IN THE SUPREME COURT OF TEXAS

NO. 05-0386

PROVIDENCE HEALTH CENTER A/K/A DAUGHTERS OF CHARITY HEALTH SERVICES OF WACO AND DEPAUL CENTER A/K/A DAUGHTERS OF CHARITY HEALTH SERVICES OF WACO, PETITIONERS,

v.

JIMMY AND CAROLYN DOWELL, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF JONATHAN LANCE DOWELL, DECEASED, RESPONDENTS

-consolidated with-

NO. 05-0788

JAMES C. PETTIT, D.O., PETITIONER,

v.

JIMMY AND CAROLYN DOWELL, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF JONATHAN LANCE DOWELL, DECEASED, RESPONDENTS

ON PETITIONS FOR REVIEW FROM THE COURT OF APPEALS FOR THE TENTH DISTRICT OF TEXAS

JUSTICE HECHT delivered the opinion of the Court, in which JUSTICE BRISTER, JUSTICE GREEN, JUSTICE JOHNSON, and JUSTICE WILLETT joined.

JUSTICE WAINWRIGHT filed an opinion concurring in part and dissenting in part.

JUSTICE O'NEILL filed a dissenting opinion, in which CHIEF JUSTICE JEFFERSON and JUSTICE MEDINA joined.

Twenty-one-year-old Lance Dowell was taken to the emergency room and treated for a superficial, self-inflicted cut on his left wrist. Distraught over losing his girlfriend, he had been threatening to kill himself earlier, but he had calmed down and did not want to be hospitalized. He was released on his promises that he would not commit suicide, would stay with his parents, and would go to the local Mental Health and Mental Retardation center for a follow-up assessment. His mother, a registered nurse, was with him and did not object to his release. He went to a family reunion and to a rodeo with his brother, repeatedly assuring his mother that he was okay. His mother and brother believed him, and no one else reported anything unusual in his behavior. But thirty-three hours after his release, he hanged himself. Lance's parents now contend that his tragic death was proximately caused by the negligence of the emergency room physician and nurse in releasing him. We hold that any connection between his release and death is too attenuated for proximate cause. Accordingly, we reverse the judgment of a divided court of appeals[1] and render judgment for petitioners.

Friday evening before Labor Day 1997, Lance took three or four Tylenol sinus capsules with a shot of whiskey and used his pocket knife to cut his wrist. The cut was about three centimeters long and two millimeters deep. A police officer and deputy sheriff called to the scene found him sitting alone in the living room of his parents' house on their farm near Teague, Texas. Lance was not bleeding, but there was blood on the porch and in the living room. While the officers tried to enter through the back door, Lance crawled out a window and hid in the woods nearby. Larry, his older brother, arrived to wait for his return, and the officers left.

About an hour and a half later, Lance returned. He was distraught because the parents of his sixteen-year-old girlfriend had told him to stay away from her. Lance told Larry to leave him alone and let him "finish it". Earlier that week, Lance had alarmed his girlfriend by telling her he had

[1] 167 S.W.3d 48 (Tex. App.–Waco 2005).

taken "some pills", and she had called his mother, Carolyn, in Waco (about 55 miles west of Teague). Lance told his mother that he had only taken a few Advil, and Carolyn checked his vital signs and found them normal. She insisted he drink plenty of water but sought no treatment for him. But in the early hours of Saturday morning, Larry thought Lance was serious and called the officers back out to the house.

Lance was saying he would kill himself if everybody left, so the deputy sheriff took him into custody, as permitted by Texas law,[2] and drove him to respondent Providence Health Care's emergency room in Waco. Lance was agitated at first but calmed down during the hour-and-fifteen-minute drive, and did not talk a lot. He was no longer saying he wanted to kill himself. They arrived at the ER at 6:47 a.m.

Lance had been there before. When he was 19, another girlfriend threatened to leave him, and he went out in the pasture and put a gun to his head. He surrendered the gun without incident, and a deputy sheriff drove him from Teague to Providence's ER. Though he was detained under an emergency warrant,[3] he consented to being admitted for treatment at respondent DePaul Center, Providence's psychiatric treatment division. He was discharged five days later and instructed to obtain counseling from the local Mental Health and Mental Retardation center, but he never did.

On this second visit, Lance was examined by a DePaul nurse, Mary Theresa Fox, and by the ER physician, respondent James C. Pettit, who sutured his cut. Pettit and Fox talked with Lance very briefly, and neither made a comprehensive assessment of his risk of suicide. Carolyn arrived, and Lance told her he did not want to be kept there. He told Fox he was not suicidal and did not want

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[2] *See* TEX. HEALTH & SAFETY CODE § 573.001(a) ("A peace officer, without a warrant, may take a person into custody if the officer: (1) has reason to believe and does believe that: (A) the person is mentally ill; and (B) because of that mental illness there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained; and (2) believes that there is not sufficient time to obtain a warrant before taking the person into custody."), (d) ("A peace officer who takes a person into custody under Subsection (a) shall immediately transport the apprehended person to: (1) the nearest appropriate inpatient mental health facility; or (2) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available.").

[3] *See id.* §§ 573.011-.012.

to be admitted to DePaul. Because he was an adult, he could not be held involuntarily for more than the holiday weekend without a court order.[4] Fox agreed to release him if he would sign a no-suicide contract (part of the standard treatment in such situations), go to the MHMR center for assessment the following Tuesday, and promise to stay with his family until then. Lance told Fox he would stay with his family and signed the contract, agreeing to talk with a friend, family member, or a staff person at DePaul if he had feelings or urges to hurt or to kill himself he felt he could not control. Carolyn had concerns about Lance's being released but did not voice them. He was discharged at 9:32 a.m.

Later Saturday morning, Carolyn drove Lance and his sister to a weekend family reunion at Lake Limestone (about 20 miles south of Teague), where, in her words, "there would be a lot of people around who loved [Lance]". Lance's father, Jimmy, was already there. Carolyn told him what had happened and that they "needed to keep a real close eye on Lance". Jimmy was retired under a long-term disability and had been hospitalized in the past for mental health problems.[5] Carolyn knew from reading the ER discharge sheet that Lance had been instructed to stay with his family until he could be seen and assessed by a counselor, and she was concerned about leaving Lance with Jimmy while she returned to Waco to work, but she knew there would be other family members around. Lance kept telling her he would be okay.

Larry was at the reunion, too, and he told Lance they should talk if Lance had a problem. To "keep his spirits up", Larry took Lance to a rodeo Saturday night. Lance talked with friends, and

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[4] See TEX. HEALTH & SAFETY CODE § 573.021 (b) (providing in relevant part that "[a] person accepted for a preliminary examination may be detained in custody for not longer than 24 hours after the time the person is presented to the facility unless a written order for further detention is obtained. . . . If the 24-hour period ends on a Saturday, Sunday, legal holiday, or before 4 p.m. on the first succeeding business day, the person may be detained until 4 p.m. on the first succeeding business day"), (c) ("A physician shall examine the person as soon as possible within the 24 hours after the person is apprehended . . . .") (post-1997 amendments omitted); *see* Act of April 29, 1991, 72dd Leg., R.S., ch. 76, §§ 1, 20, 1991 Tex. Gen. Laws 515, 577, 648 (adopting the Health and Safety Code in a nonsubstantive recodification of prior statutes).

[5] Jimmy's mental problems associated with his disability are what the dissent refers to as "a family history of severe depression", *post* at ___, and "a family history of hospitalization for depression", *post* at ___.

Larry saw nothing in his behavior to cause concern. After the rodeo, Larry drove to the farm, and Lance went alone in his pickup to see a friend. Larry did not know someone was supposed to stay with Lance at all times, and anyway, as he said, "21-year-old guys do sometimes what they want". Lance got to the farm about 2:00 a.m. and went to bed.

Sunday morning Larry and Lance slept in, then went back to the reunion for lunch. Carolyn called Lance after she got off work, and he told her not to worry, that he would be okay. Larry left Sunday afternoon after Lance agreed to join him at a cousin's party that evening. Lance stayed to help his father, but later he drove to the farm to help a family friend bale hay. When Carolyn called late Sunday afternoon, Jimmy told her where Lance had gone, and she felt okay because he would not be alone. Carolyn and Larry both testified that if they had seen or heard of anything unusual in Lance's behavior during the weekend, they would immediately have sought care for him.

About 7:00 p.m., the friend Lance had gone to help found his body hanging in a tree at the farm. In his pickup, parked nearby, a girl's picture was on the steering wheel and Lance's picture was on the driver's seat.

Almost two years later, Jimmy and Carolyn brought this wrongful death and survival action against Providence, DePaul, and Pettit. The jury found that the defendants' negligence caused Lance's death, allocated responsibility 40% to Providence, 40% to DePaul, and 20% to Pettit, and assessed damages of $400,000 for the Dowells and $400,000 for Lance's estate. The trial court rendered judgment on the verdict. A divided court of appeals affirmed.[6]

The Dowells contend that petitioners were negligent in discharging Lance from the ER without a comprehensive assessment of his risk for suicide. Petitioners argue that even if they were negligent in that respect, their negligence was not, as a matter of law, a proximate cause of Lance's death a day and a half later. We agree with petitioners.

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[6] 167 S.W.3d 48 (Tex. App.–Waco 2005).

Several things defeat causality. In the first place, although the Dowells' expert testified that many patients will consent to treatment when sternly confronted with the dangers of refusal, there is evidence that Lance himself would not have consented to treatment and no evidence that Providence could have kept Lance from being discharged. Two years earlier, Lance had agreed to five days' treatment at DePaul, but the record does not show that, on the occasion before us, either Lance, his mother, his brother, Petit or Fox believed Lance should have been hospitalized. In fact, Lance's mother testified that Lance asked her not to "let them keep me here" and told her "I don't want to be here." These statements are important because Lance had complete control over whether to stay or go–the Dowells do not argue that there were grounds to hold Lance involuntarily. Evidence that a reasonable patient would have consented to treatment might sometimes be enough,[7] but in this case, the undisputed evidence of Lance's intentions is sufficient to refute the Dowells' expert testimony of what most patients would do under similar circumstances.

Furthermore, the Dowells' expert never actually testified that hospitalization, more likely than not, would have prevented Lance's suicide.[8] The expert opined that Lance was at high risk for suicide and that his discharge from the ER in that condition caused his death. The expert also testified that he gave "strong consideration" to the similarity of Lance's suicide attempt two years earlier in concluding that if Lance had again been hospitalized as he was then, the result would "most likely" have been the same. But when asked directly about whether hospitalization would have prevented Lance's suicide, the expert answered only that Lance "would have improved" and been at a "lower risk" of suicide when he left. No one supposes hospitalization would have made Lance

[7] *Cf. McKinley v. Stripling*, 763 S.W.2d 407, 410 (Tex. 1998) (discussing the test for informed consent).

[8] *See Park Place Hosp. v. Estate of Milo*, 909 S.W.2d 508, 511 (Tex. 1995); *Kramer v. Lewisville Mem'l. Hosp.*, 858 S.W.2d 397, 404 (Tex. 1993) (explaining that the Wrongful Death Act "authorizes recovery solely for injuries that cause death, not injuries that cause the loss of a less-than-even chance of avoiding death" and refusing to adopt a common law cause of action for lost chance of survival).

worse. The issue is whether hospitalization would have made Lance's suicide unlikely, and the Dowells' expert rather pointedly did not offer that opinion.

Also, Lance's discharge from the ER was simply too remote from his death in terms of time and circumstances. After Lance's release, his mother watched him carefully and checked him repeatedly. She took him to a family retreat where he would be surrounded by people who would support him. She called to hear him assure her he was okay. Lance's brother did what he could to lift Lance's spirits and be sure that he would be in a group. They saw no cause for alarm in Lance's weekend behavior, and no one reported anything unusual to them. If Lance had followed the written discharge instructions to "[s]tay w/ parents", then as the Dowells' expert conceded, it is doubtful he would have committed suicide. And if he had been hospitalized, the Dowells' expert could not rule out the possibility that he still would have killed himself.

We faced a similar situation in *IHS Cedars Treatment Center of DeSoto, Texas, Inc. v. Mason*.[9] Two mental health patients, Mason and Thomas, were discharged from the hospital at the same time.[10] Twenty-eight hours later, the two were in a Corvette together when Thomas, who was driving at high speed, "flew into an angry rage", swerved to miss a dog in the road, and lost control of the vehicle.[11] Mason was paralyzed in the accident.[12] She sued the hospital and others, alleging that they should have known she feared Thomas, who was "manipulative and controlling",[13] and therefore Thomas posed a danger to her.[14] Mason's expert testified that she "was likely to place

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[9] 143 S.W.3d 794 (Tex. 2004).

[10] *Id*. at 797.

[11] *Id*.

[12] *Id*.

[13] *Id*. at 796, 801.

[14] *Id*. at 797.

herself in a position to cause serious harm to herself",[15] and Mason argued that it was that propensity that caused her to go along with Thomas in the first place. Although Mason's expert opined directly that the defendants' negligence caused her to be injured, we concluded that the evidence "fail[ed] to provide a sufficient causal nexus between the duties and breaches on the part of [the defendants] and the injuries suffered by Mason".[16]

The Dowells do not make a for-want-of-a-nail argument of the kind squarely rejected in *IHS Cedars*[17] that Lance's discharge set up a chain of events that ultimately led to his suicide. Rather, they contend that discharging him when he was at high risk for suicide directly resulted in his death. They argue that *IHS Cedars* is distinguishable because, as the opinion noted, Mason's mental illness did not cause the car accident, whereas Lance's illness did cause his own death. But Mason's argument was not that her illness caused a dog to run into a roadway or Thomas to speed and lose control; rather, it was that because of her inability to resist Thomas, she went along even though she knew it was dangerous. Similarly, Lance's inability to cope with personal crises led to his death.

In *IHS Cedars*, we said: "the conduct of the defendant may be too attenuated from the resulting injuries to the plaintiff to be a substantial factor in bringing about the harm".[18] In this case, the defendants' negligent conduct was their failure to comprehensively assess his risk for suicide. Because there is no evidence that Lance could have been hospitalized involuntarily, that he would have consented to hospitalization, that a short-term hospitalization would have made his suicide unlikely, that he exhibited any unusual conduct following his discharge, or that any of his family or

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[15] *Id*. at 803.

[16] *Id*.

[17] *Id*. at 800.

[18] *Id*. at 799 (citing *Doe v. Boys Clubs of Greater Dallas, Inc.,* 907 S.W.2d 472, 477 (Tex. 1995), *Union Pump Co. v. Allbritton*, 898 S.W.2d 773, 776 (Tex. 1995), and *Lear Siegler, Inc. v. Perez*, 819 S.W.2d 470, 472 (Tex. 1991)).

friends believed further treatment was required, the defendants' negligence was too attenuated from the suicide to have been a substantial factor in bringing it about.

The dissent argues that requiring evidence that Lance would have consented to hospitalization is a new and insurmountable legal hurdle, but it is neither. It is certainly not new. We have previously recognized "a duty of cooperation which patients owe treating physicians who assume the duty to care for them."[19] The dissent contends that this duty does not apply when a patient is impaired, but the undisputed evidence is that Lance did not view himself as impaired and did not want to be hospitalized, and there is no evidence that he could have been hospitalized against his will. The dissent argues that "the Court seems to imply that suicide is simply not preventable",[20] but we do no such thing. Suicide is preventable. Lance's suicide was preventable: the evidence is undisputed that if Lance had stayed with his family as instructed, he would not have hanged himself when he did. But there is no evidence that Providence and Pettit caused Lance's suicide to occur when it did. The dissent seems to imply that a health care provider who is negligent in treating a patient's mental health is liable regardless of whether the negligence caused a subsequent suicide, thereby becoming in effect an insurer of the patient's conduct, whatever it might be. There is no basis for omitting the requirement of causation for mental health care providers.

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[19] *Jackson v. Axelrad*, 221 S.W.3d 650, 654 (Tex. 2007) (quoting *Elbaor v. Smith*, 845 S.W.2d 240, 245 (Tex. 1992)).

[20] *Post* at ___.

We conclude that Lance's discharge from Providence's ER did not proximately cause his death. Petitioners raise a number of other issues we need not reach. Accordingly, we grant the petitions for review, and without oral argument,[21] reverse the court of appeals' judgment and render judgment for petitioners.

Nathan L. Hecht
Justice

Opinion delivered: May 23, 2008

[21] TEX. R. APP. P. 59.1.