

NO. A08-1478

State of Minnesota  
 In Court of Appeals

Regina C. Losen, Trustee for the Heirs and Next of Kin of Deborah Miller,  
 Deceased, Randolph C. Miller and Laurie A. Miller,

*Appellants,*

vs.

Allina Health System, d/b/a United Hospital,  
 Minnesota Epilepsy Group, P.A., a Minnesota Corporation,  
 Paul Goering, M.D., Deanna L. Dickens, M.D. and  
 Patricia E. Penovich, M.D.,

*Respondents.*

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 AND PAUL GOERING, M.D.'S BRIEF AND APPENDIX**

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## LEGAL ISSUES

- I. Did the district court correctly rule that the Civil Commitment and Treatment Act provides immunity for health care providers who make a determination under Minn. Stat. § 253B.05 that a patient cannot legally be committed?**

The district court granted summary judgment in favor of Allina Health System and Dr. Goering, holding that Minn. Stat. § 253B.23, subd. 4, “grants immunity to physicians who determine in good faith based on their actual knowledge and the information they have available that they cannot place an emergency hold on a person because that person does not meet the requirement of Minn. Stat. § 253B.[0]5.”

- II. Should Plaintiffs’ constitutional argument be addressed where it is being raised for the first time on appeal and where the Attorney General was not provided with proper notice?**

The district court was never asked to address this issue.

- III. In the alternative, should this Court affirm the judgment below on the ground that dismissal in favor of Allina Health System and Dr. Goering was required because Plaintiffs failed to satisfy the requirements of Minn. Stat. § 145.682?**

Although Allina and Dr. Goering raised the issue in their motion for summary judgment, the district court did not rule on this issue.

## STATEMENT OF THE CASE AND THE FACTS

This lawsuit arises out of Ryan Miller's in-patient hospitalization at United Hospital on July 28-29, 2003. On August 12, 2003 – 14 days after his discharge from the hospital – Ryan shot and killed his mother, Deborah Miller, and wounded his father, Randolph Miller, and his father's wife, Laurie Miller. In this lawsuit, Plaintiffs allege that negligence on the part of the Defendants in the assessment, treatment and discharge of Ryan proximately caused his criminal conduct on August 12, 2003, and the resulting death and injuries.

The basic facts are substantially undisputed:

At the time of the shootings, Ryan was a 26-year-old man who had lived for his entire life in rural Mora, Minnesota. (Hospital Respondents' Appendix, p. 3, hereafter "HRA. \_\_") Ryan developed epilepsy at age two, following a MMR vaccination. (*Id.*) Thereafter he became a patient of Defendant Minneapolis Epilepsy Group ("MEG"), where his mother, Deborah, was employed long-term as an EEG technician. (HRA.4-5) In 1988, after experiencing ten years of severe intractable epilepsy that proved to be highly resistant to conventional medical treatment, Ryan underwent a left temporal lobectomy, which was recommended as a means of reducing his seizures or providing better control of them. (HRA.4) Ryan's seizures decreased following the surgery, but he was continued on anticonvulsant medication and continued to experience simple partial and complex partial seizures which would progress to secondarily generalized tonic-clonic seizures. (*Id.*) As an adult, Ryan came under the care of MEG neurologist Patricia Penovich. (HRA.5)

### *July 28-29 Hospitalization*

Ryan was admitted to United Hospital by one of Dr. Penovich's associates, MEG neurologist Deanna L. Dickens, M.D. on July 28, 2003, for evaluation and assessment because of Deborah Miller's concerns about Ryan's behavior. (A-104) Prior to his hospitalization, Ryan had never threatened to hurt anyone and his behavior was not interpreted as a threat to anyone. (HRA.23) However, his parents reported a recent change in behavior:

In mid June, he was evaluated in the neurology clinic and at that time, changed from Tegretol to Trileptal. *He has not had any significant change in seizure frequency and has not had any overt events; however, his parents describe a slow progressive behavioral change over the past 10 to 14 days.* They were most concerned for approximately three to four days when the behavior escalated. They describe the patient as hearing voices which includes spirits of both living and dead individuals. Many of the individuals are grandparents and loved ones, including his sister and mother. He also reports contact with deceased individuals such as Marilyn Monroe. Many of these auditory hallucinations focus on military campaigns in war-type settings. He is described as being obsessed with typing the stories that he hears and the patient reports he is doing this to make money. *He is not uncomfortable or frightened by these voices. He denies the fact they are derogatory toward himself or encourage him to hurt himself or others.* The patient states that God also told him he did not have epilepsy and approximately five to seven days ago, he discontinued his medications for at least two days. Review of some of his manuscripts notes a stream of consciousness without particular direction. According to his parents, they note he looks "better today" than in the days prior. They deny the fact he has ever had an episode similar to this in the past. *The patient has not made any threatening gestures or statements toward them.* This is not an apparent seizure by their estimation; however, the mother notes that he has had a history of status epilepticus.

(A-104) (emphasis added). An EEG revealed that Ryan was not experiencing seizures that would result in the recent behavior described in the medical records, so Dr. Dickens arranged for a psychiatric consult. (HRA.28)

On July 29, 2003, Paul Goering, M.D., the Medical Director of United Hospital's Department of Psychiatry, agreed to see Ryan immediately for the purpose of carrying out a psychiatric consultation. (HRA.28-29) Ryan cooperated in the evaluation, but declined to give Dr. Goering permission to speak with his parents. (A-115) Dr. Goering conducted a thorough psychiatric evaluation, spending 35 minutes reviewing documents, including medical records and Ryan's personal writings and spoke with MEG physicians Dr. Dossa, Dr. Dickens and their nurse practitioner. He then met with Ryan for 50 minutes. (A-112)

It was Dr. Goering's impression that Ryan had a relatively sudden onset of psychosis over the last few weeks before his hospitalization. (A-115) Based upon his review of the records and the interview of the patient and other care providers, Dr. Goering concluded that Ryan was experiencing a Psychotic Disorder, Not Otherwise Specified. (*Id.*) His recommendations, from the five page psychiatric consultation, dictated before Ryan was discharged from the hospital, include the following:

At this time, it does not appear the patient's psychosis is a product of his seizure disorder. *I do think that he would benefit from psychiatric intervention.* I have discussed hospitalization (transfer) as well as antipsychotic medications. He adamantly refuses each, identifying, in his logic, that he does not need them. He declines to allow me to speak with his mother at all. He makes it clear that were he to leave the hospital, he would not agree to psychiatric followup but he would agree to continued compliance with epilepsy decisions related to his care.

*I do not see the patient as holdable given the absence of imminent risk.* However, I am concerned about his long-term risk. He is moderately psychotic and he does have poor insight. As well, it appears that at least once recently he responded to hallucination by stopping his medications. If he develops more dangerous behavior, certainly the consideration of admitting him under a 72 hour hold would be reasonable.

*If the patient would be willing to consider an antipsychotic medication or transfer after meeting with the neurologist or his mother, I would certainly continue to offer these. I think my first choice, in this individual, would be Risperdal starting at 1 mg at h.s.*

Certainly, it is relatively unusual to see this rapid a presentation with these symptoms. It has some similarities to a bipolar disorder with mania. However this is limited evidence. Given the recent changes from Tegretol to Trileptal, I must wonder if his symptoms are worse because of this. However, this is only a possible conjecture.

*I remain available for further guidance if it is necessary or desired. At this time, though, I do not see the patient as psychiatrically holdable.*

(A-115-16) (emphasis added) Dr. Goering never saw or was asked to see Ryan again.

Later in the afternoon on July 29<sup>th</sup>, Ryan removed his own IV and EEG wires and attempted to leave the facility before he was discharged. (HRA.32-33) He was angry because he was not being allowed to leave the hospital. (*Id.*) Hospital staff alerted security and Ryan was caught just outside the hospital entrance, returned to the facility and temporarily placed in restraints. (HRA.35-36) Shortly after, Dr. Dickens reevaluated Ryan, determined that he had calmed down and ordered the removal of the restraints. Dr. Dickens then called Dr. Goering at home, as he already had left the hospital, and the two of them assessed the meaning of Ryan's recent attempt to leave the hospital prior to discharge. (HRA.30) Dr. Goering's perspective after this development was that Ryan had to agree to take medication and to follow-up with psychiatric treatment, or there would have to be further reflection on whether Ryan then met the standard for implementation of an involuntary 72-hour hold. (HRA.30-31) In other words, for Ryan to be discharged from the hospital at that point required that there be "confidence that he

would take the prescribed medicine and have a follow-up with supervision.” (*Id.*) The conversation with Dr. Dickens shortly before Ryan’s discharge from the hospital was Dr. Goering’s last involvement with Ryan’s care.

Dr. Dickens did not have any further conversation with Dr. Goering about Ryan because when she met with him and his mother and father, Ryan agreed to take the Risperdal prescription that Dr. Goering suggested and she understood that his parents agreed to arrange for follow-up psychiatric care. (HRA.37) In connection with the discharge plan, Dr. Dickens also impressed upon Deborah and Randolph Miller that, if Ryan’s circumstances changed – if he began hearing voices or did anything that was alarming or concerning – they should call 911, come back to United or go to any emergency room of a local hospital. At the request of the family as Ryan was being discharged, Dr. Dickens prescribed Carbatrol, a time-released form of the anti-seizure medication Tegretal, rather than Trileptal, as Ryan seemed to “feel better” on Carbatrol. (*Id.*) With this treatment plan in place, Ryan then was discharged from the hospital.

Although Ryan had always lived with his mother, after being discharged he stayed with his father and Laurie Miller in one of the units in the triplex in which they lived. Following the recommendation of Dr. Dickens, Ryan’s guns were locked up. Between the time of Ryan’s discharge from United Hospital on July 29, 2003 and the shootings two weeks later on August 12, 2003, Ryan Miller never threatened to hurt either himself or anyone else. (HRA.39) However, his behavior began to escalate, as documented in a journal kept by Randolph Miller during the two weeks prior to the shooting incidents. (HRA.24, 40-59) For example, on July 31<sup>st</sup>, Ryan was experiencing “more symptoms

than yesterday” and was writing “algebraic formulas.” (HRA.25) That day Ryan also lied about taking his medications. (*Id.*) Later in the day, Randolph Miller found Ryan in the driveway with a hunting knife and a scabbard. (*Id.*)

The August 6<sup>th</sup> journal entries reflect that Deborah called Randolph about taking Ryan off Risperdal. (HRA.51) On that same day, Randolph writes that Deborah said “If Ryan doesn’t get better, will have to do something” and his response that “I tell her to back off – give time.” (*Id.*)

On August 11<sup>th</sup>, the day before the shootings, Randolph logged in his journal that he had called Dr. Penovich’s office at 9:00 a.m. to communicate the message that he “strongly” wanted Ryan off of the Risperdal prescription. (HRA.58) Later he noted in his journal that Beth from Dr. Penovich’s office called and said “no changes. Arrange local Psyc. to manage.” (*Id.*) He then wrote “Talk to Deborah – she agr no shrink and bring him off Risperdal” and “Reduced (Risperdal) to ½ tab (.5 mg)/evening dose.” (*Id.*)

Two weeks after his hospitalization, following his intentional criminal acts on August 12<sup>th</sup>, Ryan was confined at the Kanabec County jail, where he revealed that he had not been taking his medications for days prior to the shootings. (HRA.10)

In a bifurcated criminal proceeding in August 2005, Ryan was found guilty of the intentional second degree murder of Deborah Miller and the premeditated first degree attempted murders of Randolph and Laurie Miller. (HRA.26) It was also judicially determined that at the time of the shootings Ryan was laboring under such a defect of reason so as to not know the nature of his acts, or that his acts were wrong. (*Id.*) Subsequently, he therefore was indeterminately committed to the St. Peter Security

Hospital as mentally ill and dangerous. (*Id.*) Ryan remains confined at St. Peter Security Hospital today. (*Id.*)

## ARGUMENT

### STANDARD OF REVIEW

On appeal from summary judgment this Court reviews the district court's ruling *de novo* and focuses on two questions: (1) whether there are any genuine issues of material fact; and (2) whether the district court erred in its application of the law. *Gomez v. David A. Williams Realty & Const., Inc.*, 740 N.W.2d 775 (Minn. App. 2007) (citing *State by Cooper v. French*, 460 N.W.2d 2, 4 (Minn. 1990)).

#### **I. THE DISTRICT COURT PROPERLY FOUND THAT THE HOSPITAL DEFENDANTS ARE IMMUNE FROM LIABILITY UNDER THE MINNESOTA CIVIL COMMITMENT AND TREATMENT ACT.**

Plaintiffs argue that Dr. Goering's good faith determination of whether Ryan Miller met the statutory emergency hold criteria was not an action taken pursuant to the Commitment and Treatment Act ("the Act"). The Act provides civil and criminal immunity for all persons acting in good faith pursuant to any provision of Minn. Stat. Ch. 253B:

All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to this chapter, are not subject to any civil or criminal liability under this chapter.

Minn. Stat. § 253B.23, subd. 4.

Plaintiffs' argument ignores the essential nature of the physician's decision. The decision whether to hold a patient *must* be made pursuant to the Act because without this

statutory authority, there is no basis on which a physician may ever hold a patient in the hospital against his will. Absent the Act, Dr. Goering as the treating physician would have no power whatsoever to place a patient on an emergency hold. Therefore, any determination of whether the patient may be held (and the assessment by an examiner in order to make that determination) *must* be an act “pursuant to” a provision of the statute.

**A. Having Acted in Good Faith to Make a “Hold” Determination Under the Act, the Hospital Defendants Were Entitled to Immunity.**

Dr. Goering conducted a thorough psychiatric evaluation of Ryan, spending 35 minutes reviewing documents, including medical records and Ryan’s personal writings and spoke with MEG physicians Dr. Dossa, Dr. Dickens and their nurse practitioner. Dr. Goering then met with Ryan for 50 minutes, all of which was done in order to make a determination as to whether Ryan could be held on an emergency basis. By keeping Ryan Miller hospitalized in order to perform an examination and determine whether there was a basis on which to impose an emergency hold, Dr. Goering was acting pursuant to the emergency hold provision of the Act, and therefore is entitled to the immunity granted to *all* persons acting under *any* provision of the Act.

Minnesota law specifically states that the Act “provides complete immunity from suit, not simply a defense to liability.” *Mjolsness v. Riley*, 524 N.W.2d 528, 530 (Minn. App. 1994). The plain language of the statute unambiguously applies to all individuals acting in good faith pursuant to *any* provision of the Act, and is not limited only to those individuals who actually decide to hold or commit someone. *Id.* at 531. In *Mjolsness*, the court expressly rejected plaintiff’s argument that immunity was not applicable because

the district court ultimately dismissed the commitment petition. *Id.* at 531. The court reasoned, “[t]o hold Riley liable because Mjolsness was not ultimately committed would be contrary to the statute’s broad grant of immunity. The statute’s plain language unambiguously applies to *all* persons acting in good faith and its grant of immunity *is not limited to persons who are successful* in their efforts to commit someone.” *Id.* (emphasis added).

Accordingly, the decision that Ryan Miller could not be involuntarily hospitalized under an emergency hold pursuant to Minn. Stat. § 253B.05 – because Ryan Miller did not meet the criteria laid out in the statutory provision – is shielded from liability by the chapter’s immunity provision, unless Plaintiffs can offer some evidence that the decision not to hold Ryan Miller was done in bad faith or with malice, or was the willful violation of a known right. *See Mjolsness*, 524 N.W.2d at 530. Significantly, bad faith conduct does not include mere erroneous judgment – the decision-maker must have had a malicious intent. *Id.*

Plaintiffs do not claim that the Hospital Defendants acted in bad faith in determining not to involuntarily admit Ryan Miller for inpatient treatment, and the record certainly would not support such a claim. The undisputed facts demonstrate that Dr. Goering made a good-faith determination on July 29, 2003, that Ryan was not in danger of causing injury to himself or others if not immediately detained, and therefore the criteria for keeping him at the hospital pursuant to an emergency hold were not met. At the time of Dr. Goering’s assessment, Ryan Miller denied hearing voices, was not having thoughts of suicide, had no plan to commit suicide, had no thoughts of harming others,

had no plan to harm others, had no violent thoughts, and otherwise showed no signs of active psychosis. (A-114) On these undisputed facts, the district court correctly held that United Hospital and Dr. Goering are immune from liability under Minn. Stat. § 253B.23, subd. 4. That decision should be affirmed.

**B. In Making Commitment Decisions Pursuant to Minn. Stat. § 253B.05, Physicians Act in a Quasi-Judicial Role and are Immune From Liability Arising From Such Determinations.**

The Act provides for *judicial* commitments of persons who are dangerous to themselves or others. *See, e.g.*, §§ 253B.07-.09. Recognizing that the judicial commitment procedures outlined in the Act may not always be timely available, the legislature determined that emergency admissions, as provided for by Minn. Stat. § 253B.05, should also be available. In so doing, the legislature essentially deputized medical personnel with judicial authority to determine whether or not someone could be held involuntarily under the statute when there is not sufficient time to obtain a court-ordered hold.

Courts apply quasi-judicial immunity to persons who are an integral part of the judicial process. *See Myers v. Price*, 463 N.W.2d 773, 775 (Minn. App. 1990) (recognizing that because judicial immunity protects judicial process, immunity “extends to persons who are integral parts of that process”). The rationale justifying quasi-judicial immunity is the same as that underlying judicial immunity – it enables judicial officers to act without fear of personal legal liability when discharging official duties. *Linder v. Foster*, 295 N.W. 299, 300-01 (Minn. 1940).

In *McDeid v. O'Keefe*, CO-03-177, 2003 WL 21525128, at \*2 (Minn. App. July 8, 2003) (HRA.61), this Court stated that “the immunity provided by section 253B.23, subd. 4, for those involved in the commitment process is comparable to a prosecutor’s immunity for acts involved in the charging of crimes.” Prosecutorial immunity applies with equal force to a prosecutor’s actions and any failure to act. *See Brown v. Dayton Hudson Corp.*, 314 N.W.2d 210, 214 (Minn. 1981) (“The discretionary decision whether to charge and whether to continue a prosecution lies at the very heart of the prosecutorial function.”); *Kipp v. Saetre*, 454 N.W.2d 639, 643 (Minn. App. 1990) (holding that prosecutorial immunity extends to omissions).<sup>1</sup>

Minn. Stat. § 253B.23, subd. 4 and the doctrine of quasi-judicial immunity operate to protect the Hospital Defendants from liability for good faith decisions made in assessing whether Ryan Miller could be held in the hospital. Both the immunity provision of the statute and doctrinal immunity enable physicians, like Dr. Goering, to act without fear of personal liability for carrying out quasi-judicial duties. The district court was correct in so holding and this Court should affirm summary judgment in favor of the Hospital Defendants.

**C. The Brief of Amicus Curiae Minnesota Association for Justice Merely Restates Plaintiffs’ Arguments and is not Persuasive.**

The Minnesota Association for Justice (“the Association”) adds little, if anything, to the analysis of the issue before this Court. An amicus curiae brief should inform the

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<sup>1</sup> Minnesota courts have recognized that immunity applies to third-party claims. *See S.J.S. v. Faribault County*, 556 N.W.2d 563, 565-66 (Minn. App. 1996) (upholding grant of absolute immunity to prosecutor in suit brought by non-defendant third-party).

court of facts or matters of law that may have escaped its consideration. It should not repeat or emphasize arguments already put forth by a party. An amicus brief should not argue the facts or urge that a particular party should prevail, nor should it repeat arguments already asserted by a party. ERIC J. MAGNUSON & DAVID F. HERR, MINNESOTA PRACTICE SERIES, VOL. 3, APPELLATE RULES ANNOTATED § 129.3 (2008 ed.) (citing cases). However, the Association does just that – simply restating Plaintiffs’ argument (see page 3) beginning with an introductory sentence that provides, “[a]s appellants explain in their brief . . .” The brief then goes on to reiterate Plaintiffs’ position.

There is little to say in response to the Association’s brief. The Association seemingly alleges that there is a fact dispute – there is not. The parties agree on the facts of this matter, but disagree on whether the district court, as a matter of law, properly interpreted the Act.

The Association relies heavily on *Carrington v. Methodist Medical Center, Inc.*, 740 So.2d 827 (Miss. 1999), for the proposition that Plaintiffs have a separate medical negligence claim apart from any claim they attempt to make under the Act. However, *Carrington* is distinguishable on a number of grounds, the most important of which is that the alleged negligent conduct – failing to provide adequate surveillance – took place more than two weeks after the involuntary judicial commitment. *Id.* at 828. The court emphasized that immunity was not applicable because, unlike the facts of this case, the alleged wrongdoing was not in connection with the commitment process; it was related to the patient’s care weeks after commitment. Here, Plaintiffs’ allegations arise directly

from the determination that Ryan was not holdable under the Act. Thus, the district court was correct in finding that immunity applied.<sup>2</sup>

**D. Minnesota Law Reflects a Strong Public Policy Against Holding or Committing Individuals Unless Involuntary Hospitalization is the Least Restrictive Alternative.**

The Act states a strong preference for utilizing the least restrictive means possible to deal with patients who are in need of mental health treatment: “Voluntary admission is preferred over involuntary commitment and treatment.” Minn. Stat. § 253B.04, subd. 1(a). Therefore, the stated statutory intent, and corresponding public policy dictates that physicians, when acting in lieu of the courts in placing an individual on an emergency hold, do so only where absolutely necessary.

Under Minnesota law an examiner may place a patient on an emergency hold only if, “the examiner is of the opinion, for stated reasons, that the person is mentally ill, developmentally disabled, or chemically dependent, and is in danger of causing injury to self or others if not immediately detained.” Minn. Stat. § 253B.05, Subd. 1(a)(2). The examiner's statement shall provide: “(1) sufficient authority for a peace or health officer to transport a patient to a treatment facility, (2) stated in behavioral terms and not in

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<sup>2</sup> In addition, *Carrington* states that it is limited to the facts of that case and it involves a completely different statute. The Mississippi statute provides:

(1) All persons acting in good faith in connection with the preparation or execution of applications, affidavits, certificates or other documents; apprehension; findings; determinations; opinions of physicians and psychologists; transportation; examination; treatment; emergency treatment; detention or discharge of an individual, under the provisions of sections 41-21-61 to 41-21-107, shall incur no liability, civil or criminal, for such acts.

conclusory language, and (3) of sufficient specificity to provide an adequate record for review.” *Id.* at subd. 1(c). “If danger to specific individuals is a basis for the emergency hold, the statement must identify those individuals, to the extent practicable.” *Id.*

The Act also provides that continued commitment is only permissible when there is *clear and convincing evidence* that “(1) the person continues to be mentally ill, developmentally disabled, or chemically dependent; (2) involuntary commitment is necessary for the protection of the patient or others; and (3) there is *no alternative to involuntary commitment.*” Minn. Stat. § 253B.12, subd. 4 (emphasis added). Courts must specifically state in involuntary commitment orders that “less restrictive alternatives have been considered and rejected by the court.” *Id.* at subd. 7. The court must also expressly provide its reasons for rejecting each alternative. *Id.*

Plaintiffs’ arguments on appeal fly in the face of these express public policy determinations. By arguing that immunity applies only where a patient is ultimately placed on an emergency hold, Plaintiffs are effectively arguing for the *most* restrictive alternative – committing anyone demonstrating any “dangerous behavior” (*see* Plaintiffs’ brief, p. 3), regardless of whether the patient agrees to take medication and seek psychiatric treatment. In other words, when in doubt – hold. The district court correctly observed that this interpretation stands the law on its head:

If the Court were to interpret the statute in the way that the plaintiffs want it to be interpreted, it would result in encouraging physicians to make their medical decisions based on fear of legal liability, not upon their good-faith judgment. Dr. Goering and Dr. Dickens believed that they could not, in good faith, make Ryan stay in the hospital because he agreed to take his medication and agreed that he would seek out follow-up psychiatric care. Predicting future dangerousness is an art. Experience and scientific

training can aid a physician in making this prediction, but there is no amount of scientific training that can result in predictions being made with certainty.

(A.198). The detailed provisions of the statute support Dr. Goering's and Dr. Dickens' good faith determination that Ryan Miller could not be involuntarily held. Minn. Stat. § 253B.04, subd. 1(c) provides that if a patient is "voluntarily participating in treatment for a mental illness," he "is not subject to civil commitment" under the Act. If an individual – like Ryan Miller in this case – "is participating in a medically appropriate course of treatment, including clinically appropriate and lawful use of neuroleptic medication" that constitutes voluntary participation in treatment and he is not subject to civil commitment. Here, Dr. Goering knew that Ryan Miller had assured Dr. Dickens that he would take his medication. Ryan's parents spoke with Dr. Dickens and also assured her that Ryan would take the medication prescribed and they would follow-up with a mental health professional. In making this good faith determination regarding whether Ryan Miller could be placed on an emergency hold pursuant to Minn. Stat. § 253B.05, Dr. Goering appropriately considered the fact that Ryan agreed to take his medication and seek follow-up treatment.

The Hospital Defendants' actions in connection with Ryan Miller's treatment were consistent with Minnesota law. The decisions regarding Ryan Miller's treatment, made in good-faith pursuant to the Act, are in accord with Minnesota public policy, were appropriate under the Act, and thus are shielded from liability.

Since the district court's ruling that the Hospital Defendants are immune from liability under Minn. Stat. § 253B.23, subd 4 is fully consistent with the public policy of

this State and with Minnesota law, this Court should affirm summary judgment in favor of the Hospital Defendants.

**E. Plaintiffs Cannot Legally Maintain a Common Law Medical Negligence Claim Against the Hospital Defendants.**

From the very first sentence of their brief, Plaintiffs emphasize their position that this is a common-law medical negligence case. That is simply not true – for two reasons.

First, Plaintiffs’ entire case is premised on the claim that the Hospital Defendants should have held Ryan Miller in the hospital *pursuant to the Act*. At common law, there is not, and has never been, a cause of action based on a doctor’s determination whether to invoke an emergency hold of his patient. Physicians were not given the authority to legally “hold” a patient until the enactment of the Minnesota Hospitalization and Commitment Act, Minn. Stat. §§ 253A.01-.21 (1967)<sup>3</sup>. Presently, treating physicians have no inherent, common law authority to hold a patient against the patient’s wishes. The legal authority to hold a patient is available to a physician only through the quasi-judicial authority conferred on the physician as an “examiner” pursuant to the emergency hold provision of the Act (Minn. Stat. § 253B.05).

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<sup>3</sup> Minn. Stat. § 253A.04, subd. 1 (1967) provided:

Subdivision 1. Any person may be admitted or held for emergency care and treatment in a hospital with the consent of the head of the hospital upon a written statement by any licensed physician that he has examined the person not more than 15 days prior to the person's admission, that he is of the opinion, for stated reasons, that the person is mentally ill or inebriate and is in imminent danger of causing injury to himself or others if not immediately restrained, and that an order of the court cannot be obtained in time to prevent such anticipated injury. Such physician's statement shall be sufficient authority for a peace or health officer to transport a patient to a hospital.

Second, a health care provider owes a duty of reasonable care only to a *patient* who is receiving treatment from that provider. It is this professional relationship that creates a legal duty. *Schendel v. Hennepin County Medical Center*, 484 N.W.2d 803, 807-08 (Minn. App. 1992); *Peterson v. St. Cloud Hospital*, 460 N.W.2d 635, 638 (Minn. App. 1990). But if this duty is violated, *only the patient* has standing to sue the treating health care provider – not a third party. See *McElwain v. Van Beek*, 447 N.W.2d 442, 446 (Minn. App. 1989).

In the absence of a patient-physician relationship or any contractual relationship with United Hospital and Dr. Goering, Plaintiffs in this case simply have no standing to assert claims of medical negligence with respect to the care and treatment provided to Ryan Miller. *McElwain*, 447 N.W.2d at 446. In *McElwain*, the plaintiff was not the defendant's patient, but was in the emergency room, standing next to her brother (the patient) and holding his hand when the defendant physician administered a local anesthetic in preparation for repairing a cut on the bridge on the patient's nose. 447 N.W.2d at 444. The plaintiff apparently fainted at the sight of the injection of the anesthetic. She fell to the floor, fractured her skull, and sustained a permanent loss of hearing in her right ear. The plaintiff brought a claim of medical negligence against the physician. *Id.*

In affirming the decision of the district court to grant summary judgment to the defendant, this Court stressed the lack of a physician-patient relationship:

Under the facts of this case, there was no relationship between [the plaintiff] and Dr. Van Beek. [The plaintiff] was not a patient of Dr. Van Beek so as to impose liability under a theory of medical malpractice. There

was no contractual relationship between [the plaintiff] and Dr. Van Beek as to the emergency treatment of her brother . . . . The trial court was correct in holding as a matter of law that Dr. Van Beek owed no duty to [the plaintiff] and therefore dismissal of the claim by summary judgment was proper.

*Id.* at 446. Likewise, as third-parties, Plaintiffs simply do not have a cause of action against the Hospital Defendants for medical negligence.

**F. As Third-Parties, Plaintiffs' Only Redress is a Claim Under Minn. Stat. § 148.975 Which was not Pleaded Here Because Plaintiffs Cannot in Good Faith Allege that the Hospital Defendants had a Duty to Warn Under the Statute.**

Under certain limited circumstances, Minnesota law (Minn. Stat. § 148.975) requires a licensed psychologist or as a licensed psychological practitioner to warn third-parties of a client's potential for violent behavior. Under that statute, a psychologist has a "duty to predict, warn of, or take reasonable precautions to provide protection from, violent behavior" only if the client has communicated to the licensee "a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim." *Id.*, subd. 2. Those circumstances are not present here, which is presumably why Plaintiffs did not plead a cause of action under Minn. Stat. § 148.975.

There is no evidence in this record that Ryan Miller communicated to Dr. Goering "a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim." The duty to warn was not implicated. Furthermore, where the duty to warn is not implicated, Minn. Stat. § 148.975, subd. 3 clearly states that "no monetary liability or cause of action may arise against a licensee for failure to predict,

warn of, or take reasonable precautions to provide protection from, a client's violent behavior."

**II. BECAUSE PLAINTIFFS FAILED TO RAISE THEIR CONSTITUTIONAL CLAIM TO THE DISTRICT COURT OR NOTIFY THE ATTORNEY GENERAL, PLAINTIFFS' CONSTITUTIONAL CLAIM IS NOT PROPERLY BEFORE THIS COURT.**

Plaintiffs argue that the district court's interpretation of the immunity statute violates Minn. Const. Art. 1 § 8. Because Plaintiffs failed to raise this claim in the district court, it is waived. *Thiele v. Stich*, 425 N.W.2d 580, 582 (Minn. 1988).

In addition, Plaintiffs failed to inform the Attorney General of their challenge to the statute as required by Minn. R. Civ. P. 5A and Minn. R. Civ. App. P. 144. Notification to the attorney general and the opportunity to intervene in the district court matter are prerequisites to consideration of a constitutional claim on appeal. *See Automotive Merchandise, Inc. v. Smith*, 297 Minn. 475, 476-77, 212 N.W.2d 678, 679 (1973) (citation omitted). *See also Sartori v. Harnischfeger Corp.*, 432 N.W.2d 448, 452 (Minn. 1988) ("[I]t is extremely doubtful we would hold a statute unconstitutional if the attorney general had not been properly notified."); *In re Appeal of Leary*, 272 Minn. 34, 46-47, 136 N.W.2d 552, 560 (1965) (holding that in the absence of compliance, the court will not consider the constitutionality of a statute).

Finally, even if the constitutional issue were properly before the Court, "the Remedies Clause does not guarantee redress for every wrong, but instead enjoins the legislature from eliminating those remedies that have *vested at common law* without a

legitimate legislative purpose.” *Olson v. Ford Motor Co.*, 558 N.W.2d 491 (Minn. 1997) (citation omitted) (emphasis in original).

To the extent Plaintiffs seek redress under the Act, Article 1, § 8 is inapplicable. *See Ackerman v. American Family Mut. Ins. Co.*, 435 N.W.2d 835, 839 (Minn. App. 1989) (holding that the remedies clause does not protect statutory claims, including actions for wrongful death). As discussed above, Plaintiffs do not have a common law medical malpractice claim. *See McElwain*, 447 N.W.2d at 446. Therefore, not only have Plaintiffs waived any constitutional claim, it also fails on the merits.

**III. ALTERNATIVELY, SUMMARY JUDGMENT IN FAVOR OF THE HOSPITAL DEFENDANTS SHOULD BE AFFIRMED BECAUSE PLAINTIFFS’ EXPERT AFFIDAVITS FAIL TO SET FORTH THE NECESSARY STANDARD OF CARE AND CHAIN OF CAUSATION REQUIRED UNDER MINN. STAT. § 145.682.**

The Hospital Defendants also raised Plaintiffs’ failure to satisfy the expert review statute, Minn. Stat. § 145.682, in their motion for summary judgment in the district court. Having determined that the Hospital Defendants were entitled to immunity under Minn. Stat. § 253B.23, subd. 4, however, the district court never ruled on this issue.

On appeal, this Court may review the issue pursuant to Minn. R. Civ. App. P. 103.04. *See Semler v. Klang*, 743 N.W.2d 273, 279, n.5 (Minn. App. 2007) (“[The statute of limitations] issue was presented to, but not addressed by the district court, which dismissed the claims against Huber, Koop, and Bolduc on the ground of official immunity. We address it in the interest of completeness. *See* Minn. R. Civ. App. P. 103.04”). Minnesota law also provides that this Court may affirm summary judgment on an alternate ground where there is no genuine issue of material fact. *Northway v.*

*Whiting*, 436 N.W.2d 796, 798 (Minn. App. 1989) (“we may affirm a summary judgment if there are no genuine issues of material fact and if the decision is correct on other grounds”) (citing *Braaten v. Midwest Farm Shows*, 360 N.W.2d 455, 457 (Minn. App. 1985)).

To establish a *prima facie* case of medical malpractice, a plaintiff must produce the following evidence:

- (1) Expert testimony establishing the standard of care recognized by the community;
- (2) Expert testimony as to how the defendant departed from the standard of care; and
- (3) Expert testimony that the defendant’s departure from the standard of care was a direct cause of the injuries to the plaintiff.

*Plutshack v. Univ. of Minn. Hosp.*, 316 N.W.2d 1, 5 (Minn. 1982); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 692 (Minn. 1977).

Minn. Stat. § 145.682 requires that in order to commence a medical malpractice action, a plaintiff’s attorney must provide, along with the complaint, an affidavit signed by the attorney which states:

[T]he facts of the case have been reviewed by the plaintiff’s attorney with an expert whose qualifications provide a reasonable expectation that the expert’s opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff . . . .

Minn. Stat. § 145.682, subd. 3(a). The statute then requires the plaintiff’s attorney to serve a second affidavit within 180 days of commencement of the suit that contains a detailed explanation of the expert’s opinions, including:

[T]he identity of each person whom plaintiff expects to call as an expert witness at trial to testify with respect to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. . . .

Minn. Stat. § 145.682, subd. 4(a).

It is well-established that under Minn. Stat. § 145.682, an expert affidavit must set out, “[a]t a minimum . . . ‘specific details concerning their experts’ expected testimony, including the applicable standard of care, the acts or omissions that plaintiffs allege violated the standard of care and an outline of the chain of causation’ between the violation [of] the standard of care and the plaintiff’s damages.” *Lindberg v. Health Partners, Inc.*, 599 N.W.2d 572, 577 (Minn. 1999) (citing *Sorenson v. St. Paul Ramsey Med. Ctr.*, 457 N.W.2d 188, 193 (Minn. 1990)).

Plaintiffs’ experts have not followed the guidance of the Minnesota Supreme Court as detailed in *Lindberg* and *Sorenson*, failing to sufficiently set forth both the applicable standard of care and the chain of causation – specifically failing to account for the two week lapse between the alleged negligence and the harm. For these reasons the Hospital Defendants are alternatively entitled to dismissal of the claims against them pursuant to Minn. Stat. § 145.682.

**A. The Hospital Defendants are Entitled to Mandatory Dismissal of Plaintiffs’ Claims Because Their Experts’ Opinions Fail to Adequately Set Forth the Applicable Standard of Care.**

Plaintiffs’ experts make a number of broad brushed claims, including that Dr. Goering’s evaluation of Ryan Miller was inadequate, that he failed to properly prescribe anti-psychotic medication, and that he should have placed Ryan on a 72-hour hold.

However, Plaintiffs' experts fail to sufficiently define the applicable standard of care and never explain what the standard of care required Dr. Goering to do, based on these facts, regarding assessment, prescribing anti-psychotic medication, and what facts form the basis of the applicable standard of care requiring a 72-hour hold. Without sufficient expert support, Plaintiffs' claim that Dr. Goering breached the standard of care fails.

*1. The Alleged Failure to Adequately Evaluate*

A general assertion that Dr. Goering "departed from accepted standards of practice by failing to assess more thoroughly Ryan's dangerousness" (A-131), is not sufficient to set forth the applicable standard of care. The Minnesota Supreme Court has held that statements that a defendant "failed to properly evaluate" or "failed to properly diagnose" are not legally sufficient to satisfy the requirements of section 145.682, subd. 4. *Sorenson*, 457 N.W.2d at 192-93. "These are empty conclusions which, unless shown how they follow from the facts, can mask a frivolous claim." *Id.* at 193. The purpose of expert testimony is to "interpret the facts and connect the facts to conduct which constitutes malpractice and causation." *Id.* at 192.

Dr. Krakowski also opines that "the doctors" did not "determine that Ryan Miller was clearly dangerous during his hospital stay" and that further evaluation was warranted. (HRA.67) Again, Dr. Krakowski never explicitly sets forth what "further evaluation" is required by the applicable standard of care, except to speculate that:

if they had convinced Ryan Miller to voluntarily stay or if they had placed him on an emergency hold, this would have allowed for round-the-clock observation by health care professionals. This would have allowed for a better assessment of the risk for violence. The risk of violence would have

been undeniable. Appropriate treatment, including medication, teaching, therapy and extended commitment would have been initiated.

(HRA.67)

Likewise, Dr. Krakowski provides no support for his opinion that “appropriate treatment, including medication, teaching, therapy and extended commitment would have been initiated.” (*Id.*) He does not explain what the standard of care requires in terms of assessment of dangerousness, nor does he extrapolate how the standard of care calls for further assessment that would ultimately lead to “medication, teaching, therapy and extended commitment.” (*Id.*)

Plaintiffs’ conclusory allegation that the doctors, presumably including Dr. Goering, “failed to determine Ryan Miller was clearly dangerous” fails to take into account the specific facts of this case and to connect those facts to the resulting harm. Neither Dr. Krakowski, nor Dr. Holtzman explain what the applicable standard of care required Dr. Goering to do in terms of further evaluation or assessment under the facts of this case. Plaintiffs’ experts offer no substantive opinion that if the undefined “further evaluation” had been conducted, there would have been a legal basis on which to hold Ryan and that the presumed commitment would have prevented the ultimate harm. As a result, Plaintiffs’ claim fails.

## *2. The Alleged Failure to Properly Prescribe Anti-Psychotic Medication*

Dr. Goering prescribed Risperdal for Ryan. Dr. Krakowski states, “Risperdal 1 mg q HA is a very low and sub therapeutic dose.” (A-138) The glaring deficiency in Dr. Krakowski’s opinion is his failure to state what dose should have been prescribed

according to the applicable standard of care, why, or how Ryan's symptoms would have decreased, or how a different dose or different medication would have eliminated the harm.

Dr. Krakowski states that "[i]t was important for Ryan to remain in the hospital in order to establish the proper dosage of medication and to watch for side effects." (HRA.69) Dr. Krakowski seems to suggest, without sufficient explanation, that whenever anti-psychotic medication is prescribed, the standard of care requires that an individual be hospitalized in order to evaluate the proper dosage. The record reflects that Dr. Goering's preference was to hospitalize Ryan Miller, however there was no legal basis on which to voluntarily hold him and Ryan refused voluntary hospitalization. Dr. Krakowski fails to articulate what the standard of care was given the facts of this case. Dr. Krakowski does not offer an opinion that contradicts Dr. Goering's conclusion that he could not hold Ryan – to monitor his medication, or otherwise.

### *3. The Alleged Failure to Place Ryan Miller on a 72-Hour Hold*

At the time of the shootings, Minn. Stat. § 253B.05 concerning involuntary admission or an emergency hold provided, in part:

#### **Subdivision 1. EMERGENCY HOLD.**

- (a) Any person may be admitted or held for emergency care and treatment in a treatment facility with the consent of the head of the treatment facility upon a written statement by an examiner that:

\* \* \*

- (2) The examiner is of the opinion, for stated reasons, that the person is mentally ill, mentally retarded or chemically

dependent, and is in danger of causing injury to self or others if not immediately detained;

Minn. Stat. § 253B.05, subd. 1 (emphasis added). Ryan did not demonstrate a danger to himself or others if not immediately detained. In the history and physical it was noted that Ryan had not made any threats toward his parents.

According to his parents, they note he looks “better today” than in the days prior. They deny the fact he has ever had an episode similar to this in the past. *The patient has not made any threatening gestures or statements toward them.* This is not an apparent seizure by their estimation; however, the mother notes that he has had a history of status epilepticus.

(A-104) (emphasis added) Dr. Goering also indicated that based on his extensive evaluation Ryan was not “holdable.” (A-115)

Plaintiffs’ experts fail to articulate on what basis a 72-hour hold was legally available, again failing to apply the specific facts of this case to their conclusions. Dr. Krakowski concludes that “accepted standards of medical practice required Dr. Goering to admit Ryan on a 72-hour emergency hold” (A-131), that “[a]ccepted standards of medical practice required admitting Ryan under a 72-hours [sic] hold” (A-135), and that “[f]ailure to do so was a departure from accepted standards of medical practice.” (A-135)

Dr. Krakowski does not explain how the facts as presented to Dr. Goering establish the applicable standard of care – allegedly that a 72-hour hold was necessary and legally possible. Therefore, Plaintiffs fail to meet the requirements of Minn. Stat. § 145.682 mandating dismissal of their claims.

**B. The Hospital Defendants are Entitled to Mandatory Dismissal of Plaintiffs’ Claims Because Their Experts’ Opinions Fail to Adequately Outline the Chain of Causation.**

The alleged harm occurred two weeks after Ryan's hospitalization. To satisfy the causation requirements of Minn. Stat. § 145.682, Plaintiffs' experts must establish a detailed causal chain of events, proving that the Hospital Defendants' purported negligence on July 28 and 29 "caused" the harm on August 12. Bald assertions that the medical providers were generally negligent and that such undefined breaches of the standard of care caused or contributed to the alleged harm are not legally sufficient.

In *Teffeteller v. University of Minnesota*, 645 N.W.2d 420, 426 (Minn. 2002), the Minnesota Supreme Court held that the plaintiff's expert opinion on causation, which stated "the departures from accepted levels of care, as above identified, were a direct cause of [plaintiff's] death" contained only "facile declarations" which did not establish causation. *Id.* at 429. Instead, the court explained, "[t]he gist of expert opinion evidence as to causation is that it explains the 'how' and the 'why' malpractice caused the injury." *Id.* at n. 4.

Similarly, in *Lindberg*, the Minnesota Supreme Court dismissed the plaintiff's medical malpractice claim specifically because plaintiff's expert affidavit provided only "broad and conclusory statements as to causation." 599 N.W.2d at 578. In that case, the expert opinion offered by the plaintiff stated:

Based upon a reasonable degree of medical certainty, it is more probable than not, that if, among other things, Debra Lindberg had been instructed to seek medical treatment at the time of her phone call on the morning of March 28, 1994, Lukas Stewart Lindberg would not have died. Based upon a reasonable degree of medical certainty, Lukas Stewart Lindberg died as a result of negligent and careless conduct of the defendants and/or their agents and employees.

*Id.* The *Lindberg* court held that this expert disclosure failed to provide the specificity required to support the necessary causal link between the alleged deviation from the standard of care and the damages asserted by plaintiff, necessitating mandatory dismissal. *Id.* at 575.

Here, Plaintiffs' experts, Dr. Krakowski and Dr. Holtzman, allege that the following negligent conduct, all of which took place *two weeks* prior to the alleged harm, caused their damages: (1) Dr. Goering's inadequate assessment of Ryan Miller; (2) Dr. Goering's failure to recognize the "imminent danger to Ryan's family;" (3) the improper dose of antipsychotic medication prescribed to Ryan Miller; and (4) the failure to place Ryan Miller on a 72-hour hold. (A-139; A-143-45)

Like the experts in *Teffeteller* and *Lindberg*, Plaintiffs' experts provide insufficient, minimal, conclusory opinions on causation. Initially, Dr. Krakowski's entire causation opinion was summarized in a single sentence:

It is Dr. Krakowski's opinion that had Ryan been provided care that met the accepted standards of medical practice, it is more likely than not that the acute psychosis would have been successfully treated and that the ultimate outcome, i.e., the murder and shootings, would not have occurred.

(A-139) After Defendants' moved for summary judgment and to dismiss Plaintiffs' claims, Plaintiffs attempted to cure the expert opinion deficiencies by supplementing the opinion of Dr. Krakowski. Dr. Krakowski's supplemental opinion, like the original disclosure, similarly makes only general conclusions on causation:

If Ryan had been adequately evaluated by the physicians treating him at United hospital in July 2003 his psychosis would have been appropriately identified as dangerous and adequately treated and the shootings most likely would have been avoided.

\*\*\*\*

With the proper antipsychotic treatment, Ryan Miller's psychotic symptoms would have been reduced or eliminated and the risk of violent behavior would have also been significantly reduced and more likely than not the shootings would not have occurred.

\*\*\*\*

If the medication dose would have been correctly prescribed; the psychotic symptoms effectively suppressed and more likely than not, the shootings would have been avoided.

(HRA.68, 70, 71) Plaintiffs' experts' state only that "If Ryan had been adequately evaluated by the physicians treating him at United hospital in July 2003 his psychosis would have been appropriately identified as dangerous and adequately treated and the shootings most likely would have been avoided." (HRA.68, 70-71) Dr. Krakowski concludes that the "risk of violence would have been undeniable," but this conclusion is wholly unsupported by the record. (HRA.67) Dr. Krakowski cites no evidence in the medical record or otherwise to support that statement. It is nothing more than Dr. Krakowski's best guess about what might have happened if Ryan had been held.

Dr. Krakowski applies the wrong standard. He opines that "adequate assessment over a 72 hour period would *most likely* have revealed the risk for violent behavior." (HRA.70) (emphasis added) In addition Dr. Krakowski states that if a 72-hour hold had been placed, "Ryan *may have* been receptive to education regarding his diagnosis and increase his willingness to be compliant with the treatment." (*Id.*) (emphasis added) Dr. Krakowski summarily concludes, "[i]f the medication dose would have been correctly prescribed; the psychotic symptoms effectively suppressed *and more likely than not*, the

shootings would have been avoided.” (HRA.71) (emphasis added) “Most likely,” “may have,” and “more likely” are not the applicable standards. Plaintiffs must provide expert disclosures stating that it is “more probable than not” that a 72-hour hold was legally possible and that had the hold been placed, the shootings two weeks later would not have occurred. Plaintiffs’ experts have failed to meet this threshold.

Plaintiffs’ experts fail to connect the causal chain – providing only a generalization as to what Dr. Goering should have done, never applying those generalized observations to the facts of this case, and failing to link the alleged breach of the standard of care to the harm in this case. Dr. Menahem Krakowski’s supplemental opinion still falls far short of the requirements set forth in Minn. Stat. § 145.682. The supplemental opinion attempts to establish causation by offering further opinions as to the standard of care. Thus, the supplement provides no more substantive opinion on causation than the initial disclosures did.

As for Dr. Holtzman’s purported testimony on causation, it is set forth in two sentences:

It is expected that Dr. Holtzman will testify that it is more likely than not that Ryan Miller’s symptoms of acute psychosis would be effectively controlled with medications. With appropriate treatment of Ryan Miller’s symptoms of psychosis in July and August of 2003, it is more likely than not that the shootings would not have occurred.

(A-145) Dr. Holtzman’s opinion was never supplemented. Plaintiffs’ experts have failed to establish that even if Ryan had been hospitalized for 72 hours, it was more probable than not that the harm would have been prevented.

Plaintiffs' experts never address how a 72-hour hold would have prevented the shootings that took place *two weeks* after Ryan's discharge. As noted above, Dr. Krakowski can only say that Ryan "may have" become compliant with treatment. This is raw speculation without any support. Ryan's parents requested that he discontinue the Risperdal, and although the doctor said not to do so, they evidently determined a lesser dose was warranted. Ryan's father wrote in his journal that Beth from Dr. Penovich's office called and said "no changes. Arrange local Psyc. to manage." (*Id.*) He then wrote "Talk to Deborah – she agr no shrink and bring him off Risperdal" and "Reduced (Risperdal) to ½ tab (.5 mg)/evening dose." (HRA.58) The record reflects that Ryan stopped taking his medication for days prior to the shootings. (HRA.10) Plaintiffs' experts fail to address any of these facts and the causal gap between the time of discharge – even if Ryan had been placed on a 72 hour hold – and the shootings. This causal gap, wholly unaccounted for by Plaintiffs' experts, is fatal to Plaintiffs' claim.

Plaintiffs' experts' opinions make only vague, conclusory statements that the alleged breaches caused Plaintiffs' harm. Plaintiffs fail to set forth an outline of the chain or causation, and therefore have failed to meet the threshold expert affidavit requirements of Minn. Stat. § 145.682. Plaintiffs' failure to comply with Minn. Stat. § 145.682 provides an alternate basis on which this Court can affirm summary judgment in favor of United Hospital and Dr. Goering.

### CONCLUSION

The district court correctly ruled that the Civil Commitment and Treatment Act provides immunity for health care providers who determine under Minn. Stat. § 253B.05

that a patient does not meet the criteria for involuntary hospitalization. This Court therefore should affirm the district court's grant of summary judgment in favor of Allina Health System and Dr. Goering. Plaintiffs' constitutional argument should not be considered, as it is being raised for the first time on appeal. Even if the constitutional argument had been properly raised, it fails on the merits.

Alternatively, this Court should affirm the judgment below on the ground that dismissal in favor of Allina Health System and Dr. Goering was mandated by Plaintiffs' failure to satisfy both the standard of care and causation requirements of Minn. Stat. § 145.682.

**BASSFORD REMELE**  
**A Professional Association**

Dated: 12/2/2008

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