Boundaries of Absolute Immunity for Clinicians

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Clinicians Who Initiate Emergency Medical Holds Do Not Have Absolute Immunity

In *Thomas v. Kaven*, 765 F.3d 1183 (10th Cir. 2014), M.T., the 12-year-old daughter of the plaintiffs, Legina and Todd Thomas, was admitted to the University of New Mexico Children's Psychiatric Center (UNMCPC) after stating that she had suicidal tendencies during a police investigation of potential sexual assault. The doctors at UNMCPC opined that M.T. had several severe psychiatric disorders, and they sought administration of psychiatric medication. Mrs. Thomas rejected the diagnoses and medication recommendations and, after several weeks, sought to remove M.T. from the inpatient setting. M.T.'s psychiatrist and psychologists expressed concern about M.T.'s safety and pursued an involuntary residential treatment commitment in state court. However, seven days later, she was released to her parents before the involuntary commitment, following notification that the parents' insurance would no longer cover her commitment. The parents subsequently filed suit under 42 U.S.C. § 1983 (2000) against the treating clinicians (i.e., Mary Kaven, PhD, Jill Straits, PhD, and Anilla Del Fabbro, MD), citing the Fourteenth Amendment rights of parents to direct their child's medical care and to familial association.

Facts of the Case

In April 2010, Mr. and Mrs. Thomas learned their minor daughter (M.T.) had alledgedly had a sexual relationship with a friend's older brother. They contacted the Lea County Sheriff's Department to investigate the claim; however, during the interview, M.T. expressed suicidal ideation, which the officers determined to be valid. She was transported to a local hospital where she was interviewed by hospital staff and a representative from the New Mexico Child, Youth, and Families Department (CYFD). Because of concerns for her safety, CYFD urged the parents to admit her to UNMCPC for psychiatric observation. On April 13, she was admitted, although UNMCPC staff noted that her suicidal claims had been an attempt to divert attention from the sexual abuse investigation. Regardless, her treating psychiatrist (Dr. Del Fabbro) believed that M.T. had genuine hallucinations and depression, with possible schizophrenia. Dr. Del Fabbro contacted Mrs. Thomas requesting consent to administer psychotropic medications. Mrs. Thomas again refused, citing the desire to explore alternative treatments. On April 16, Dr. Del Fabbro contacted Mrs. Thomas and repeated the request to administer psychotropic medications, and permission was again denied.

On April 20, a psychological evaluation was conducted by Dr. Mary Kaven, who diagnosed major depressive disorder, borderline personality disorder, and early-onset schizophrenia in M.T. M.T's therapist, Dr. Jill Straits, contacted Mrs. Thomas and revealed the findings of the evaluation, telling Mrs. Thomas that the doctors also believed M.T. had an intellectual disability due to the combination of schizophrenia, mental disability, and childhood *petit mal* seizures. Throughout the hospitalization, Mrs. Thomas informed different treatment staff that her daughter was not a behavioral problem and was an honor roll student. On April 26, Dr. Del Fabbro again contacted Mrs. Thomas requesting permission to administer medications, which Mrs. Thomas denied. In the following several days, Dr. Strait contacted CYFD two times and ultimately accused Mrs. Thomas of medical neglect for not allowing the administration of medications.

On April 29, Mrs. Thomas met with the treatment providers but reported that she did not believe her daughter was suicidal or had hallucinations; she again refused consent for medication. Dr. Del Fabbro informed Mrs. Thomas that she did not believe Mrs. Thomas was competent to make medical decisions on her child's behalf. Following the interaction, Dr. Del Fabbro placed M.T. on a medical hold to prevent her from being released and then contacted CYFD to report medical neglect by M.T.'s parents for failing to consent to medication. Dr. Del Fabbro then petitioned for involuntary residential treatment with the state court and a hearing was scheduled. However, before the hearing on May 5, Dr. Strait contacted Mrs. Thomas, telling her to pick up her daughter immediately because their insurance carrier would no

longer cover the treatment costs. The clinicians indicated that there was an adequate safety plan to discharge M.T., who was discharged on May 6. The commitment order was discontinued at that time.

Mr. and Mrs. Thomas filed suit under 42 U.S.C. § 1983 (2000) against the treating clinicians, citing Fourteenth Amendment rights to familial association and to direct their child's medical care. The clinicians cited their right to absolute immunity (i.e., complete immunity from legal retaliation) and qualified immunity (i.e., immunity from liability for civil damages as long as constitutional or statutory rights were not violated) and filed a motion to dismiss. The United States District Court for the District of New Mexico granted the motion, and the case was dismissed. Mr. and Mrs. Thomas appealed to the Tenth Circuit Court of Appeals.

Ruling and Reasoning

The Tenth Circuit held that treating physicians were not entitled to absolute immunity. The court ruled that Mr. and Mrs. Thomas' claim that allegations of medical neglect, which interfered with their right to direct their child's medical care, were not clearly established and their assertion that their right to familial association was violated when the defendants initiated a temporary medical hold was justified. Regarding absolute immunity, the court stated that this concept is applied to prosecutorial activities that are connected to the "judicial phase of the criminal process" (*Thomas*, p. 1191, quoting *Imbler v. Pachtman*, 424 U.S. 409 (1976)). To determine the applicability of absolute immunity, the court uses a functional approach and looks at the actions being performed, not the individual who is performing them. In addition, the court stated that the farther the function is from the judicial process, the less likely that absolute immunity will apply (*Snell v. Tunnell*, 920 F.2d 673 (10th Cir. 1990)). In the present case, the clinicians placed M.T. on a seven-day hold to prevent her possible discharge. The petition for involuntary commitment was filed five days later, and M.T. was discharged during that time. The court determined that Mr. and Mrs. Thomas were not injured by the commitment petition because it was never enacted. Instead, they were affected by the emergency medical hold, which was not by judicial order, and therefore did not qualify for absolute immunity. The court ruled that per the New Mexico Children's Code, treating clinicians who believe that a minor patient is going to be discharged against their best interests should contact a children's court attorney to issue an involuntary treatment order, thereby making the process judicial. The role of the clinician is to initiate a legal action by contacting the child's court attorney, who subsequently can petition to pursue involuntary commitment. The clinicians failed to follow these procedures and the failure additionally removed absolute immunity safeguards. The Tenth Circuit briefly addressed qualified immunity, but stated that this concept is usually applied to a summary judgment stage, not a dismissal stage. As there was insufficient information to make a determination, the issue was remanded.

Regarding the parents' right to direct their child's medical care, the court stated that the right is not absolute and "[W]hen a child's life or health is endangered by her parents' decisions, in some circumstances a state may intervene without violating the parents' constitutional rights" (*Thomas*, p. 1195, quoting *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182 (10th Cir. 2010)). However, Mr. and Mrs. Thomas argued that the allegations of neglect amounted to a violation of their right to direct their child's care and thus caused them harm. The court stated that M.T. was not committed to involuntary residential treatment, and therefore no violation of the parents' right to direct their child's medical care had occurred. The lower court had originally dismissed this claim, and the Tenth Circuit Court affirmed the dismissal.

Finally, Mr. and Mrs. Thomas claimed that their right to familial association was violated when the clinicians placed M.T. on an emergency medical hold and pursued involuntary residential treatment. The court again stated that the question was not about involuntary commitment, because there had been none. Instead the question pertained to the matter of the medical hold. The court stated that it did not appear the M.T. would have posed an imminent threat for suicide had she been discharged. In fact, on the day the petition for commitment was issued, there was no documentation showing M.T.'s risk for suicide. In order for the medical hold to be constitutionally justified and subsume the right to familial association, an imminent risk of suicide must be present. The court ruled that it was the clinicians' responsibility to show the imminence or seriousness of M.T.'s suicidal threats during the seven-day emergency hold, which they had not done. M.T. was released as soon as staff at UNMCPC discovered that insurance would not cover the cost of her treatment. As a result, the court

determined that the clinicians had violated clearly established laws regarding the right of familial association.

Discussion

The court's determination clarified immunity for treating clinicians, as well as the scope of the parents' right to direct a child's treatment and to familial association. To begin with, absolute immunity applies to the judicial process, and unless a psychiatrist is acting in a judicial capacity, this concept does not apply. In addition, informing an agency of parental medical neglect does not violate the parental right to direct treatment. Finally, familial association is a constitutional right well founded in existing case law. In the present case, the "defendants cannot establish as a matter of law at this point in the proceedings that the relevant state interests outweighed the Thomases' interest in their right to familial association" (*Thomas*, p. 1188). Unless there is a well-documented imminent risk of suicide, which a reasonable official would have discovered, familial association supersedes the state's interests.

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Veterans Affairs Entitlement for Service-Connected Disability Caused by Posttraumatic Stress Disorder

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Medical Diagnosis of Posttraumatic Stress Disorder Is Necessary to Establish an Effective Date for an Award of Service Connection Due to the Disorder

In *Young v. McDonald*, 766 F.3d 1348 (Fed. Cir. 2014) the United States Court of Appeals, Federal Circuit, upheld a Veterans Court decision that the effective date for Mr. Young's service-connected disability entitlement as a result of posttraumatic stress disorder (PTSD) was March 10, 1989, the earliest date when a medical diagnosis of PTSD could be established. He had appealed, arguing that the effective date for his service-connected entitlement should be September 7, 1984, when he had first submitted an application for benefits. The court of appeals determined that the Veterans Court had not erred in its determination and that a medical diagnosis was necessary to establish a service-connected disability.

Facts of the Case

From October 1965 until August 1967, Robert G. Young had served as an Army combat engineer while on a tour of duty in Vietnam. In September 1984, he submitted an application for benefits with the Veterans Affairs (VA) Regional Office (RO) based on his reported symptoms of "anxiety," "bad nerves," and "[inability] to adjust to society." However, after he failed to present for a medical examination to establish his diagnosis, the VA denied his request for benefits.

Subsequently, in 1989, a VA psychiatrist submitted a letter stating that Mr. Young "has been under my care since March 10, 1989," and that he "is suffering from PTSD." Nevertheless, the RO denied Mr. Young's claims in serial rating decisions in December 1989, February 1990, and April 1991, because of the lack of a record of an established in-service exposure. He appealed the decisions to the Board of Veterans' Appeals but his claim was again denied in July 1991. When he did not further appeal the Board's decision to the Veterans Court, the decision became final.

Mr. Young requested to have his file reopened in August 1992, but his request was denied by the RO in decisions in October 1992, June 1993, February 1995, and March 1997. Then, in May, 1998, service department records that established Mr. Young's exposure to an in-service stressor but were previously not a part of his file were received by the RO, and his claim was subsequently reopened. The RO granted him service connection with a 100 percent disability rating, assigning his award an effective date of August 1992, when he had originally submitted the request to have his file reopened.

In March 2007, Mr. Young argued that the RO had committed a "clear and unmistakable error" (CUE) in its May 1998 Rating Decision for assigning his award an effective date of August 1992. He argued that September 7, 1984, the date of his original claim, should be used as the effective date for his