B-2(e) defines "Health Care" as:

> (1) Any act, service or treatment provided under, pursuant to or in the furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis or treatment;
>
> (2) Any act, service or treatment performed or furnished, or which should have been performed or furnished, by any health care provider or person supervised by or acting under the direction of a health care provider or licensed professional for, to or on behalf of a patient during the patient's medical care, treatment or confinement, including, but not limited to, staffing, medical transport, custodial care or basic care, infection control, positioning, hydration, nutrition and similar patient services; and
>
> (3) The process employed by health care providers and health care facilities for the appointment, employment, contracting, credentialing, privileging and supervision of health care providers.

In the instant case, Respondents did not dispute that the parties met the definitions of patient and health care providers as defined in the MPLA. The circuit court's Order acknowledged that "Decedent was a long-time patient of the [Respondents]." (JA0211) Therefore, Ms. Wade was a member of the class the MPLA was designed to protect. This undisputed fact establishes the existence of a duty owed by defendant health care providers to the decedent patient and should have ended the court's inquiry on questions of law and resulted in denial of the motion to dismiss.

But that did not happen.

ii. The Breach Inquiry

After establishing the existence of a duty in negligence cases, the parties engage in discovery and fact-based issues are addressed. First, a determination must be made as to whether the duty owed was breached. In medical malpractice claims, the MPLA explains that a breach is established by plaintiff's presentation of expert testimony on the nature of the standard of care and the actions constituting a breach. W. Va. Code § 55-7B-7. In this case, Petitioner below supplied Respondents with the statutorily required screening certificate of merit, which outlined the basis for the assertion that a duty was breached.[6] (JA0157-181)

iii. The Causation Inquiry

All negligent actions, regardless of origin, next include an adjudication on causation. Specifically, plaintiff must prove that defendant's breach of duty was the proximate cause of the

[6] In an effort to ward off frivolous medical malpractice claims and lawsuits, the MPLA requires that a plaintiff comply with certain pre-suit requirements at least 30 days before filing suit. Syllabus Point 6, *Hinchman v. Gillette,* 217 W. Va. 378, 618 S.E.2d 387 (2005). Specifically, plaintiff is required to provide each health care provider defendant a notice of claim which states the basis for the theories of the case, a list of all health care providers receiving the notice of claim, along with a screening certificate of merit. W. Va. Code. § 55-7B-6(b). The screening certificate of merit is a written statement from a health care provider who qualifies as a medical expert and which describes the provider's: qualifications as an expert, familiarity with the medical standard of care appropriate to the circumstances under which plaintiff was treated, opinion as to how defendant failed to provide treatment in accordance with the applicable standard of care, and how that failure resulted in injury to plaintiff. *Id.*

injury which occurred. Syl. Pt. 2, *McCoy v. Cohen,* 149 W. Va. 197, 140 S.E.2d 427 (1965). At this stage of the litigation, depending on the jurisdiction, a defendant may raise affirmative defenses such as comparative negligence, contributive negligence, assumption of risk, or intervening cause, in which a defendant asserts that even if he breached a duty, other acts and not his breach caused the harm plaintiff suffered. Each of these is a question of fact for the jury. Syllabus Point 2, *Evans v. Farmer,* 148 W. Va. 142, 133 S.E.2d 710 (1963).

iv. The Intervening Cause Inquiry

Most relevant to the matter before this Court is the defense of an intervening cause, a defense which may be raised if defendant believes there to be a separate negligent act or omission which severed the causal connection between the defendant's actions and the damages to plaintiff. *Sydenstricker v. Mohan,* 217 W. Va. 552, 559, 618 S.E.2d 561, 568 (2005) (citing *Harbaugh v. Coffinbarger,* 209 W. Va. 57, 64, 543 S.E.2d 338, 345 (2000)). An intervening cause may exculpate the original tortfeasor from liability when it: "operates independently of any other act, making it and it only, the proximate cause of the injury," as long as the intervening acts were "not **reasonably foreseeable** by the original tortfeasor at the time of his negligent conduct." Syllabus Points 8, 9; *Harbaugh v. Coffinbarger,* 209 W. Va. 57, 543 S.E.2d 338 *W. Va. 2000) (emphasis added). However, if the defendant's negligent acts set in motion the plaintiff's injuries, he will be liable even for the subsequent negligence of another if such negligence was reasonably foreseeable or triggered by defendant. *Id.* (citing Syllabus Point 13, *Anderson v. Moulder,* 183 W. Va. 77, 394 S.E.2d 61 (1999)). For example, this Court performed an intervening cause analysis in *Harbaugh v. Coffinbarger,* wherein decedent's estate brought a negligence case against gunowners and homeowners after decedent accessed a gun at their home and proceeded to play Russian roulette, resulting in his death by gunshot wound to the head. *Harbaugh v. Coffinbarger,* 209 W. Va. 57, 64, 543 S.E.2d 338, 345 (2000). The question at issue was whether the intervening act of playing

Russian roulette (whether performed with reckless disregard or for the purpose of suicide) was foreseeable to the defendants. *Id.* Because the decedent had given no indication that he might shoot himself, the suicide was an intervening cause which negated proximate causation of any act of defendant. *Id.*

To be clear, as with other questions of proximate cause, where reasonable minds could differ on whether the intervening cause at issue was the sole cause of the harm which occurred, this is a question of fact for the jury. *Hershberger v. Ethicon Endo-Surgery, Inc.,* No. 2:10-cv-00837, 2012 WL 1067941, *4 (S.D.W. Va. Mar. 29, 2012) (citing *Evans v. Farmer,* 148 W. Va. 142, 133 S.E.2d 710 (1963)). In this case, reasonable minds can, and indeed do, differ as to whether Respondents should have foreseen Decedent's suicide. Therefore, this is a question that should have been reserved for the jury.

Nevertheless, the circuit court in this matter assumed the role of the jury while interpreting Respondents' Rule 12(b)(6) motions and improperly concluded that Mrs. Wade's suicide was an "intervening act" without performing the intervening cause analysis as outlined above. (JA0208) The analysis would negate Respondents' liability only if: (1) the suicide operated independently of any other act making it the only proximate cause of the injury suffered and (2) the suicide was not foreseeable to Respondents. While Decedent's act of committing suicide arguably operated independently of any acts of Respondents, it cannot be said that her suicide was unforeseeable by Respondents given that Respondents' own records indicate Decedent's increased distress, deteriorating mental stability, and expressed suicidal ideations just days prior to her suicide, coupled by the fact that Respondents did not change any part of her treatment in an effort to improve her condition. (JA0002-JA0013) The circuit court erred by ignoring facts that clearly indicated Mrs. Wade's suicide was entirely foreseeable or, in the alternative, by failing to

acknowledge that reasonable minds could differ as to its foreseeability given Ms. Wade's well-documented mental decline and expressed suicidal ideations shortly before her suicide. Either way, the circuit court erred by not permitting the question of fact concerning intervening cause and the foreseeability of Ms. Wade's suicide to be resolved by a jury. Thus, because the alleged intervening cause was foreseeable, and possibly even driven in part by Respondents' failure to respond to Decedent's cries for help, the suicide would not be an intervening cause immunizing Respondents from liability.

Noteworthy and possibly dispositive of the issues presented here, in *Martin v. Smith*, this Court affirmed a judgment against a psychiatrist in a wrongful death action where it was alleged that decedent committed suicide at his mother's house while on temporary release from a psychiatric unit, which the psychiatrist negligently permitted said visitation without providing his mother with instructions about the visit or inquiring into the accessibility of weapons in the mother's home. 190 W. Va. 286 (1993). This, despite the fact the patient was no longer under custodial control having permitted the decedent to leave the hospital. This is a clear indication that the existence of suicide does not cloak a negligent health care provider with immunity from suit based on an alleged intervening cause where the suicide was foreseeable.

Similar analyses of suicide as an intervening cause have been performed by other courts when considering whether suicide bars health care provider liability in negligence actions. In *Edwards v. Tardiff,* the Connecticut Supreme Court set aside a jury verdict and found malpractice occurred where health care provider prescribed decedent a large dose of medication over the phone without ever having seen her, failed to monitor patient and have follow up visits, and the patient committed suicide. 240 Conn. 610 (Conn. 1997).

In *Seastrunk v. United States,* the court explained that, "a professional's duty to prevent suicide requires the exercise of that degree of skill and care necessary to prevent a patient's suicide that is ordinarily employed by members of the profession under similar conditions and circumstances" and the question whether the duty has been breached turns on the professional's departure from the standard of care rather than the event of suicide itself." 25 F. Supp. 3d 812 (2014 D. S.C.) (citing *Hoeffner v. The Citadel,* 311 S.C. 361, 429 S.E.2d 190, 194 (S.C. 1993)).

In this case, however, rather than engage in the appropriate fact-based intervening cause inquiry described above, the circuit court decided as a matter of law that the case must be dismissed because Respondents had no duty to prevent the suicide from occurring given that Respondents did not have a duty of custodial care over Decedent at the time she committed suicide. It is critical that the wide-spread ramifications of this radical position be considered. The result of this reasoning is that absent a patient's admission to a facility, the law would impose no actionable duty on a health care provider who knows a patient to be suicidal. This approach is antithetical to public policy and not supported by West Virginia law.

III. The Circuit Court Erred by applying the *Moats/Hull* precedent in a manner that does not treat all persons within the class of medical negligence claimants equally in violation of the Equal Protection guarantee in Article III §17 of the West Virginia Constitution.

As applied by the circuit court, the *Moats/Hull* precedent treats medical negligence claimants differently in violation of the Equal Protection guarantee in Article III. This Court had occasion to examine the application of the Equal Protection guarantee to an MPLA matter in *Robinson v. Charleston Area Medical Center, Inc.*, 186 W. Va. 720, 414 S.E.2d 877 (1991). In *Robinson*, the West Virginia Supreme Court ruled that the MPLA's provisions dealing with caps on non-economic damages did not violate state or federal equal protection under a "rational basis" analysis merely because it differentiated or discriminated against medical professional liability

victims versus other tort victims. In sum and substance, because the West Virginia Supreme Court believed that the MPLA's non-economic damages caps applied equally to all medical professional liability victims, that the cap, in and of itself, was not an impermissible discrimination under an equal protection analysis.

Importantly, in *Robinson*, the Supreme Court reiterated its holding in Syl. Pt. 4 of *Gibson v. West Virginia Department of Highways*, 185 W. Va. 214, 406 S.E.2d 440 (1991) where the Court had held that:

> Where economic rights are concerned, we look to see whether the classification is a rational one based on social, economic, historic or geographic factors, whether it bears a relationship to a proper governmental purpose, and *whether all persons within the class are treated equally*...

(emphasis added). This is the very essence of both the State of West Virginia and the United States equal protection guarantees. The equal protection guarantee assures that all similarly situated persons be treated alike. Thus, everyone stands before the law on equal terms to enjoy the same rights, and to bear the same burden as are imposed upon others in a like situation. As was expressed in *State ex rel. Piccirillo v. City of Follansbee*, 160 W. Va. 329, 233 S.E.2d 419 (1997), the equal protection guarantee contained in Article III §17 of the West Virginia Constitution parallels the equal protection standards under the Fourteenth Amendment to the United States Constitution.

In this case, Petitioner is not merely asserting that the *Moats/Hull* precedent is unconstitutional under an equal protection analysis because it differentiates between victims of medical negligence versus all other tort actions. Instead, Petitioner asserts that the *Moats/Hull* precedent as applied by the circuit court is unconstitutional under an equal protection analysis because "all persons within the class [medical negligence claimants] are [not] treated equally." Syl. Pt. 4 of *Gibson, supra.*

By way of example, the *Moats/Hull* precedent as applied by the circuit court requires mental health medical malpractice claimants seeking to pursue a medical malpractice action to file a notice of claim, screening certificate of merit, and a verification that the patient was receiving inpatient medical care to a degree that would be considered "custodial." By doing so, it discriminates against patients that receive mental health care and specifically discriminates against patients that receive outpatient mental healthcare. Indeed, the *Moats/Hull* precedent as applied by the circuit court acts to extinguish any wrongful death claims on behalf of mental health patients that suffer from suicide while receiving outpatient care. In other words, not only would the circuit court's application require another procedural hurdle for mental health patients to establish health care was rendered while in "custody" but as applied it goes one step further and finds that failure to plead a "custodial" element constitutes the failure to state a claim upon which relief can be granted.

Thus, certain classes of medical negligence plaintiffs would be required to clear additional procedural hurdles – such as establishing "custodial" care – that is explicitly not required by the MPLA of other medical negligence plaintiffs. A medical malpractice claimant that alleges she was injured due to a delayed diagnosis need only file a Notice of Claim and Screening Certificate of Merit, whereas the Decedent in the current matter must complete those tasks and also show that a "custodial" relationship existed at the time said medical care was rendered. Under a rational basis type of equal protection analysis, it is clear that under the circuit court's application of *Moats/Hull* not all persons within the class of medical negligence plaintiffs are treated equally as contemplated in *Gibson v. West Virginia Department of Highways, supra*, and the Court must find that the circuit court's application of *Moats/Hull* is unconstitutional under an equal protection analysis.

CONCLUSION

A bedrock principle in West Virginia's medical malpractice jurisprudence is that all healthcare providers are required to provide medical care in a manner that is consistent with the standard of care. There are no exceptions to this fundamental expectation, and for good reason. Patients are entitled to expect, and are entitled to receive, quality healthcare consistent with the standard of care without needing to create exceptions to this bedrock principle. Indeed, the MPLA confirms the receipt of quality health care as a fundamental right and establishes the parameters by which all healthcare is to be measured and liability is to be determined. The circuit court's dismissal of Petitioner's medical malpractice Complaint, despite strict compliance with the MPLA and the pleading standards of the West Virginia Rules of Civil Procedure, is concerning and ignores Petitioner's fundamental rights.

In addition to adhering to the additional pleading standards set forth in the MPLA, Petitioner's Complaint identified the standards of care applicable to Respondents and that a deviation or breach occurred that caused Ms. Wade's preventable death. In doing so, as set forth more fully above, the Respondents failed to meet their burden of establishing that "it appears beyond all doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Syl. Pt. 3, *Chapman v. Kane Transfer Co.*, 160 W. Va. 530, 236 S.E.2d 207 (1977). A Notice of Claim and a Screening Certificate of Merit prepared by a highly qualified expert witness strongly suggested otherwise.

Without question, if accepted, the circuit court's application of the *Moats/Hull* precedent would create immunity from suit for all health care providers that provide outpatient psychiatric care. Even more troubling, the circuit court's Order creates an exemption from the medical standard of care for health care providers practicing outpatient psychiatric care, as well as operate to exclude those same health care providers from the MPLA. The Respondents may disagree with

Petitioner's expert witness opinions as to the standard of care applicable to each; however, the proper resolution of that disagreement is before a jury that has had an opportunity to weigh the credibility of competing expert witness testimony, not on a procedural motion to the Court in which Respondents seek an exception to foundational principles of medical malpractice jurisprudence in West Virginia.

For all the reasons set forth above, Petitioner respectfully requests that this Court reverse the circuit court's Order on motion to dismiss and remand this matter to the docket of the Circuit Court of Ohio County for further proceedings.

PETITIONER, CHRISTOPHER MORRIS, individually and as Administrator of the ESTATE OF AMY CHRISTINE WADE

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IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Docket No. 20-0750

CHRISTOPHER MORRIS, individually and as Administrator of the ESTATE OF AMY CHRISTINE WADE,

Plaintiff Below, Petitioner,

v.

Case No. 20-0750
(On Appeal from Circuit Court of Ohio County, Civil Action No. 20-C-140)

STEVEN CORDER, M.D; MELANIE BASSA, M.A.; MARTHA DONAHUE, N.P.; NORTHWOOD HEALTH SYSTEMS, INC.; MID-VALLEY HEALTHCARE SYSTEMS, INC.; and JOHN DOES 1-5,

Defendants Below, Respondents.

CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of December, 2020, I served a true and correct copy of the **PETITIONER'S BRIEF** on the following individuals, via electronic mail:

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