

finding him guilty except for insanity with respect to the remaining charges. Mr. Meiser appealed the murder conviction. He argued that by implicitly accepting the prosecution’s interpretation of the insanity statute, the trial court had committed a reversible error.

The court of appeals affirmed the trial court’s verdict. The appeals court agreed with the prosecution’s argument that Oregon’s insanity statute required defendants to prove that a qualifying mental disorder was the sole cause of their mental impairment at the time of the criminal act. The appeals court determined that a reasonable factfinder could conclude that Mr. Meiser’s mental condition at the time of the offense was influenced by both schizophrenia and antisocial personality disorder, that is, not exclusively by a qualifying disorder. Therefore, the appeals court ruled, the trial court had not erred by rejecting his insanity defense.

Mr. Meiser sought review from the Oregon Supreme Court, which granted *certiorari* as to whether “a combination of a qualifying and nonqualifying impairments” is a permissible cause of insanity under state law (*Meiser*, p 405).

Ruling and Reasoning

The Oregon Supreme Court rejected the appeals court’s determination that the state’s insanity statute required Mr. Meiser to prove that “his asserted lack of capacity was solely the result of his schizophrenia and in no part the result of his antisocial personality disorder” (*Meiser*, p 406). The case was remanded to the appellate court for further consideration.

The state supreme court concluded that the appellate court’s interpretation of Oregon’s insanity statute was contrary to legislative intent. The state legislature had amended the statute in 1983 to exclude personality disorders from the definition of “mental disease or defect.” The stated motivation for adding this exclusion was to prevent “recidivists” from qualifying for insanity based only on a personality disorder or repeated antisocial conduct. But, the legislature’s drafting task force specifically emphasized that an individual with “a personality disorder plus a psychosis . . . may still qualify” (Oregon State Legislature Tape Recording, House Committee on Judiciary, May 31, 1983, HB 2075, Tape 386, Side A, statement of Legal Counsel Linda Zuckerman). The legislature did not desire to narrow the insanity defense to the extent that a defendant with a qualifying mental disorder would become ineligible for a finding of insanity due to a co-occurring personality disorder.

Discussion

Given the high rate of comorbid personality disorders observed in justice-involved individuals with severe mental illness, the state supreme court’s ruling in *Meiser* has the potential to affect many defendants in Oregon considering a plea of guilty except for insanity. This ruling makes clear that impairment from a combination of qualifying mental disorder and a co-occurring personality disorder may hypothetically meet Oregon’s standard for insanity. But, it remains unresolved if there is an upper limit to the permissible contribution from a personality disorder, above which a defendant becomes ineligible to be found insane.

In the absence of a known limit, the forensic mental health evaluator can aid the trier of fact in parsing the relative contributions of qualifying and nonqualifying disorders to the defendant’s mental state at the time of the crime. In addition to insanity, the concepts raised by this case may apply to other legal situations requiring a nexus between a qualifying mental disorder and a criminal act, such as pretrial mental health diversion. Without specific statutory guidance, it will be left to the courts to determine whether individuals with both qualifying and nonqualifying disorders are eligible for these programs.

Litigation Challenges in Cases Involving Patient Suicide

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Plaintiffs are Tasked with Proving “But For” Causation to Establish Defendant’s Negligence in Cases of Suicide

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In *Pediatrics Cool Care v. Thompson*, 649 S.W.3d 152 (Tex. 2022), the Supreme Court of Texas

examined the causation standards in a case involving negligence and patient suicide. The parents of 14-year-old patient A.W. sued providers at the Pediatrics Cool Care practice for negligence following her suicide. Although a jury found the practice's supervising physician and physician assistant (PA) proximately caused A.W.'s death, which was affirmed by the court of appeals, the Supreme Court of Texas reversed the judgment in favor of the practice providers, stating the appellate court had erred in omitting an important causation standard in its analysis.

Facts of the Case

On March 12, 2012, A.W. presented to the pediatrics clinic with her mother, Ginger Thompson, for depressive symptoms, including feelings of sadness and difficulty controlling her feelings. She was seen by PA Jenelle Robinson, who quickly diagnosed her with depression without a comprehensive assessment. The PA did not ask to interview A.W. outside her mother's presence or use the clinic's diagnostic depression screening checklist. She proceeded to prescribe a 30-day supply of citalopram for depression. In transcribing the PA's prescription order, the clinic's medical assistant (MA) added three refills to the 30-day prescription in error. At trial, Ms. Robinson testified that she could not recall if she had asked A.W. about thoughts of suicide or self-harm. The PA stated that she recommended counseling to A.W. and asked for a follow-up in one week, but A.W.'s mother testified that the PA did not provide such recommendations. In addition, Ms. Thompson testified that A.W. had refused to go to counseling earlier, preferring to talk with a teacher at school instead.

Approximately six weeks later, A.W. presented to the clinic with complaints of migraine headaches and was seen by Allyn Kawalek, a nurse practitioner (NP). Ms. Kawalek noted in the medical record that A.W. and her mother had reported an improvement in A.W.'s mood, but there was no indication that other symptoms of depression were explored or that a follow-up appointment was arranged. The medical record was altered by an unknown person approximately two years after the visit to reflect that A.W. had been asked to return to the clinic in 30 days.

Four months after A.W.'s initial clinic visit, Ms. Thompson called the clinic requesting a refill of A.W.'s antidepressant. The MA who took the call refilled the medication without scheduling a follow-up appointment or speaking to any of the practice's

providers. After learning of A.W.'s suicide, the MA attempted to alter A.W.'s medical records to hide this.

Approximately two weeks after the phone call with the MA, A.W. died by suicide by an overdose of diphenhydramine. Her parents subsequently sued Pediatrics Cool Care providers, including the clinic supervisor, Dr. Jose Salguero, along with Meses. Robinson and Kawalek for negligence and gross negligence. Of note, A.W.'s parents testified that neither they nor A.W.'s friends noticed anything unusual about her before her suicide; she did not appear depressed or voice any depressive or suicidal thoughts.

At trial, Dr. Herschel Lessin, a pediatrician, testified on the shortcomings in the providers' care, which included grossly inadequate evaluation before antidepressant prescription; medical chart transcription errors; authorization of medication refills without a follow-up evaluation or approval from providers; inadequate follow-up care; poor recordkeeping, including inadequate documentation; poor record review; and alterations of the medical records in an apparent attempt to conceal errors.

Dr. Fred Moss, a psychiatrist who stated that he had experience treating both pediatric and adult patients, none of whom had died by suicide, testified that the practice providers' negligence proximately caused A.W.'s death. Dr. Moss opined that had the clinic conducted a more thorough evaluation, A.W.'s responses would have "created pathways toward treatment options" (*Pediatrics Cool Care*, p 156) that would have prevented A.W.'s suicide. Testifying that A.W. should not have been prescribed citalopram, Dr. Moss listed the treatment options to include "counseling, nutritional counseling, group therapy, sports, exercise, meditation, and establishing relationships with teachers and advocates" (*Pediatrics Cool Care*, p 165). Dr. Moss could not, however, identify a specific path that would have reliably prevented A.W.'s suicide. He acknowledged that even if the providers had followed the standard of care, A.W. still could have died by suicide. Dr. Armando Correa, an assistant professor in pediatrics at Baylor College of Medicine testified that teenage suicides are usually impulsive and unforeseeable, while opining that A.W.'s suicide was an "impulsive, unpreventable act" (*Pediatrics Cool Care*, p 157).

The jury found that the practice physician and the PA proximately caused A.W.'s death, but the NP

was not liable. In the jury charge, proximate cause was defined as "a cause that was a substantial factor in bringing about an occurrence, and without which cause, such occurrence would not have occurred" (*Pediatrics Cool Care*, p 157). The physician and PA appealed, challenging the sufficiency of the evidence proving their causation and liability of A.W.'s suicide along with the admissibility of Dr. Moss' testimony.

The court of appeals affirmed the trial court's verdict. Although the trial court had included the but-for causation standard as part of the jury instructions in determining proximate cause, the appellate court excluded analysis of it and found that Dr. Moss' testimony was sufficient to conclude that the practice physician and PA's negligence caused A.W.'s death. The physician and PA then petitioned the Texas Supreme Court to review the case.

Ruling and Reasoning

Justice Bland, writing for the Texas Supreme Court majority, said that the appellate court incorrectly omitted analysis of the but-for causation standard. In addition, the court held that there was no evidence that the providers' care proximately caused A.W.'s suicide, so it reversed the appeals court's decision and rendered judgment for the providers.

The Texas Supreme Court concluded that Dr. Moss' expert testimony was primarily based on assumptions and speculations, not grounded by the facts in the record. There was no evidence to suggest A.W. had any suicidal thoughts during her initial evaluation. On the contrary, the facts indicated that A.W. had never disclosed any suicidal thoughts to anyone, and she had refused to go to counseling. Dr. Moss did not provide any supporting basis for his conclusions on what A.W. and her parents would have done had the providers conducted a more comprehensive assessment, followed up appropriately, or discussed different available treatment options.

In addition, Dr. Moss' assumption that his suggested treatment pathways would have prevented A.W.'s suicide was not reliably supported because he could not identify a particular treatment pathway that would have prevented suicide. Even if the providers had done everything perfectly, Dr. Moss agreed that A.W. might still have died by suicide. Finally, Dr. Moss did not address in his testimony the possibility that A.W.'s suicide was an impulsive and unpreventable act.

Justice Busby concurred, agreeing that Dr. Moss did not identify a treatment plan that likely would have prevented suicide and could not explain what factors differentiated adequately treated patients who died by suicide from those who did not. Focusing on the challenges of proving causation in medical negligence cases, Justice Busby suggested that alternative processes (e.g., a medical board investigation) that do not require such a high standard could be employed to hold erring providers accountable.

Justices Boyd and Lehrmann dissented, observing that the jury believed A.W.'s parents met the burden of proof needed to conclude that the providers' negligence proximately caused A.W.'s suicide. They found Dr. Moss' testimony legally sufficient for the jury to conclude that A.W. would not have died by suicide "but for" the providers' negligence.

Discussion

This case highlights the challenges plaintiffs face when filing a malpractice suit against medical providers in cases of patient suicide where plaintiffs must prove that a provider's negligence was the proximate cause of a patient's suicide.

Although experts opined that the care provided to A.W. in this case fell below the standard of care, it would be difficult to conclude with a reasonable degree of medical certainty that had A.W. received the suggested care, she would not have died by suicide. Practicing psychiatrists are aware of patients who have died by suicide despite receiving excellent care. Dr. Moss' suggestion that his comprehensive evaluations and presentation of treatment options have prevented his patients from death by suicide risks attributing blame for a patient's suicide squarely on their treatment providers' shoulders while ignoring the complicated nature of suicide. The expert's statements that a particular patient would express suicidal thoughts when asked privately or that the patient and family members would reliably engage in recommended treatment are assumptions in many cases. Patients do not always disclose what they are thinking to their providers, and they may die by suicide impulsively. For these reasons, it is challenging for an expert witness to testify in cases involving suicide. Expert witnesses are left contending with the tensions between recognition of any errors in care delivery, providing answers to give solace to a family coping with the suicide's aftermath, and applying the relevant legal causation standards.