STATE OF MINNESOTA

IN SUPREME COURT

A20-0711

Court of Appeals

Hudson, J.
Dissenting as to Part I, Anderson, J.,
Gildea, C.J., Moore, III, J.

David Smits, as Trustee for the next of kin for Brian Short, Karen Short, Madison Short, Cole Short, Brooklyn Short,

Respondent,

Anderson, J.
Dissenting as to Part II, Hudson,
Thissen, JJ.

vs.

Filed: September 7, 2022
Office of Appellate Courts

Park Nicollet Health Services, et al.,

Appellants.

Ronald J. Schutz, Patrick M. Arenz, Brenda L. Joly, Robins Kaplan LLP, Minneapolis, Minnesota; and

Marc R. Stanley, Scott Kitner, Stanley Law Group, Dallas, Texas, for respondent.

Aaron D. Van Oort, Emily Zambrana, Hannah M. Leiendecker, Faegre Drinker Biddle & Reath LLP, Minneapolis, Minnesota; and

Mark A. Solheim, Anthony J. Novak, Kevin T. McCarthy, Larson King, LLP, Saint Paul, Minnesota, for appellants.

Mark R. Bradford, Bassford Remele, P.A., Minneapolis, Minnesota, for amici curiae American Medical Association, Minnesota Medical Association, and Minnesota Hospital Association.

Christopher Kubacki, Kubacki Law PLLC, Treasure Island, Florida, for amicus curiae Brady United Against Gun Violence.

James W. Balmer, Falsani, Balmer, Peterson & Balmer, Duluth, Minnesota, for amici curiae David Healy, M.D., DataBasedMedicine, WoodyMatters, & Kim Witczak.

Brock J. Specht, Robert L. Schug, Nichols Kaster, PLLP, Minneapolis, Minnesota; and

Jessie B. Mishkin, Sarah M. Sternlieb, Weil, Gotshal & Manges LLP, New York, New York, for amici curiae Everytown for Gun Safety Support Fund and Battered Women's Justice Project.

Matthew J. Barber, Schwebel, Goetz & Sieben, PA, Minneapolis, Minnesota, for amici curiae Frederic G. Reamer, Ph.D, and Ofer Zur, Ph.D.

Patrick Stoneking, Jeff Anderson & Associates PA, Saint Paul, Minnesota, for amicus curiae Minnesota Association for Justice.

Dyan J. Ebert, Steven R. Schwegman, Ryan L. Paukert, Quinlivan & Hughes, PA, Saint Cloud, Minnesota; and

Richard J. Thomas, Burke & Thomas, PLLP, Saint Paul, Minnesota, for amicus curiae Minnesota Defense Lawyers Association.

Christopher W. Madel, Matthew J.M. Pelikan, Madel PA, Minneapolis, Minnesota, for amicus curiae Scholars Regarding Mental Health Care and Harm to Family and Community.

Shaun D. Redford, Olson, Redford & Wahlberg, PA, Edina, Minnesota, for amicus curiae Scientists and Clinicians for Effective and Ethical Mental Health Treatments.

S Y L L A B U S

1. Healthcare providers have a duty to exercise the degree of skill and care possessed and exercised by practitioners engaged in the same type of practice under like circumstances; a patient committing suicide does not relieve a mental healthcare provider of this duty.

2. A mental healthcare provider's duty of care to its patient does not extend to uninvolved family members, and a patient's violence against his family is not foreseeable when the patient made no violent threats, had no history of violent action, repeatedly denied

suicidal ideation, was rational and planning for the future, and consistently referenced others only in a positive and supportive fashion.

Affirmed in part, reversed in part, and remanded.

OPINION & DISSENT[1]

HUDSON, Justice.

After receiving outpatient treatment for anxiety and depression for approximately 3 months, Brian Short purchased a shotgun and killed his wife, his three children, and then himself. Respondent, the trustee for the next of kin of the five Short family members, brought a wrongful death action against appellants, the mental healthcare providers, alleging that they had provided negligent care. The district court granted summary judgment to the mental healthcare provider and dismissed the action, concluding that it did not have a duty to protect or control Brian or his wife and children in the absence of a custodial "special relationship" or foreseeability of harm. The court of appeals reversed and remanded for trial, holding that the mental healthcare provider owed a duty of care to Brian that was not negated by his suicide, and genuine issues of material fact existed as to whether the provider's conduct created a foreseeable risk to Brian's wife and children. We affirm with respect to the wrongful death action on behalf of Brian, *see* Part I *infra* at 13–19, holding that a mental healthcare provider owes a duty of reasonable care to its patient, which is not negated by a lack of total control over the patient. We reverse with respect to Brian's wife and children, *see* Part II of the opinion of Justice Anderson, *infra* at 36–44,

[1] Part I of this opinion is the opinion of the court with respect to the duty a mental healthcare provider owes in cases of patient suicide.

holding that the harm to the family members was outside the scope of the duty of care and unforeseeable as a matter of law.

FACTS

This court case arose from an undeniable tragedy. In 2015, Brian[2] was 45 years old. He was married and had three children, Madison, Cole, and Brooklyn. Brian had been a registered nurse for several years, and then founded a web business related to nursing. This business was successful, and Brian hired several employees. In summer 2015, Brian sought treatment for anxiety and depression from appellants Park Nicollet Health Services, Park Nicollet Clinic, Park Nicollet Methodist Hospital, Park Nicollet Enterprises, and Group Health Plan, Inc. d/b/a HealthPartners Medical Groups (collectively Park Nicollet). In early September 2015, Brian killed his wife and his three teenage children, and then killed himself.

Brian first sought treatment from a Park Nicollet urgent care clinic on June 16, 2015. He complained of "tightness" or "pressure" in his chest. He also reported some difficulty sleeping. He attributed these symptoms to work-related stress stemming from financial difficulties at his business. But he also had a history of minor heart issues and said that he wanted to confirm that his heart condition was not returning. Brian saw a physician assistant, who concluded that the symptoms were caused by anxiety. Brian had not been previously treated for anxiety or depression and reported no history of psychological issues.

[2] This dispute involves five people with the last name Short. To avoid ambiguity, we will refer to these parties by first names.

He also stated that his appetite was normal and denied any "suicidal or homicidal ideations." The physician assistant prescribed Xanax for his anxiety.

Two days later Brian saw his primary care physician at a different Park Nicollet clinic. He stated that his "mood [had] been a little bit down here over the last 2 or 3 weeks" and reported recent weight loss of 20 or 30 pounds. Brian's vital signs were normal, and he denied any suicidal ideation. Brian's physician prescribed him the antidepressant Zoloft at 50 milligrams per day. The physician told Brian to come back in 5 weeks if his symptoms had not resolved.

Brian returned to the Park Nicollet urgent care clinic 9 days later on June 27. Brian reported further difficulty sleeping; he believed that the Xanax was initially helping but wore off too quickly and stated that the Zoloft was not yet helping.[3] He was again asked about, and again denied, suicidal ideation. Brian was prescribed Ativan, a short-term anxiety medication, and Ambien to help him sleep.

Brian saw his primary care physician again on July 6 and reported continued anxiety and occasional panic attacks. He had lost an additional 11 pounds since his visit on June 18. His physician increased the dosage of Zoloft from 50 to 100 milligrams per day. The physician also changed Brian's sleep medication from Ambien to Trazodone out of concern for possible interactions between Ambien and Ativan. The physician referred Brian to mental health counseling.

---

[3] Antidepressant medications often take up to 6 weeks to become fully effective. *Antidepressants: Selecting One That's Right for You*, Mayo Clinic (Dec. 31, 2019), https://www.mayoclinic.org/diseases-conditions/depression/in-depth/antidepressants/art-20046273.

On July 15, Brian received a diagnostic assessment from Park Nicollet's psychiatry department, where he saw an Advanced Practice Registered Nurse (APRN). Brian reported "extreme anxiety" about his business and his expenses. He also reported low energy and that he was feeling "irritable, overwhelmed and hopeless." He admitted some idle thoughts of suicide but specifically denied "any plan or intent" and said that he had never made any suicide attempts. The APRN administered a standardized patient assessment called a PHQ-9,[4] on which Brian scored 23 out of 27—indicating severe depression. The APRN diagnosed Brian with "[m]ajor depression, single episode, severe, without psychosis." However, the APRN concluded that it was too early in the treatment to assess Brian's Zoloft dose. The APRN referred Brian to therapy and told him to return in 4 weeks "or sooner if needed."

Brian attended therapy with a Park Nicollet-employed licensed social worker on July 16. He continued to report feeling anxious and depressed. The social worker administered another PHQ-9. Brian again scored 23, responded, "several days," to a question on thoughts of suicide and self-harm, and handwrote next to the question that he "wouldn't say several days but a few." Brian was also separately asked about, and denied

[4] A PHQ-9 is a nine-question assessment, asking about common symptoms of depression. The patient responds zero to three for each question, where zero indicates that a patient did not experience a particular symptom in the prior 2 weeks, one indicates experiencing the symptom on "several days," two indicates experiencing the symptom on "more than half" of the days, and three indicates experiencing a symptom "nearly every day." The answers for each question are then added together to calculate a final score. A score of 20 or higher indicates severe depression.

having, any "suicidal/homicidal ideation, intent, or plan." The social worker set a treatment goal of decreasing Brian's PHQ-9 score to "3 or below for 3 consecutive appointments."

On July 28, Brian called Park Nicollet and left a message, stating that his medications were "not helping to decrease his anxiety." The APRN directed another nurse to increase Brian's Zoloft dose from 100 to 150 milligrams per day. The nurse told Brian to increase his dose over the phone.

Brian returned to Park Nicollet for two more therapy sessions with the same social worker on August 4 and 12. He continued to report anxiety and depression, though he denied suicidal/homicidal "ideation, intent, or plan." Brian was not administered a PHQ-9 at either the August 4 or August 12 appointments. The social worker did not administer Brian a PHQ-9 on August 4 because Brian arrived late for his appointment, and the social worker did not record why Brian was not given a PHQ-9 on August 12.

On August 14, Brian saw the APRN and reported that his symptoms were either unchanged or worse, except that his ability to sleep had improved. His PHQ-9 score had improved from 23 to 20, largely due to the improvements in sleep. Brian specifically denied suicidal/homicidal "ideation, intent or plan," though he also stated on the PHQ-9 form that he experienced thoughts of suicide or self-harm on "several days." The APRN changed Brian's antidepressant from Zoloft to Lexapro, asked him to continue treatment otherwise unchanged, and told him to return in 4 to 6 weeks. The appointment lasted approximately 15 minutes. Brian was scheduled for another therapy visit on August 27 but called to reschedule it to September 10. Brian died before the September 10 appointment occurred.

During this time, Brian's family and employees were aware that he was experiencing mental health trouble. They reported that Brian was restless and spent time pacing. Brian's employees testified that although the financial troubles facing Brian's business were not large, "it was a crisis for him." Brian's wife Karen told her sister that she was worried Brian might become suicidal "because he hadn't slept for days." But at the same time, nobody voiced concerns that Brian might become violent. According to family members, Brian had a reputation as a peaceful man who had "never in his life been violent."

Brian owned a shotgun, which he stored in the attic of his home. On September 6, 2015, Brian purchased a second shotgun. On or around September 10, Brian used the second shotgun to kill his wife and children, and he then killed himself.

David Smits, as the trustee for the next of kin of Brian, Karen, Madison, Cole, and Brooklyn Short (the trustee), filed a wrongful death action against Park Nicollet. *See* Minn. Stat. § 573.02, subd. 1 (2020) (allowing a trustee to bring a death by wrongful act action on behalf of an estate "if the decedent might have maintained an action, had the decedent lived"). The trustee alleged that Park Nicollet had negligently treated Brian's depression and anxiety by deviating from the appropriate standard of care. The trustee alleged that Park Nicollet had committed malpractice in its treatment of Brian and that appropriate treatment would have prevented him from killing his family and himself.

Park Nicollet moved for summary judgment, asserting that it did not owe a duty of care for Brian's independent violent actions and that the trustee had failed to present evidence establishing that Park Nicollet caused Brian's harm. In response to Park

Nicollet's motion for summary judgment, the trustee presented expert testimony in support of the negligence claims. This testimony claimed that Park Nicollet committed malpractice by failing to follow the standard of care. Dr. Harrison Pope, a psychiatrist and professor of psychiatry at Harvard Medical School, opined that Park Nicollet committed a series of errors in its treatment. Dr. Pope highlighted Brian's PHQ-9 scores and "irrational beliefs" and opined that the Park Nicollet staff Brian saw lacked adequate training and "mischaracteriz[ed]" the severity of Brian's illness. Dr. Pope opined that Park Nicollet should have referred Brian to a psychiatrist, asked for permission to contact Brian's family, and taken steps to ascertain and limit his access to firearms. And Dr. Pope asserted that Park Nicollet staff spent inadequate time on Brian's case. One of Brian's appointments lasted for approximately 15 minutes, and in another instance his medication dosage was adjusted over the phone without an in-person visit. Dr. Pope opined that it was negligent to make complex healthcare decisions based on such brief interactions.

Dr. Pope also opined that Park Nicollet repeatedly erred with respect to Brian's medications. The FDA requires prominent warning labels, known as "black box warnings," on certain medications to warn of potential serious side effects. *See* 21 C.F.R. § 201.57(c)(1) (requiring warnings for "[c]ertain contraindications or serious warnings, particularly those that may lead to death or serious injury"). The medications Zoloft and Lexapro each have black box warnings. The black box warning for Zoloft warns that it has been found to increase the risk of "suicidal thinking and behavior" in children and young adults. It warns that patients of all ages beginning treatment with Zoloft "should be monitored appropriately and observed closely for clinical worsening, suicidality, or

unusual changes in behavior." The black box warning for Lexapro contains identical language. Dr. Pope asserted that the standard of care for providers prescribing Zoloft or Lexapro requires the provider to warn patients of these risks, closely monitor patients, and ask the patient for permission to involve their family members in monitoring their behavior. Dr. Pope noted that Brian's health records do not record Park Nicollet ever notifying Brian of the black box warnings for either Zoloft or Lexapro or asking to involve Brian's family.

Further, Dr. Pope asserted that Park Nicollet failed to prescribe a proper antidepressant dosage. Brian was on a 50-milligram Zoloft dose for nearly 3 weeks before it was increased to 100 milligrams per day. Dr. Pope claimed that a person of Brian's size should have been started at a larger dose, potentially as high as 200 milligrams per day. Dr. Pope asserted that Trazodone is known to inhibit the effectiveness of selective serotonin reuptake inhibitor (SSRI) antidepressants, a group of medications including both Zoloft and Lexapro. And Dr. Pope believed that Park Nicollet should have discussed alternative treatment methods once it was apparent that Brian was not responding to his medications. Dr. Pope's claims were reinforced by similar opinions from Dr. Robert Kinscherff, a psychologist, Dr. Jay Callahan, a psychotherapist and professor at Loyola University Chicago, and Carolyn Lucas-Dreiss, a clinical nurse specialist at Johns Hopkins Medicine specializing in behavioral health.

The trustee's experts point to a variety of symptoms that they assert made Brian's murder/suicide foreseeable. He reported being "fidgety or restless" and showed rapid weight loss—potential warning signs of side effects from the antidepressants he was prescribed. He showed worsening symptoms of serious depression and did not respond to

treatments. Brian suffered from depression and was the senior male and sole breadwinner of his household. Brian also owned a firearm. The trustee's expert witnesses opined that this forensic profile should have alerted Park Nicollet to watch out for familicide-suicide, as individuals with this profile may come to the irrational belief that killing their loved ones is a beneficent act necessary to spare them from the suffering that the individual is experiencing. Additionally, the trustee's expert witnesses opined that, had Brian been treated properly, it likely would have prevented the tragedy.

The district court granted Park Nicollet's motion for summary judgment with regard to duty and dismissed the trustee's case with prejudice. The court concluded that Park Nicollet did not owe a duty to Brian or his family members because Park Nicollet had no duty to control or protect Brian absent a custodial "special relationship" that was not present given the outpatient nature of the treatments. Further, the court held that Brian's actions were unforeseeable as a matter of law since he had neither made prior threats of violence nor engaged in prior violent acts. In the alternative, the district court concluded that there were genuine issues of material fact regarding causation and denied Park Nicollet's motion for summary judgment as to causation.

The court of appeals reversed and remanded for trial. *Smits v. Park Nicollet Health Servs.*, 955 N.W.2d 671, 674 (Minn. App. 2021). The court of appeals concluded that Park Nicollet, "as a mental-health treatment provider, owed a duty to [Brian] as its patient" with respect to his suicide. *Id.* at 680. The court of appeals reasoned that "a mental-health provider's lack of custody or control over a patient does not undermine or negate its legal duty to provide treatment in accordance with the applicable standards of care." *Id.* The

court of appeals also concluded that Park Nicollet may have owed "a duty of care to [Brian's] family members as [Brian's] healthcare provider if harm to [Brian's] family members was a foreseeable risk of the alleged departures from the standard of care." *Id.* at 681. The court of appeals reasoned that genuine issues of material fact existed as to whether familicide was a foreseeable harm and whether Brian's family members were foreseeable plaintiffs. *Id.* at 683. We granted Park Nicollet's petition for review.

ANALYSIS

We review summary judgment decisions de novo. *Warren v. Dinter*, 926 N.W.2d 370, 374–75 (Minn. 2019). The district court shall grant summary judgment when "there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law." Minn. R. Civ. P. 56.01. We do not weigh conflicting evidence; summary judgment "is inappropriate when reasonable persons might draw different conclusions from the evidence presented." *Osborne v. Twin Town Bowl, Inc.*, 749 N.W.2d 367, 371 (Minn. 2008) (citation omitted) (internal quotation marks omitted). In reviewing summary judgment decisions, we "view the evidence in the light most favorable to the nonmoving party . . . and resolve all doubts and factual inferences against the moving parties." *Rochester City Lines, Co. v. City of Rochester*, 868 N.W.2d 655, 661 (Minn. 2015).

Whether Park Nicollet owed a legal duty of care to Brian, or to his wife and children, is a question of law. *See Montemayor v. Sebright Prods., Inc.*, 898 N.W.2d 623, 629 (Minn. 2017). The question of whether to impose a legal duty is "one of policy." *Erickson v. Curtis Inv. Co.*, 447 N.W.2d 165, 169 (Minn. 1989); *see also* W. Page Keeton, et al., *Prosser and Keeton on the Law of Torts* § 53, at 358 (5th ed. 1984). A legal duty depends

"on the relationship of the parties and the foreseeable risk involved." *Erickson*, 447 N.W.2d at 168–69. No duty exists when the connection between the alleged danger created by a negligent act and the injury caused is too remote. *Montemayor*, 898 N.W.2d at 629. What risk is foreseeable "depends heavily on the facts and circumstances of each case." *Doe 169 v. Brandon*, 845 N.W.2d 174, 179 (Minn. 2014). But when the issue of foreseeability is not clear and reasonable persons might draw different conclusions based on the evidence presented, "close cases" must be submitted to a jury. *Senogles v. Carlson*, 902 N.W.2d 38, 43 (Minn. 2017).

I.[5]

As in all negligence actions, a prerequisite to finding malpractice liability is the existence of a duty running from the defendant to the plaintiff. *Warren*, 926 N.W.2d at 375. We first consider whether Park Nicollet owed a duty of care to Brian, its patient. The trustee presents expert testimony claiming that Park Nicollet failed to exercise the "degree of skill and care" required of all healthcare providers. *Becker v. Mayo Found.*, 737 N.W.2d 200, 216 (Minn. 2007). But Park Nicollet argues that it cannot be liable for medical malpractice here because, in committing suicide, Brian caused his own death. Park Nicollet claims that it cannot be held liable for the independent actions of another.

It is true that traditionally we have been reluctant "to impose liability on others for self-inflicted harm." *Donaldson v. Young Women's Christian Ass'n of Duluth*, 539 N.W.2d 789, 792 (Minn. 1995). We will impose a duty to protect another person from

[5] This part represents the opinion of the court with respect to the duty a mental healthcare provider owes in cases of patient suicide.

self-inflicted harm only when the parties have a "special relationship" where "the plaintiff is in some respect particularly vulnerable and dependent on the defendant, who in turn holds considerable power over the plaintiff's welfare." *Id.* Park Nicollet asserts that Brian taking his own life was an independent action relieving Park Nicollet of its ordinary duty of care to a patient, and thus the trustee must prove that Park Nicollet had a special relationship with Brian. We disagree.

Nothing about the trustee's claims requires reaching beyond ordinary principles of negligence. "Once a physician undertakes to treat a patient, that physician owes the patient a duty to act with the required standard of skill and care." *Becker*, 737 N.W.2d at 216. Brian was a patient of Park Nicollet seeking treatment for "severe" depression and anxiety. Park Nicollet undertook to treat Brian's depression and anxiety, prescribing medications and referring Brian for recurring therapy appointments. In doing so, Park Nicollet owed a duty—as do all healthcare providers treating all conditions—to exercise "that degree of skill and care possessed and exercised by practitioners engaged in the same type of practice under like circumstances." *Id.* A claim for medical malpractice further requires proof (1) of the standard of care in the relevant medical community, (2) that the defendant breached the accepted standard of care, and (3) that this breach caused harm. *Id.* The trustee presents expert testimony purporting to show the standard of care in the relevant medical community. The trustee alleges that Park Nicollet negligently failed to meet this standard of care and supports these allegations with evidence. And the trustee claims that this negligence harmed Brian. The trustee has raised a claim of medical malpractice.

The dissent argues that, by holding that the trustee has raised a medical malpractice claim, we are expanding the scope of liability. But this is not the case. The trustee fundamentally claims that Park Nicollet's alleged negligence caused harm to occur outside of the treatment itself. We previously considered a similar circumstance—harm arising outside of treatment after allegedly deficient care—in *Becker*. There, an infant was treated for suspicious injuries of a type frequently caused by child abuse. 737 N.W.2d at 204–05. Although hospital staff questioned the infant's parents, they did not report any suspected child abuse. *Id.* at 204. The injuries were in fact from abuse, and after release the infant was permanently injured by further abuse. *Id.* The infant's later guardians sued the hospital, alleging that the standard of care required reporting suspected child abuse to prevent the specific type of injuries the infant suffered. *Id.* at 205. In *Becker*, we held that the hospital did not owe a duty to *protect* the infant, as there was no "special relationship" with a discharged former patient. *Id.* at 213. Nevertheless, we held that the plaintiffs "presented a prima facie case of medical malpractice" against the hospital because the standard of care in the particular circumstances could have included reporting suspected child abuse. *Id.* at 217. In other words, when the standard of care requires medical providers to take action to prevent a particular injury, a hospital can be liable for failing to exercise the requisite degree of skill and care even when that injury is caused by the intentional, criminal wrongdoing of a third party outside of the hospital's control and hospital grounds. Here, the trustee raises a similar claim to *Becker* and has presented evidence that the standard of care given Brian's symptoms required Park Nicollet to be alert to and to take actions to reduce the risk of patient suicide.

Park Nicollet attempts to cabin *Becker* by claiming that it established only a limited duty to report child abuse. But nothing in our decision restricted the analysis to child abuse. Indeed, in *Becker* we specifically declined to recognize a civil cause of action for failure to report suspected child abuse. *Id.* at 211. Rather, we considered the claim that the "treating physicians deviated from the expected standard of professional skill and care." *Id.* at 213. The plaintiffs in *Becker* showed the purported standard of care through expert testimony and references to professional literature. *Id.* at 216–17. Here, the trustee has likewise presented expert testimony and professional literature and is likewise entitled to an opportunity to prove his case in front of a jury.

Park Nicollet asserts that we should nevertheless dismiss the trustee's claims as it would be bad policy to allow a malpractice claim to proceed after a patient commits suicide. The existence of duty is a question of policy to be determined by the court. *Erickson*, 447 N.W.2d at 168–69. Park Nicollet argues that potential liability for patient suicide will raise the cost of healthcare and limit accessibility for prospective patients. And it argues that it and other healthcare providers will be placed in an impossible position: unable to control a patient's behavior yet still liable for the results of that behavior. But we do not hold that Park Nicollet had a duty to *control* Brian or to prevent his suicide. We simply hold that Park Nicollet had a duty to provide treatment that met the standard of care. And a healthcare provider's lack of control over a patient does not negate that duty.

Declining to relieve Park Nicollet of its duty of care in this case also promotes the accountability of healthcare providers. Park Nicollet asserts that the specter of liability will cause healthcare providers to choose unnecessarily invasive and expensive treatments

out of fear of pecuniary liability rather than what is in the patient's best interests. But the existence of a legal duty incentivizes a thorough and careful approach to critical healthcare decisions. *Cf. 80 S. Eighth St. Ltd. P'ship v. Carey-Canada, Inc.*, 486 N.W.2d 393, 398 (Minn. 1992) (noting that an objective of tort law is to deter unreasonable risks); W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 4, at 25 (5th ed. 1984). Relieving Park Nicollet of its duty of care extinguishes this incentive to provide thoughtful medical care.

Moreover, tort law serves to allocate and balance risk among parties based on "their capacity to avoid the loss, or to absorb it, or to pass it along and distribute it in smaller portions among a larger group." W. Page Keeton, *supra*, § 4, at 24. Park Nicollet's position places practically *all* of the risks associated with mental-health treatment onto the patient who, as the layperson, is not in a position to fully understand these risks or take action to mitigate them. We reject this one-sided risk allocation; the risk distribution must be balanced. We will not absolve Park Nicollet of the duty to meet the standard of care because its patient committed suicide.

Finally, Park Nicollet argues that to the extent that it owed a duty of care to Brian, the standard of care for mental-health treatment should be a narrow one. Rather than the duty that applies to virtually all other healthcare decisions—namely, the duty to act with "that degree of skill and care possessed and exercised by practitioners engaged in the same type of practice under like circumstances," *Becker*, 737 N.W.2d at 216—Park Nicollet argues that it should be subject only to a duty to exercise a "good faith professional judgment." We are not persuaded. Again, we do not hold that Park Nicollet had an

absolute duty to prevent Brian's suicide. Rather, it owed a duty to provide reasonable medical care. As the trustee notes, the standard of reasonable care is not unfair. And although it is true that providing mental healthcare is a difficult and uncertain task, it is also true for all forms of healthcare. We decline to hold a therapist treating severe depression to a lower standard than, say, a hospitalist treating a severe viral infection, *see Warren*, 926 N.W.2d at 378, or a physician treating a complex leg fracture, *see Manion v. Tweedy*, 100 N.W.2d 124, 129 (Minn. 1959). Both mental and physical medical care require the exercise of professional judgment and skill, and both mental and physical treatment require the exercise of reasonable care.

Accordingly, we hold that Park Nicollet owed Brian, its patient, a duty to act with that degree of skill and care possessed and exercised by practitioners engaged in the same type of practice under like circumstances. *Accord Schuster v. Altenberg*, 424 N.W.2d 159, 162 (Wis. 1988) ("We can conceive of no reason why a psychiatrist, as a specialist in the practice of medicine, should not be compelled, as are all other practitioners, to meet the accepted standard of care established by other practitioners in the same class.").

It is important to note the limitations of our holding today. We hold only that Park Nicollet owed Brian a duty to provide reasonable medical care. Again, Park Nicollet did not have an absolute duty to prevent Brian's suicide. Rather, Park Nicollet owed a duty to exercise "that degree of skill and care possessed and exercised by practitioners engaged in the same type of practice under like circumstances." *Becker*, 737 N.W.2d at 216. And we express no opinion on whether Park Nicollet did, in fact, breach the standard of care

because doing so would be inappropriate where, as here, we are limited to reviewing the summary judgment decision.

Indeed, the fact that we are reviewing a summary judgment decision is critical to our holding. *Staub v. Myrtle Lake Resort, LLC*, 964 N.W.2d 613, 620 (Minn. 2021) ("That this case comes to us following a grant of summary judgment is central to our decision today."). In reviewing a summary judgment decision, we may not weigh the credibility of the testimony and must view all facts in the light most favorable to the nonmoving party. *Montemayor*, 898 N.W.2d at 628. Critically, nothing in our holding prevents Park Nicollet from presenting evidence at trial that it acted with the requisite degree of skill and care. A jury may well agree. Even if a jury finds that Park Nicollet breached its duty of care, the jury could still find that this breach was not a substantial factor in bringing about Brian's injury. *See Staub*, 964 N.W.2d at 620 ("[T]he injury must be a foreseeable result of the negligent act and the act must be a substantial factor in bringing about the injury."). Whether Park Nicollet breached the standard of care and whether that breach was the proximate cause of Brian's actions are questions that must be resolved by a jury.

II.[6]

The trustee asserts that Park Nicollet's failure to provide reasonable care to Brian also supports malpractice liability for the harm suffered by the family members he killed. This claim arises from Brian's relationship with his mental healthcare providers, which did not involve his family members. Although "most medical malpractice cases involve an

[6] This part represents the dissenting opinion of Justice Hudson with respect to the duty between a mental healthcare provider and a patient's family.

express physician-patient relationship," a physician-patient relationship is not necessary to maintain a medical malpractice action under Minnesota law. *Warren v. Dinter*, 926 N.W.2d 370, 375 (Minn. 2019). Even in the absence of a physician-patient relationship, "a duty arises between a physician and an identified third party when the physician provides medical advice and it is foreseeable that the third party will rely on that advice." *Id.* at 376. I agree with the court that Park Nicollet's care for Brian does not support a medical malpractice action by Brian's family members on this basis. *See infra*, at 37–38. There is no indication in the record that it was foreseeable that those family members would rely on Park Nicollet's advice to shape their own conduct. But I respectfully part ways with the court's conclusion that the harm to Brian's family was not foreseeable as a matter of law.

Although the general rule in tort is that a party owes no duty to prevent harm caused by a third party, we have nevertheless determined that a duty exists in two circumstances. *Doe 169 v. Brandon*, 845 N.W.2d 174, 177–78 (Minn. 2014). The first is where the defendant has a "special relationship" with either the party causing the harm or the party suffering the harm, and the harm was foreseeable. *Id.* at 178. The second is where "the defendant's own conduct creates a foreseeable risk of injury to a foreseeable plaintiff." *Id.* (citation omitted) (internal quotation marks omitted) (emphasis omitted). The trustee's expert witnesses testified that the harm to Brian's wife and children was a foreseeable result caused by Park Nicollet's breach of the applicable standard of care. Because we may not evaluate the credibility of testimony when we review a decision on summary judgment, I am not convinced that summary judgment was appropriate on this issue.

A.

I first consider whether a "special relationship" exists that could impose liability upon Park Nicollet for Brian's actions. A special relationship exists when a defendant assumes control over another person. *Lundgren v. Fultz*, 354 N.W.2d 25, 27 (Minn. 1984). The trustee alleges that Park Nicollet had a special relationship with Brian, such that it should have acted to prevent Brian from harming others. But the harm here occurred outside of Park Nicollet's control, and Park Nicollet did not have custody of Brian or control over his behavior at any point. There was no special relationship. *See Becker v. Mayo Found.*, 737 N.W.2d 200, 213 (Minn. 2007) (concluding that no special relationship existed when the harm "was suffered outside the hospital at the hands of a third party [which the hospital] could not control, and because [the hospital] did not accept custody of" the victim).

B.

I next consider the "own conduct" exception to the rule that a party is not liable for harm caused by another. This exception requires a showing that (1) a defendant's own conduct, (2) created a foreseeable risk, (3) to a foreseeable plaintiff. *Fenrich v. The Blake Sch.*, 920 N.W.2d 195, 203 (Minn. 2018).

1.

To establish a duty, a defendant's own conduct must constitute misfeasance rather than mere nonfeasance.[7] *Doe 169*, 845 N.W.2d at 178. Misfeasance is " 'active misconduct working positive injury to others.' " *Id.* (quoting W. Page Keeton, et al., *Prosser and Keeton on the Law of Torts* § 56, at 373 (5th ed. 1984)). Nonfeasance is mere " 'passive inaction or a failure to take steps to protect [others] from harm.' " *Id.* (quoting Keeton et al., *supra*, § 56, at 373) (alteration in original). A party may commit misfeasance by assuming "supervision and control" over an activity. *Fenrich*, 920 N.W.2d at 203.

In *Fenrich*, a high school cross-country runner caused a fatal car accident while driving to an out-of-state extracurricular race. Although the meet was not an official team event, the school was still involved in organizing the trip. *Id.* at 204. The team's head coach "strongly encouraged" team members to participate. *Id.* An assistant coach paid the

---

[7] Park Nicollet suggests that the "own conduct" rule applies only to negligent misconduct and would not support liability for the intentional or criminal misconduct of another. In support of this claim, it cites our prior decision in *State v. Back*, where we held that "there is generally no duty to protect strangers from the criminal actions of a third party." 775 N.W.2d 866, 870 (Minn. 2009). In *Back* we recognized that a duty may attach given a "special relationship," *id.*, but did not discuss the "own conduct" rule. Park Nicollet argues that this is functionally a prohibition on the use of "own conduct" in situations involving intentional misconduct, and that because Brian intentionally killed his wife and children the "own conduct" rule does not apply. Park Nicollet reads *Back* too narrowly. We have recognized duties beyond an absolute duty to protect arising out of intentional misconduct. For example, in *Erickson v. Curtis Investment Company*, we held that the owner of a parking garage owed those parking their cars there—hardly a custodial entrustment of power and control over their persons—a "duty to use reasonable care to deter criminal activity on its premises." 447 N.W.2d 165, 170 (Minn. 1989). And in *Becker* we held that a hospital could be liable for malpractice for failing to report a child's injuries caused by criminal abuse that occurred outside of the hospital after the child was discharged as a patient. 737 N.W.2d at 205, 216.

event's registration fee, attended voluntary practices to prepare for the race, recruited volunteer coaches to further prepare the team, and coordinated transportation and lodging. *Id.* The assistant coach expressly approved the plan to have the high-school runner, and not the runner's parents, drive to the meet. *Id.* We held that this was sufficient "supervision and control" to constitute misfeasance, not simply nonfeasance. *Id.*

The facts here show that Park Nicollet assumed at least as much "supervision and control" over Brian as the school had over the cross-country team in *Fenrich*. Park Nicollet accepted Brian as a patient. It chose which providers he saw and scheduled his appointments. Park Nicollet controlled what medications Brian was prescribed. When Brian reported that his symptoms had not improved, Park Nicollet changed his medications and dosages. All care occurred at Park Nicollet facilities and was provided by Park Nicollet employees. The trustee, through currently unchallenged expert testimony, alleges significant errors in how Park Nicollet managed Brian's condition. These alleged errors include inadequate attention, incorrect medication doses, proscribing multiple medications allegedly known to adversely interact with each other, and failing to collect necessary information. Based on this evidence, a reasonable fact-finder could conclude that Park Nicollet engaged in misfeasance.

2.

I now turn to whether Park Nicollet's conduct created a foreseeable risk of harm. We review determinations of foreseeability de novo. *Fenrich*, 920 N.W.2d at 205. A harm is not foreseeable when it is merely conceivably possible; rather, it must be "objectively reasonable to expect." *Warren*, 926 N.W.2d at 378 (citation omitted) (internal quotation

marks omitted). But the specific mechanism and circumstances of the injury need not be foreseeable. *Domagala v. Rolland*, 805 N.W.2d 14, 27 (Minn. 2011). Instead, the question is whether "the possibility of an accident was clear to the person of ordinary prudence." *Connolly v. Nicollet Hotel*, 95 N.W.2d 657, 664 (Minn. 1959).

It is not necessary for the trustee to prove that Park Nicollet knew Brian would take the exact actions he did. Rather, the trustee must show only that Park Nicollet knew, or should have known, that there was an unreasonable risk that Brian might become dangerous. *See id.* The court holds that Brian's violence toward his wife and children was unforeseeable as a matter of law because he had no history of violence and made no violent threats. But a history of violent acts, or of violent threats, are just two potential warning signs. To make "prior acts or threats" the sole or preeminent factor in foreseeability is too restrictive and ignores the diversity of human experience.

This case is a good example of why we should consider more than just the presence or absence of prior threats. The evidence, when viewed in the light most favorable to the trustee as the nonmoving party, presents a medley of potential warning signs. The trustee's experts opined that—based on Park Nicollet's treatment records—Park Nicollet knew that Brian was not responding to treatment and did very little, if anything, to find more effective options. Dr. Pope opined that the providers Brian saw were "not adequately trained in psychopharmacology." Specifically, Brian was allegedly prescribed an insufficient dose of his antidepressant medications. When that did not work, the dose was slowly increased. When that still did not work, he was changed from one medication, Zoloft, to another similar medication, Lexapro. He was prescribed at least two different sleeping medications

and two different short-term anxiety medications, though Dr. Pope asserted that "neither of these medications would be expected to alleviate his worsening depression." Brian reported that his symptoms were worsening, presenting what Dr. Pope described as a "documented downward, worsening trajectory." According to the trustee's expert witnesses, a mental healthcare provider assessing Brian's worsening condition should have foreseen the risk that he may become violent and should have acted to mitigate that risk. The trustee's expert witnesses assert that Brian's failure to respond to treatment is a foreseeable warning sign of violence and that Park Nicollet repeatedly failed to take adequate actions to either refer Brian to more qualified providers, such as a psychiatrist, or discuss alternative treatments. Thus, this is not a case about Park Nicollet's failure to "do more" as the court claims. Rather, it is about Park Nicollet's alleged repeated failure to properly intercede in Brian's "documented downward, worsening trajectory."

In addition, the trustee's expert witnesses specifically assert that Brian showed many risk factors for so-called "altruistic homicide."[8] Dr. Pope asserted that, "as a severely depressed senior male of a household, who also possessed a firearm," Brian presented a specific risk of homicidal violence. Although the court blithely dismisses the "senior male of household" risk factor, the court's unscientific opinion is irrelevant and, more importantly, is contradicted by the informed medical testimony of the trustee's experts. In

[8] Dr. Pope describes "altruistic homicide" or "altruistic murder" as "an irrational, delusional perception that taking the life of family members will prevent and save those family members from the emotional pain, anxiety, and terror that the depressed individual is suffering and experiencing." It is described as "altruistic" because the killing is motivated not by malice, but by the delusion that the individual is helping their loved ones by killing them.

any event, the expert testimony was not limited—as the court suggests—to that particular risk factor. Specifically, Brian also experienced symptoms of akathisia, or an agitated restlessness. The expert witnesses opine that akathisia is a specific warning sign of an increased risk of violence. The trustee's witnesses assert that the antidepressant medications Brian was on are known to cause increased risk of patient violence—as further indicated by the FDA-mandated "black box" warnings. The trustee's witnesses assert that one of Brian's sleeping medications is known to adversely interact with his antidepressant medications, an alleged error further increasing the risk that he may harm those around him. Brian experienced catastrophic and irrational thinking, and his condition deteriorated at an alarming speed. He experienced rapid and severe weight loss, hopelessness, and feelings of being overwhelmed, and was described by those close to him as "doom and gloom" and "bleak." According to the trustee's expert witnesses, these specific, known facts about Brian made him a foreseeable risk of harm to others. Although Brian did not make prior threats of violence, Brian exhibited a plethora of other well-known warning signs, all indicating that the risk he may commit violence should have been foreseeable to Park Nicollet.

In reviewing summary judgment, we may not weigh the credibility of conflicting evidence. *Montemayor v. Sebright Prods., Inc*., 898 N.W.2d 623, 628 (Minn. 2017). And we must "view the evidence in the light most favorable to the nonmoving party." *Rochester City Lines, Co. v. City of Rochester*, 868 N.W.2d 655, 661 (Minn. 2015). The trustee supports his claims with expert testimony. These experts base their opinions on detailed examinations of Brian's medical records. For the purpose of summary judgment, I would

hold that this at least presents a "close case" of foreseeable risk that must be submitted to a jury.

In holding otherwise, the court ignores our recent precedent. We have considered the foreseeability of harm in the context of summary judgment in four cases since 2017. In *Montemayor*, an employee was severely injured by a piece of industrial machinery. 898 N.W.2d at 626. The machine's manufacturer argued that the injury was unforeseeable as a matter of law as the employee had disregarded several warning signs and safety features built into the machine and had not received adequate training in using the machine—all contrary to the manufacturer's directions. *Id.* at 631–32. In *Senogles v. Carlson*, a landowner argued that it was unforeseeable as a matter of law that a 4-year-old child would decide to swim in a river alone and unsupervised. 902 N.W.2d 38, 47 (Minn. 2017). In *Fenrich*, a school argued that it was unforeseeable as a matter of law that a student would be involved in a car crash while traveling to an event. 920 N.W.2d at 205. And in *Warren*, a physician told a nurse practitioner that one of the nurse practitioner's patients did not need to be admitted to a hospital. 926 N.W.2d at 373. The physician later argued that it was unforeseeable as a matter of law that the patient—who had never seen or spoken with the physician—would rely on this advice. *Id.* at 378. In all four cases, we held that summary judgment was inappropriate and that the question of foreseeability should be presented to a jury. *Montemayor*, 898 N.W.2d at 633; *Senogles*, 902 N.W.2d at 48; *Fenrich*, 920 N.W.2d at 206; *Warren*, 926 N.W.2d at 378. In doing so, we have repeatedly shown a strong preference for allowing juries to resolve complex and uncertain

"close cases" of foreseeability. I see no reason—and the court offers none—why we should act differently here.

For similar reasons, I reject the court's claims that under my position, "every case is a close case" and that the court would effectively abdicate our responsibility by sending this case to a jury. This case involves complex medical testimony regarding the foreseeability of the actions of a patient who was not "simply" depressed, but who suffered from debilitating depression—evidenced in part by Brian repeatedly scoring a 23 out of 27 on the PHQ-9 patient assessment, which is indicative of severe depression. Thus, Brian was unlike the "millions of Americans" referenced by the court, who seek and receive treatment for depression and lead productive lives. To the contrary, Brian was not responding to treatment; had lost up to 40 pounds in a matter of weeks; was feeling hopeless and overwhelmed; and, in addition to his status as senior head of household, was exhibiting behaviors consistent with akathisia shortly before his death. The expert witnesses opined that akathisia—as well as the other above-listed factors—indicated an increased risk that Brian would harm himself or others. In *Montemayor,* we relied on expert testimony to conclude that genuine issues of material fact existed as to foreseeability. 898 N.W.2d at 632–33. The court offers no explanation for why we should not do the same here. Even if there was not an explicit factual dispute in the record, reasonable persons might differ as to the foreseeability of Brian's actions under these circumstances. *See Ill. Farmers Ins. Co. v. Tapemark Co.*, 273 N.W.2d 630, 633 (Minn. 1978) ("A motion for summary judgment should be denied if reasonable persons might draw different conclusions from the evidence presented."). Thus, although Brian had no history of violence, viewing the

evidence in the light most favorable to Brian as the nonmoving party, this is plainly a "close case," where genuine issues of material fact exist regarding foreseeability. Accordingly, it must be resolved by the jury, not the court.

3.

Finally, I consider whether Brian's wife and children were foreseeable victims. Again, the trustee's expert witnesses provide exhaustive testimony that Brian was a risk to himself and to those around him. His immediate family members were, of course, most likely to be "those around him" at any given time. The family lived together in the same house. And Dr. Pope and Dr. Callahan opined that Brian's symptoms and profile made him a risk to his close family specifically. If Brian's violence was foreseeable, then the risk to his immediate family was "not in any way remote or attenuated." *Fenrich*, 920 N.W.2d at 206.

The trustee presents a broad constellation of risk factors and warning signs, supported by expert testimony, showing that the risk Brian may become violent to himself and to those around him was foreseeable. The court holds that because one specific warning sign—verbal threats of violence—was not present, the rest do not matter. But in reviewing a summary judgment decision, it is not our job to weigh the evidence. The trustee presents expert testimony, about facts specific to this case, which alleges that Park Nicollet's deficient care created a foreseeable risk that Brian would harm his wife and children. I would hold that this is sufficient to submit this issue to a jury.

O P I N I O N & D I S S E N T[9]

ANDERSON, Justice.

Brian murdered his wife and children and then committed suicide. These facts are heartbreaking. But not every tragedy is compensable in litigation. Here, Brian took the independent and affirmative act of killing his wife, his children, and then himself. The trustee for the next of kin of the five Short family members argues that Park Nicollet committed medical malpractice and seeks damages from Park Nicollet. We conclude that Park Nicollet did not owe a duty of care to Brian's wife and children because the claims of the trustee fall outside the boundaries of medical malpractice and none of the traditional third-party negligence duties apply. I would go further and conclude that Park Nicollet did not owe a duty of care in these circumstances to Brian himself because the harm was caused by Brian's independent and uncontrollable actions in taking his own life.

Summary judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Minn. R. Civ. P. 56.01. Mere speculation or conjecture about a fact will not prevent summary judgment. *McBee v. Team Indus., Inc*., 925 N.W.2d 222, 230 (Minn. 2019). Parties must provide substantial evidence to establish genuine issues of material fact. *Gunderson v. Harrington*, 632 N.W.2d 695, 704 (Minn. 2001). A factual dispute is "material" when its resolution

[9] Part II of this opinion is the opinion of the court with respect to the duty between a mental healthcare provider and a patient's family. I also concur with the overview and statement of facts in Justice Hudson's opinion.

will affect the outcome of the litigation. *Antonello v. Comm'r of Revenue*, 884 N.W.2d 640, 645 (Minn. 2016).

This dispute involves a claim of medical malpractice, a type of professional negligence. As with all claims for negligence, to find liability a court must first make the prerequisite determination that the defendant owed a duty to the plaintiff. *Warren v. Dinter*, 926 N.W.2d 370, 375 (Minn. 2019). Here, Park Nicollet argues that it owed no duty to Brian or his wife and children.

It is well settled that the existence of a legal duty generally is a question of law to be determined by the court. *Doe 169 v. Brandon*, 845 N.W.2d 174, 177 (Minn. 2014) ("The existence of a duty of care is a question of law that we review de novo."); *Larson v. Larson*, 373 N.W.2d 287, 289 (Minn. 1985) ("Generally, the existence of a legal duty is an issue for the court to determine as a matter of law."). This practice dates back as far as the English common law. *See, e.g.*, *Tenant v. Goldwin* (1704) 92 Eng. Rep. 222, 224; 2 Ld. Raym. 1091, 1092–93 (holding that a landowner has a duty to prevent sewage from running onto a neighbor's property). No party has presented us with a compelling reason to depart from this centuries-long practice.

I.[10]

I first consider the question of whether Park Nicollet owed a duty to Brian. The trustee argues that this is ordinary medical malpractice litigation. I disagree because Park Nicollet did not perpetrate the ultimate harm. Rather, Brian took the independent and, to

[10] This part represents the dissenting opinion of Justice Anderson with respect to the duty a mental healthcare provider owes in cases of patient suicide.

Park Nicollet, uncontrollable action of committing suicide. It is true that healthcare providers owe their patients a duty of care. But we "have traditionally shown reluctance to impose liability on others for self-inflicted harm." *Donaldson v. Young Women's Christian Ass'n of Duluth*, 539 N.W.2d 789, 792 (Minn. 1995).

All our prior decisions contemplating liability for the suicide of another involve *custodial inpatient treatment*. Over 85 years ago we recognized that a party could, under these limited circumstances, be liable for the suicide of another. *Mesedahl v. St. Luke's Hosp. Ass'n of Duluth*, 259 N.W. 819, 820 (Minn. 1935). *Mesedahl* concerned an inpatient who was treated for a "nervous and depressed condition." *Id.* at 819. We held that, given his custodial inpatient status, if a reasonable person should have anticipated that the patient would attempt suicide, "then reasonable care should have been exercised to prevent such act." *Id.* at 820. In *Clements v. Swedish Hospital*, we again considered the potential liability of a hospital for an inpatient's suicide attempt. 89 N.W.2d 162, 165 (Minn. 1958). And in *Tomfohr v. Mayo Foundation*, we agreed that a duty existed in circumstances in which an inpatient reported that "he was worried about killing himself, his parents, and children," that he "pled for treatment," and that he "requested immediate hospitalization" to prevent him from committing suicide. 450 N.W.2d 121, 122 (Minn. 1990). But, in *Donaldson*, we held that the proprietor of a lodging house owed no duty to prevent the suicide of its residents because the lodging house had not accepted "custody and control of the person to be protected." 539 N.W.2d at 792–93.

There is a good reason these decisions have focused on the presence, or absence, of a *custodial* special relationship. Among the central purposes of tort law is providing an

incentive for prosocial behavior. *80 S. Eighth St. Ltd. P'ship v. Carey-Canada, Inc.*, 486 N.W.2d 393, 398 (Minn. 1992) ("One objective of tort law is to deter unreasonable risks of harm."); W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 4, at 25 (5th ed. 1984). That is, potential tort liability should encourage a party to adjust its behavior and choose a less risky alternative course. But when a party cannot change its behavior, or when changing its behavior will not affect the eventual risk, no incentive exists. Thus, we have held that "[i]mplicit in the duty to control is the *ability* to control." *Lundgren v. Fultz*, 354 N.W.2d 25, 27 (Minn. 1984). We are reluctant to impose a duty when there is no clear way to satisfy it. *Cf. Funchess v. Cecil Newman Corp.*, 632 N.W.2d 666, 673 n.4 (Minn. 2001) (noting that "crime prevention is essentially a government function, not a private duty"); *Pietila v. Congdon*, 362 N.W.2d 328, 333 (Minn. 1985) (holding that a landowner owed no duty to a person murdered by a third party because there was no way for the landowner to know ahead of time whether security measures were adequate).

Inpatient care represents a custodial relationship between the patient and the hospital. Inpatients are largely under the control of a hospital. *See Tomfohr*, 450 N.W.2d at 125 (noting that a hospital admitting an inpatient voluntarily undertakes a duty to protect the patient). Hospital personnel frequently monitor inpatients and directly administer medications. The hospital controls access to the patient and controls the patient's access to potentially harmful items. *E.g.*, *id.* at 122 ("[H]ospital personnel attempted to remove from [the patient] all belongings which might be used self-destructively."). None of this is true for outpatients. Although healthcare providers may tell an outpatient to take a

certain medication and may ask about symptoms, the providers are entirely reliant on the patient to actually take the medications as prescribed and to accurately report symptoms.

Park Nicollet did not assume the degree of power and control over Brian associated with inpatient treatment. Park Nicollet providers saw Brian nine times between June and August 2015, each time on an outpatient basis. Brian never sought admission as an inpatient. And Brian had not had any contact with Park Nicollet for approximately 3 weeks before his suicide. During his last visits, Brian reported to Park Nicollet that his ability to sleep was improving and expressed hope about the future. And Brian provided no reason for Park Nicollet to second-guess his descriptions of his symptoms. Further, Brian purchased the firearm he used to commit these tragic acts on his own after his last treatment with Park Nicollet. Park Nicollet could not have known about this purchase and could not have done anything about it if it had known. It is not reasonable to hold Park Nicollet responsible for Brian's independent decision to commit suicide absent some degree of custodial control over his actions.

In holding otherwise, the court today expands medical malpractice as a cause of action to include cases of patient suicide. We have never before held a healthcare provider liable for the suicide of a patient absent custodial control. In *Tomfohr* we held that, where "the patient could not be at fault *because he lacked the capacity to be responsible for his own well being*," the independent decision to commit suicide would not serve to abrogate the hospital's duty. 450 N.W.2d at 125 (emphasis added). But the patient in *Tomfohr* sought admission as an inpatient in a locked hospital ward specifically because he was concerned that he lacked self-control. *Id.* at 122. The trustee has presented no comparable

evidence here. Brian neither asked to be admitted to a locked ward nor expressed concern that he could not control his actions. Rather, Brian took the independent action of committing suicide, which Park Nicollet could not control. We have "traditionally shown reluctance to impose liability on others for self-inflicted harm," *Donaldson*, 539 N.W.2d at 792; *accord Logarta v. Gustafson*, 998 F. Supp. 998, 1003 (E.D. Wis. 1998) (holding that suicide is a "separate, voluntary, and intentional act" breaking the chain of causation), and the trustee presents no compelling reason to depart from this practice.

We have previously recognized new common law rights and causes of action. *See, e.g.*, *Cent. Hous. Assocs. v. Olson*, 929 N.W.2d 398, 409 (Minn. 2019). But we have been reluctant to do so. *Dukowitz v. Hannon Sec. Servs*., 841 N.W.2d 147, 151 (Minn. 2014). This is because "[t]he public policy of a state is for the legislature to determine and not the courts."[11] *Mattson v. Flynn*, 13 N.W.2d 11, 16 (Minn. 1944). Absent an indication that the Legislature intends for us to expand the common law, we will do so only when there is

[11] Indeed, the Legislature *has* determined the public policy of the state in a closely related issue by codifying a limited cause of action when treating psychologists fail to warn of a patient's violent tendencies. "The duty to predict, warn of, or take reasonable precautions to provide protection from, violent behavior arises only when a client or other person has communicated to the [treatment provider] a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim." Minn. Stat. § 148.975, subd. 2 (2020). And "[i]f no duty to warn exists under subdivision 2, then no monetary liability and no cause of action may arise against a [treatment provider] for failure to predict, warn of, or take reasonable precautions to provide protection from, a client's violent behavior." *Id.*, subd. 3 (2020). The trustee attempts to skirt this statutory limitation by focusing on alleged deficiencies in Brian's treatment rather than on a failure to warn Brian's family. This may be enough to avoid an absolute statutory bar to recovery—though the Legislature could certainly act to expand section 148.975's limitation to cover the scenario here as well. But the Legislature's policy choice in such a closely related area should further counsel a cautious approach and is yet another reason to deny liability here.

"a compelling reason to do so." *Olson*, 929 N.W.2d at 408. The trustee has provided us with no such compelling reason. Rather, the court's holding causes us to break from the well-established common law rule that a party owes no duty for the actions of another—a reason *not* to expand malpractice liability. *Cf. Dukowitz*, 841 N.W.2d at 152 (explaining that our reluctance to expand the common law "applies with equal, if not greater, force" when a party's argument "requires us to depart from the traditional American common-law").

Brian's suicide was an independent action, occurring beyond Park Nicollet's supervision or control. And holding that a patient's suicide is compensable under medical malpractice imposes liability upon healthcare providers for actions they cannot control. I would therefore hold that Brian's suicide imposed no duty of care on Park Nicollet.

II.[12]

We also address whether Park Nicollet owed a duty of care to Brian's wife and children. The trustee asserts two sources for the purported duty between Park Nicollet and Brian's wife and children. First, medical providers have a duty to avoid causing foreseeable harm to their patients. *Warren v. Dinter*, 926 N.W.2d 370, 375 (Minn. 2019). And second, a party may owe a duty of care in some circumstances involving a foreseeable risk of harm. *E.g.*, *Fenrich v. The Blake Sch.*, 920 N.W.2d 195, 201–02 (Minn. 2018). But the trustee presented no evidence that Brian's wife and children were patients of Park Nicollet, were in contact with Park Nicollet, or were under the control of Park Nicollet.

[12] This part represents the opinion of the court with respect to the duty between a mental healthcare provider and a patient's family.

Brian never threatened violence against his family, had no prior history of violent acts, and showed no warning signs that would distinguish him from other patients suffering from depression and anxiety. His actions in killing his wife and children were unforeseeable as a matter of law. We therefore hold that Park Nicollet owed no duty of care to Brian's wife and children.

A.

The trustee asserts that Park Nicollet owed a duty to Brian's wife and children as a matter of ordinary medical malpractice. Yet unlike Brian, Brian's wife and children were not patients of Park Nicollet. Nor were they in contact with Park Nicollet in any way. Most medical malpractice cases involve a physician-patient relationship. *Warren*, 926 N.W.2d at 375. It is true that in narrow circumstances such a relationship is not "necessary to maintain a [medical] malpractice action under Minnesota law." *Id.* A duty may arise where a provider gives medical advice, and it is foreseeable that an identifiable third party will rely on that advice. *Id.* at 376. Park Nicollet gave Brian medical advice—it prescribed medications for him to take, assessed his mental health, and enrolled him in counselling. But there is no evidence that Brian's wife and children relied on any of Park Nicollet's advice to shape their conduct, or that there was any reason for Park Nicollet to expect them to do so. *Cf. Molloy v. Meier*, 679 N.W.2d 711, 719 (Minn. 2004) (finding that a duty existed where negligently performed genetic testing of a child foreseeably led the patient's mother to decide that it was safe to have additional children); *Skillings v. Allen*, 173 N.W. 663, 663 (Minn. 1919) (finding that a duty existed when a doctor's negligent advice that a patient with scarlet fever was not contagious foreseeably caused the patient's

parents to visit the patient). Absent any evidence that Park Nicollet should have foreseen that Brian's wife and children would use Park Nicollet's medical advice to shape their behavior, Park Nicollet did not assume a duty of care to Brian's wife and children when it undertook to treat Brian.

B.

The trustee also asserts that Park Nicollet owed a duty of care to Brian's wife and children because it created a foreseeable risk that they would be harmed. Minnesota follows "the general common law rule" that a person does not owe a duty of care for harm caused by the actions of a third party. *Doe 169 v. Brandon*, 845 N.W.2d 174, 177–78 (Minn. 2014). Whether we will recognize an exception to this rule depends on "the relationship of the parties and the *foreseeable* risk involved." *Erickson v. Curtis Inv. Co*., 447 N.W.2d 165, 168–69 (Minn. 1989) (emphasis added). This is a question for the court to decide. *Doe 169*, 845 N.W.2d at 177; *Domagala*, 805 N.W.2d at 27.

The traditional rule that a party is not liable for the actions of another has two specific exceptions: "special relationship" and "own conduct." *Doe 169*, 845 N.W.2d at 178. The "special relationship" exception imposes a duty based on assuming power and control over another such that it creates a *foreseeable risk*. *Id.* The "own conduct" exception applies when there is a *foreseeable risk*, created by the defendant's acts, affecting a foreseeable plaintiff. *Fenrich*, 920 N.W.2d at 203. Both exceptions require a foreseeable risk in addition to other elements. We therefore begin by addressing whether the risk of harm to Brian's wife and children was foreseeable.

To assess whether a risk was foreseeable, we ask "whether it was objectively reasonable to expect the specific danger causing the plaintiff's injury." *Domagala v. Rolland*, 805 N.W.2d 14, 27 (Minn. 2011). The "precise nature and manner" of the injury need not be foreseeable. *Id.* But "the possibility of an accident" must be "clear to the person of ordinary prudence." *Connolly v. Nicollet Hotel*, 95 N.W.2d 657, 664 (Minn. 1959). When the question of foreseeability is a "close case," the question must be submitted to a jury to resolve. *Montemayor v. Sebright Prods., Inc*., 898 N.W.2d 623, 631 (Minn. 2017). But when foreseeability is clear, it should be decided by the court as a matter of law. *Larson v. Larson*, 373 N.W.2d 287, 288–89 (Minn. 1985) (holding that an injury was unforeseeable when the only threat of it occurring was a vague comment by an intoxicated person 2 months prior).

Our prior cases establish that not every case is a close case. In *Clements*, we held that a patient's suicide attempt was unforeseeable as a matter of law because the patient was seeking treatment for injuries arising from an unrelated automobile accident. 89 N.W.2d at 166. And in *Doe 169*, we held that it was not foreseeable to a church council that its actions in renewing the ministerial credentials of a man would lead to the man harming a third party through an unrelated volunteer program that was not managed or overseen by the council. 845 N.W.2d at 179. In neither case did we suggest that the issue must be left for the jury to decide.

We do not accept the trustee's argument that this dispute is a "close case" of foreseeability. The general rule, long-established in our history, is that determinations of duty are questions for the court to decide. *Id.* at 177. Although "close cases" exist in which

the issue of foreseeability must be left to the jury, *Warren*, 926 N.W.2d at 378, the dissent, on this issue, would effectively abdicate our responsibility and hold that in practice nearly every duty claim is a "close case." Brian sought treatment for depression—like millions of other Americans who do not commit familicide. Brian was specifically asked by Park Nicollet employees about homicidal thoughts, and he reported none. And he never admitted to, or even mentioned, a desire to harm anyone and certainly said nothing about harming his wife and children. He reported that his ability to sleep was improving. Park Nicollet staff described him as forward-looking, appropriately groomed and dressed at all his appointments, normal of thought process and affect, and committed to his treatment. He was planning for the future and stated that he was looking forward to going on vacation with his wife and children. He had no history of violence of any kind. To the extent that Brian mentioned his wife and children to Park Nicollet, he reported that they were supportive of his treatment. Brian presented Park Nicollet with no reason to suspect that his report of his condition was inaccurate.

The dissent argues that the act of Brian killing his wife and children was foreseeable because he suffered from *severe* depression. To the extent that we agree with this characterization of Brian's mental illness, it does not explain how Brian's actions were foreseeable. Although Park Nicollet knew that Brian suffered from anxiety and depression, nothing about his behavior suggested that he was a particular danger to those around him. And severe depression on its own cannot make patient violence legally foreseeable—indeed, all cases of patient violence related to depression are likely to involve "severe" depression because the mere fact that a patient commits violent acts could likely support

identifying the patient's mental illness as "severe." In the context of mental illness and violence, arguing that Brian's severe depression alone made his killings foreseeable leads to the "close case" exception swallowing the general rule that courts decide the existence of legal duties.

The trustee's experts allege that deficiencies existed in the treatment that Brian received for anxiety and depression. The trustee asserts that because of these deficiencies, it was foreseeable that Brian would commit multiple homicides. Instead, the supposed warning signs of familicide were simply that Brian was a man, with a wife and children, who had severe depression. Our prior decisions make it clear that this is not sufficient to put Park Nicollet on notice of potential violence. In *Red River Lumber Co. v. State*, we held that a patient presented a foreseeable risk because the patient had been committed to a locked hospital ward from which he had escaped six or seven times, the patient repeatedly engaged in destructive behavior, and the patient "had demonstrated a tendency to engage in violent acts" by assaulting staff members and fellow patients. 282 N.W.2d 882, 884 (Minn. 1979). Because of this foreseeable risk, and because the hospital had custodial control over the patient, we held that the hospital potentially could be liable to a third party for intentional violent actions taken by the patient. *Id.* And in *Lundgren*, a patient presented a foreseeable risk to those around him because his "thought content was violent and paranoid," he had been repeatedly hospitalized for psychiatric treatment (and while hospitalized he assaulted one of his doctors), he "continued to talk of hurting people," and "he was likely to respond to stress with irritable outbursts of anger." 354 N.W.2d at 26–27. Because of this foreseeable risk, and because the patient had been in a doctor's custody

until the doctor took actions to release the patient, we held that the doctor potentially could be liable to a third party for the intentional violence of the patient. *Id.* at 29. Here, the trustee identifies no comparable warning signs that would justify holding that Park Nicollet should have foreseen Brian killing his wife and children.

Further, the specific deficiencies the trustee alleges are simply failures to do *more*: the trustee alleges that Park Nicollet should have given Brian more medications, at higher doses, and engaged him in more invasive treatments. The logical conclusion of the trustee's position would require us to hold that had Park Nicollet done *nothing* to treat Brian's mental illness, his actions in killing his wife and children still would have been foreseeable. We decline to do so. Our prior decisions imposing a duty of care for patient violence against third parties involved patients who had been previously involuntarily committed precisely because of their uncontrollable violent behavior. *See Red River Lumber Co.*, 282 N.W.2d at 884; *Lundgren*, 354 N.W.2d at 26–27. In the absence of a similar documented history of violent behavior, or even violent threats, we will not impose liability on a healthcare provider for the independent actions of patients not under the provider's control.

We have long expressed concern about adding to the stigma associated with mental illness. *See, e.g.*, *Lundgren*, 354 N.W.2d at 29. Holding that any patient with untreated depression and anxiety is a foreseeable murderer is not supportable and would certainly serve to stigmatize a population in need of further assistance. Imposing liability here would also create perverse incentives for mental healthcare providers. The trustee argues that Park Nicollet had a duty to refer Brian to see a psychiatrist, rather than a therapist. And

the trustee argues that Park Nicollet needed to enroll Brian in more specialized and more invasive treatments. But such specialized mental health treatments are not always practically available, especially in smaller communities. And even where technically available, these added specialists and extra treatments can present a significant financial barrier to patients. In circumstances in which prospective patients are unwilling, or *unable*, to pay for these extra steps, the threat of liability for independent actions taken by the patient would create a clear incentive for providers to not accept the patient for treatment in the first place. And all of these perverse incentives will appear most strongly for those patients whose mental illness is the most severe and who have the least external support. In other words, those who most need access to treatment would be those most likely denied it.

To hold that Brian's familicide was foreseeable—with no prior violent threats, no prior violent acts, no reported violent ideation of any kind, and consistently positive references to his family's support—is not supported by this record. We hold that Brian's familicide was unforeseeable as a matter of law. We therefore need not—and do not—address whether Park Nicollet's actions meet any of the remaining elements necessary to establish the existence of a legal duty. Summary judgment on whether Park Nicollet owed a duty of care to Brian's wife and children was appropriate, and therefore we reverse the court of appeals.

CONCLUSION

For the foregoing reasons, we affirm in part and reverse in part the decision of the court of appeals, and remand to the district court.

Affirmed in part, reversed in part, and remanded.

GILDEA, Chief Justice (dissenting in part).

I join in the opinion and dissent of Justice Anderson.

CHUTICH, Justice.

I join in part I of the opinion of Justice Hudson and part II of the opinion of Justice Anderson.

McKEIG, Justice.

I join in part I of the opinion of Justice Hudson and part II of the opinion of Justice Anderson.

THISSEN, Justice (dissenting in part).

I join in the opinion and dissent of Justice Hudson.

MOORE, III., Justice (dissenting in part).

I join in the opinion and dissent of Justice Anderson.