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DETERMINING A PSYCHIATRIST'S LIABILITY WHEN A PATIENT COMMITS SUICIDE: *HAAR V. ULWELLING* MAGGIE MURRAY*

I. INTRODUCTION

In 2007, the estate of Eric Haar sued his former psychiatrist, William Ulwelling, for wrongful death, alleging negligent treatment resulting in Haar's suicide.¹ In an issue of first impression, the New Mexico Court of Appeals concluded that the psychiatrist did not owe a duty of care to Haar because the doctor-patient relationship had been terminated.² The court found that Dr. Ulwelling did not have sufficient control over Haar and therefore did not have an affirmative duty to prevent him from killing himself.³

Haar v. Ulwelling was not appealed and the court of appeals' opinion offers minimal guidance for determining what, if any, circumstances would be necessary to find that a psychiatrist did owe a duty of care to prevent, or reasonably attempt to prevent, the suicide of his patient. Considering that failure to prevent suicide is one of the leading causes for malpractice suits against mental health care providers,⁴ New Mexico courts will likely need to decide if and under what circumstances the state's tort law and public policy would support the finding of a duty for a psychiatrist to prevent the self-destructive acts of a patient.

If the court determined that such a duty existed, New Mexico courts would then be asked to consider which defenses the psychiatrist would be permitted to employ.⁵ While many jurisdictions have found that a psychiatrist does owe a duty of care to his patient,⁶ they have not been consistent in deciding whether the partial defenses of contributory negligence or comparative fault can be applied.⁷ Many states have determined that there can be neither comparative fault nor contributory negligence attributed to the suicidal patient because the duty of the psychiatrist includes preventing that very harm.⁸ Because New Mexico is a comparative fault state, refusing to allow the defense could cause the psychiatrist to bear 100 percent of the fault for his patient's suicide. Eventually, New Mexico courts will need to determine if and how to evaluate the comparative fault of the suicidal patient when determining the liability of the psychiatrist.

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1. See *Estate of Haar v. Ulwelling*, 2007-NMCA-032, ¶ 1, 154 P.3d 67, 68.

2. *Id.* ¶ 28, 154 P.3d at 73.

3. *Id.* ¶ 30, 154 P.3d at 73.

4. Charles J. Williams, *Fault and the Suicide Victim: When Third Parties Assume a Suicide Victim's Duty of Self-Care*, 76 NEB. L. REV. 301, 302 (1997) (citing BRUCE BONGAR, *THE SUICIDAL PATIENT: CLINICAL AND LEGAL STANDARDS OF CARE* 39 (1991)). Although this Note focuses on the liability of psychiatrists when a patient commits suicide, many of the legal arguments apply to other mental health care providers sued for negligence resulting in suicide.

5. See discussion *infra* Part III.A.5.

6. See, e.g., *Hobart v. Shin*, 705 N.E.2d 907, 910 (Ill. 1998); *Cowan v. Doering*, 545 A.2d 159, 164 (N.J. 1988); see also *Kockelman v. Segal*, 71 Cal. Rptr. 2d 552, 560 (Cal. Ct. App. 1998).

7. See discussion *infra* Part III.D.

8. See, e.g., *McNamara v. Honeyman*, 546 N.E.2d 139, 146 (Mass. 1989); *Cowan*, 545 A.2d at 164.

This Note explores New Mexico tort law and public policy to determine if a psychiatrist's duty should include the duty to prevent the suicide of his patient. Part II summarizes the facts of *Haar v. Ulwelling* and provides an overview of the court's reasoning.⁹ Part III outlines the background law relevant to this issue including the elements of a negligence claim,¹⁰ the development of duty law in recent New Mexico cases,¹¹ and the use of comparative fault as a policy argument for determining duty.¹² Part III concludes by considering the existing arguments both for and against asserting the defense of comparative fault in cases involving mentally ill and suicidal patients.¹³

Finally, Part IV analyzes the relevant New Mexico law and public policy and argues that although a court should find that a duty exists for psychiatrists to prevent or reasonably attempt to prevent the suicide of their patients, the duty should be imposed in limited situations.¹⁴ Particularly, in order to impose a duty to prevent suicide, the doctor-patient relationship must be substantial and the psychiatrist must be in a position to reasonably control the actions of his patient.¹⁵ This Note further suggests that the goals of tort law support considering the comparative fault of the patient's self-destructive acts. However, because of the inability of many mentally ill patients to appreciate the significance of their actions, the court should adopt and employ a reduced capacity standard for determining the fault of mentally ill patients.¹⁶

II. STATEMENT OF THE CASE

In December of 1999, Eric Haar began psychiatric treatment with Dr. William Ulwelling at which time Haar was diagnosed and treated as bipolar and suicidal.¹⁷ After completing five office visits with Dr. Ulwelling, Haar arrived at Dr. Ulwelling's office unannounced on March 8, 2008. Haar waited and then met with Dr. Ulwelling; when Haar left the office, he told his girlfriend that Dr. Ulwelling "doesn't give a shit."¹⁸ Dr. Ulwelling's records show that Haar then proceeded to miss two appointments scheduled for the 13th and 15th of March.¹⁹

Haar was voluntarily admitted to an inpatient psychiatric hospital on March 17th. That day, Haar's mother called Dr. Ulwelling to inform him that her son had been admitted.²⁰ However, Dr. Ulwelling was not consulted about the admission. Haar was discharged on his own request three days later, only to be admitted as an outpatient at the same hospital. As an outpatient, Haar attended group counseling sessions. On March 27th, he was discharged from outpatient treatment due to non-attendance.²¹ Haar continued to participate in individual and group therapy ses-

9. See *infra* Part II.

10. See *infra* Part III.A.

11. See *infra* Part III.B.

12. See *infra* Part III.C.

13. See *infra* Part III.D.

14. See *infra* Part IV.A.

15. See *infra* Part IV.A.3.

16. See *infra* Part IV.C.1.

17. Estate of Haar v. Ulwelling, 2007-NMCA-032, ¶¶ 1-3, 154 P.3d 67, 68.

18. *Id.* ¶ 3, 154 P.3d at 68.

19. *Id.* ¶ 4, 154 P.3d at 69.

20. *Id.* ¶ 5, 154 P.3d at 69.

21. *Id.*

sions with a new doctor, but failed to attend at least one session. On May 3rd, Haar died by suicide at the age of twenty-one years in the backyard of his girlfriend's home.²² Dr. Ulwelling had not seen Haar since March 8th, and had not heard about Haar's condition since Haar's mother called him on March 17th.²³

Following Eric Haar's suicide, Haar's estate filed suit against Dr. Ulwelling, alleging that Dr. Ulwelling had breached his duty to treat Haar in a manner that would protect against his suicide.²⁴ The district court granted Dr. Ulwelling's motion for summary judgment holding that the plaintiff failed to establish the special relationship and ability to control necessary to create a legal duty on the part of Dr. Ulwelling.²⁵ The Haar estate appealed from the court's order granting summary judgment. The New Mexico Court of Appeals affirmed the district court's summary judgment in favor of Dr. Ulwelling.²⁶

To determine whether the district court erred by granting Dr. Ulwelling's motion for summary judgment, the New Mexico Court of Appeals addressed whether Dr. Ulwelling owed a duty to the plaintiff to prevent him from committing suicide.²⁷ The court first cited the general duty of a physician to "possess and apply the knowledge and to use the skill and care ordinarily used by reasonably well-qualified specialists practicing under similar circumstances."²⁸ However, the court asserted that the question of duty could not be resolved simply by looking to general standards. Instead, it stated that the case involved the issue of whether the undisputed facts were sufficient to establish that between the time of Haar's last visit with Dr. Ulwelling and the time of his suicide, Dr. Ulwelling "continued to have a duty of care to treat Haar in a manner that would protect against Haar's suicide."²⁹ By asking if Dr. Ulwelling "continued" to have a duty, the court presupposed that such a duty existed when Dr. Ulwelling was actively treating Haar. The court therefore emphasized the importance of determining whether a special relationship continued to exist between Dr. Ulwelling and Eric Haar. Finding that ordinarily a person does not have a duty to act affirmatively to protect another, the court stated that in order to impose such a duty, "a relationship must exist that legally obligates a defendant to protect a plaintiff."³⁰

Although the court arguably presupposed a duty to protect against suicide, its opinion continues by considering policy and precedent in order to determine if such a duty should be imposed. Determining whether a duty exists, the court stated, requires consideration of both foreseeability and policy. The public policy determination involves whether "the responsibility or obligation asserted . . . 'is one to which the law will give recognition and effect.'"³¹ The foreseeability analysis, meanwhile, concerns issues of causation.³²

22. *Id.* ¶ 6, 154 P.3d at 69.

23. *Id.* ¶ 7, 154 P.3d at 69.

24. *Id.* ¶ 8, 154 P.3d at 69.

25. *Id.* ¶¶ 1–2, 154 P.3d at 68.

26. *Id.* ¶ 40, 154 P.3d at 76.

27. *Id.* ¶¶ 12–13, 154 P.3d at 70.

28. *Id.* ¶ 12, 154 P.3d at 70 (quoting UJI 13-1102 NMRA 1998).

29. *Id.* ¶ 13, 154 P.3d at 70 (emphasis added).

30. *Id.* ¶ 15, 154 P.3d at 70 (alterations omitted) (quoting *Johnstone v. City of Albuquerque*, 2006-NMCA-119, ¶ 7, 145 P.3d 76, 80).

31. *Id.* (quoting *Johnstone*, 2006-NMCA-119, ¶ 9, 145 P.3d at 80).

32. *Id.*

Finding that *Haar v. Ulwelling* presented an issue of first impression for New Mexico, the court turned to three relevant cases to determine if Dr. Ulwelling owed a duty to Haar to prevent him from committing suicide: *Wilschinsky v. Medina*,³³ *Lester v. Hall*,³⁴ and *Weitz v. Lovelace Health System, Inc.*³⁵ Although the court recognized that these cases involved the duty of physicians to third parties and were therefore distinguishable, it found that the cases could nevertheless provide guidance for its analysis.³⁶

In *Wilschinsky*, the New Mexico Supreme Court considered whether a physician has a duty to third parties when he knowingly administers drugs that could affect judgment and driving to a patient who drives away after treatment and injures a third party.³⁷ The court in *Wilschinsky* determined that such a duty does exist.³⁸ The *Wilschinsky* majority recognized two sources of duty for the medical profession, including “when a doctor exerts control over a patient, or when a doctor is aware of threats against specific, identifiable third parties.”³⁹ The court determined that in this case liability could only stem from “the doctor’s control over his offices and the administration of powerful drugs in those offices.”⁴⁰

Finding that related out-of-state cases, although relevant, were not entirely analogous, the *Wilschinsky* court applied a balancing test to determine if a duty should be imposed. The court considered “the likelihood of injury, the reasonableness of the burden of guarding against it, and the consequences of burdening the defendant.”⁴¹ Balancing what the court found to be a “high” likelihood of accidents and injuries caused by such injections with a comparatively low burden placed on doctors to remain “consistent with professional standards” and not allow those who would be substantially impaired to drive after injections, the court concluded that a doctor owes a duty to “the driving public” when he administers drugs to a patient.⁴²

The *Haar* court then looked to *Lester v. Hall*, in which the physician had prescribed medication which may have impaired the patient’s driving.⁴³ In *Lester*, the medication was prescribed five days before the accident.⁴⁴ The New Mexico Supreme Court specifically declined to extend the duty articulated in *Wilschinsky* to prescription cases.⁴⁵ The court did however use the same balancing test employed in *Wilschinsky*, which they renamed the “*Wilschinsky* Balancing Test.”⁴⁶ Applying the test, the court argued that the likelihood of injury was remote considering that the accident occurred many days after the physician prescribed the medication.⁴⁷

33. 108 N.M. 511, 775 P.2d 713 (1989).

34. 1998-NMSC-047, 970 P.2d 590.

35. 214 F.3d 1175 (10th Cir. 2000).

36. *Haar*, 2007-NMSC-032, ¶ 16, 154 P.3d at 70–71.

37. *Wilschinsky*, 108 N.M. at 512, 775 P.2d at 714.

38. *Id.* at 515, 775 P.2d at 717.

39. *Id.* at 513, 775 P.2d at 715.

40. *Id.*

41. *Id.* at 515, 775 P.2d at 717 (adopting the test from *Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 396 (Ill. 1987)).

42. *Id.*

43. *Estate of Haar v. Ulwelling*, 2007-NMCA-032, ¶ 18, 154 P.3d 67, 71.

44. *Lester v. Hall*, 1998-NMSC-047, ¶ 2, 970 P.2d 590, 591.

45. *Id.* ¶ 3, 970 P.2d at 591.

46. *Id.* ¶ 5, 970 P.2d at 592.

47. *Id.* ¶ 6, 970 P.2d at 592.

Additionally, the court determined that the burden on physicians would be substantial if a duty were imposed, noting the “potentially chilling effect” the opposite holding might have on the use of prescription medication in medical care.⁴⁸

The court then considered whether such a duty would be supported by policy considerations, finding that the New Mexico Legislature had spoken on the issue with the Medical Malpractice Act.⁴⁹ The court stated that the damage caps imposed by the Act demonstrate “[t]he Legislature’s determination that health care providers’ liability must be limited in order to assure New Mexicans’ access to medical care.”⁵⁰ The *Lester* court went on to argue that while it did have the authority to recognize a duty, as it had in *Wilschinsky*, “[that] authority must be exercised sparingly, especially when the Legislature has spoken in a manner inconsistent with the expansion of tort liability for health care providers.”⁵¹ Considering the remoteness of injury, the high burden that would be placed on physicians, and the stance of the legislature in the Medical Malpractice Act, the court concluded that the duty of physicians should not be expanded to include a duty to a third-party driver injured as a result of the side effects of prescription medication.⁵²

The *Haar* court turned lastly to *Weitz v. Lovelace Health System, Inc.*, in which the Tenth Circuit Court of Appeals considered whether a mental health care provider owed a duty to control a patient by either preventing him from harming his family or warning his family about the danger he posed.⁵³ The court primarily addressed whether the health care provider had a duty to control the patient.⁵⁴ The *Weitz* court found that New Mexico had not established whether a duty exists to third parties arising from control when the patient is being treated on an outpatient basis.⁵⁵ However, the court found that New Mexico would likely not impose a duty under such circumstances because “[i]n most instances, the relationship a psychiatric outpatient has with the health care provider is less involved than that of an inpatient.”⁵⁶ Stating that outpatient treatment affords the physician only limited opportunities to supervise the patient, the court found that “imposing a duty to control in the outpatient context would require providers to exercise a degree of care and oversight that would be practically unworkable.”⁵⁷ After considering the extent and duration of his relationship with the provider, the court determined that the relationship was not substantial enough to give rise to a duty.⁵⁸

The *Haar* court highlighted the importance of the control element emphasized in *Weitz* and addressed New Mexico precedent which held that “in order to create a duty based on a special relationship, the relationship must include the right or

48. *Id.* ¶¶ 7–8, 970 P.2d at 592–93.

49. *Id.* ¶ 11, 970 P.2d at 593 (citing the Medical Malpractice Act, NMSA 1978, §§ 41-5-1 to -29 (1997)).

50. *Id.* (citing NMSA 1978, § 41-5-6 (1992)).

51. *Id.* ¶ 11, 970 P.2d at 594–95.

52. *Id.* ¶ 25, 970 P.2d at 598.

53. *Weitz v. Lovelace Health Sys., Inc.*, 214 F.3d 1175, 1181 (10th Cir. 2000).

54. *Id.*

55. *Id.* at 1181–82.

56. *Id.* at 1182.

57. *Id.*

58. *Id.*

ability to control another's conduct."⁵⁹ The court found that the New Mexico precedent relating to special relationships from these cases should apply to a psychiatrist under these circumstances.⁶⁰ Because of the circumstances of this case, the court concluded that the Estate of Haar had failed to demonstrate that Dr. Ulwelling maintained the ability to control Haar's actions.⁶¹

The special relationship between Dr. Ulwelling and Haar had been terminated. The court found that there was no requirement that Dr. Ulwelling continue to seek out Haar and "impose his views and treatment" when Haar himself had chosen to terminate the relationship by failing to attend sessions.⁶² The conclusion that the special relationship had been terminated, combined with the court's recognition that the legislature had spoken to limit health care provider liability, led the court to find that no affirmative duty existed.⁶³

By emphasizing the termination of the special relationship in coming to its decision, the court's opinion arguably presupposed a duty for psychiatrists who are actively treating suicidal patients.⁶⁴ However, the court's analysis and policy considerations demonstrate that the court was debating the implications of imposing such a duty. Although the court held that no affirmative duty existed for Dr. Ulwelling to prevent Haar's suicide, the opinion did not effectively state whether, under New Mexico law, a psychiatrist owes a duty to prevent the suicide of his patient.

III. BACKGROUND LAW

A. *The Elements of a Negligence Tort*⁶⁵

1. Duty

Duty is considered the "gateway issue" for tort liability.⁶⁶ Within the common law, an individual owes a duty to any foreseeable plaintiff to exercise reasonable care with regard to any foreseeable risk of harm that might arise from his actions.⁶⁷ Duty is a question of law and is therefore decided by the court.⁶⁸ While tort law imposes a duty for defendants whose actions create a risk of injury, in certain situations, the law has likewise imposed a duty even when the defendant does not create the risk, but merely fails to prevent harm.⁶⁹

59. Estate of Haar v. Ulwelling, 2007-NMCA-032, ¶ 23, 154 P.3d 67, 72 (alteration omitted) (quoting Grover v. Stechel, 2002-NMCA-049, ¶ 12, 45 P.3d 80, 84).

60. *Id.* ¶ 25, 154 P.3d at 72.

61. *Id.* ¶ 30, 154 P.3d at 73.

62. *Id.* ¶ 27, 154 P.3d at 73.

63. *Id.* ¶¶ 27-28, 154 P.3d at 73.

64. *See id.* ¶ 13, 154 P.3d at 70.

65. DOMINICK VETRI, LAWRENCE C. LEVINE, JOAN E. VOGEL & LUCINDA M. FINLEY, TORT LAW AND PRACTICE 76-78 (3d ed. 2006). A negligence tort has five elements: duty, breach of duty, causation, scope of liability (proximate cause), and damages. I will not discuss damages in this section because they are not germane to my topic. Additionally, while available defenses are not considered an element of a tort, when a plaintiff establishes a prima facie case of negligence, the defendant has the opportunity to prove any defenses.

66. *Id.* at 76.

67. *Id.*

68. *Id.*

69. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 373-75 (5th ed. 1984).

Generally, a claim for nonfeasance,⁷⁰ in which the risk of harm did not arise from the defendant's action, is not actionable.⁷¹ However, there are exceptions when a special relationship exists between the parties that obligates the defendant to protect the plaintiff.⁷² These relationships generally exist when the plaintiff is particularly vulnerable and dependent upon the defendant and when the defendant holds some power or control over the plaintiff's actions and safety.⁷³ Accordingly, courts have found special relationships between child and parent⁷⁴ as well as jailor and prisoner.⁷⁵ Doctor-patient relationships, including psychiatrist-patient relationships, are generally considered special relationships⁷⁶ because they involve treatment in which the physician or psychiatrist has some level of direct custody or control over the patient.⁷⁷ Because of this special relationship, psychiatrists can be held liable for nonfeasance.⁷⁸

Another important consideration for determining whether a special relationship exists is the level of control that one party has over the actions and conduct of the other.⁷⁹ For this reason, many courts have distinguished between inpatient and outpatient conditions when considering whether the special relationship was sufficient to create an affirmative duty for the psychiatrist.⁸⁰ However, more recently, some courts have found that the same duty is owed to patients in both inpatient and outpatient treatment, stressing that the status of the patient as an outpatient cannot determine the issue of duty as a matter of law.⁸¹

2. Breach

The second element of a tort claim is breach of duty.⁸² If the court determines that a duty does exist as a matter of law, whether that duty has been breached becomes a factual question for the jury, and the plaintiff has the burden of proof.⁸³ Breach relates to whether the defendant failed to meet the standard of care, or legal obligation, owed to the plaintiff.⁸⁴ Generally, the court must ask whether the

70. Nonfeasance is defined as "[t]he failure to act when a duty to act existed." BLACK'S LAW DICTIONARY 1153 (9th ed. 2009).

71. See VETRI ET AL., *supra* note 65, at 255.

72. *Id.*

73. See KEETON ET AL., *supra* note 69, § 56, at 373-74; see also *Johnstone v. City of Albuquerque*, 2006-NMCA-119, ¶ 14, 145 P.3d 76, 82.

74. See RESTATEMENT (SECOND) OF TORTS § 316 (1965).

75. See, e.g., *City of Belen v. Harrell*, 93 N.M. 601, 603, 603 P.2d 711, 713 (1979).

76. See *Johnstone*, 2006-NMCA-119, ¶ 11, 145 P.3d at 81 (citing *English v. Griffith*, 99 P.3d 90, 94 (Colo. App. 2004)).

77. *Id.* ¶14, 145 P.3d at 82.

78. There are also occasions in which a psychiatrist's actions might cross the line into misfeasance. This would occur when the actions of the defendant begin to affect the interest of the plaintiff adversely rather than merely failing to confer a benefit upon him. See KEETON ET AL., *supra* note 69, § 56, at 375.

79. See *Johnstone*, 2006-NMCA-119, ¶ 14, 145 P.3d at 82.

80. See, e.g., *Bellah v. Greenson*, 146 Cal. Rptr. 535, 538 (Cal. Ct. App. 1978); *Lawlor v. Orlando*, 795 So. 2d 147, 147-48 (Fla. Dist. Ct. App. 2001).

81. See *Kockelman v. Segal*, 71 Cal. Rptr. 2d 552, 560 (Cal. Ct. App. 1998) ("[W]e do not by any means purport to endorse a rule which imposes an absolute duty on a psychiatrist to prevent a patient's suicide. We find only that a psychiatrist's duty of care to a patient, which may include taking appropriate suicide prevention measures if warranted by all of the circumstances, is not negated by the patient's status as an outpatient.").

82. *Id.* at 76.

83. See VETRI ET AL., *supra* note 65, at 78.

84. *Id.*

act or failure to act were reasonable or unreasonable in light of the circumstances.⁸⁵ The question for the jury becomes what a reasonably prudent person would have done under the same or similar circumstances.⁸⁶

The standard of care for physicians is distinct. In New Mexico, a physician's standard of care is stated in the Uniform Jury Instructions: "In treating a patient, [the physician] is under the duty to possess and apply the knowledge and to use the skill and care ordinarily used by reasonably well-qualified doctors practicing under similar circumstances. . . . A doctor who fails to do so is negligent."⁸⁷

In medical malpractice claims, custom and common practice play a particularly large role in setting the standard of care and determining what deviation from that standard constitutes a breach of duty.⁸⁸ Custom evidence is usually provided to the jury in the form of expert testimony from other practicing psychiatrists or physicians as to what they believe constitutes reasonable care under the circumstances.⁸⁹ Often, the opinions of other professionals in the field provide the jury with the means to distinguish between an error in judgment, which is usually not actionable, and malpractice.⁹⁰ Courts have held that a doctor's judgments as to the treatment of a patient cannot be questioned by the jury without expert testimony to contest the factors on which the doctor based his treatment decisions.⁹¹ However, while professional judgments are often protected, decisions that are not based on careful examination and a sound medical foundation can give rise to liability.⁹² If the jury concludes that the psychiatrist breached the standard of care and committed malpractice, the plaintiff must then demonstrate that the psychiatrist's conduct was the actual cause of his injuries.

3. Causation

After establishing that a duty was breached, causation must be established to directly tie the defendant's action or inaction to the plaintiff's injury.⁹³ Causation is a question for the jury and requires the fact finder to consider if the alleged wrongful conduct contributed to the resulting injury and if the harm would not have occurred in the absence of such conduct.⁹⁴

85. *Id.*

86. *Id.*

87. UJI 13-1101 NMRA 1998.

88. VETRI ET AL., *supra* note 65, at 204.

89. *Id.* at 213.

90. Patricia C. Kussmann, Annotation, *Liability of Doctor, Psychiatrist, or Psychologist for Failure to Take Steps to Prevent Patient's Suicide*, 81 A.L.R. 5th 167 (2000) (citing *e.g.*, *Topel v. Long Island Jewish Med. Ctr.*, 431 N.E.2d 293, 294-95 (N.Y. 1981); *Bell v. N.Y. City Health & Hosps. Corp.*, 456 N.Y.S.2d 787, 792-95 (N.Y. App. Div. 1982)).

91. See *Topel*, 431 N.E.2d at 295; *Darren v. Safier*, 615 N.Y.S.2d 926, 927 (N.Y. App. Div. 1994).

92. See *Bell*, 456 N.Y.S.2d at 794.

93. VETRI ET AL., *supra* note 65, at 76.

94. *Id.* at 438. New Mexico applies a hybrid of the "substantial factor" and the "but for" tests for causation. See UJI 13-305 NMRA 2005 ("An [act] [or] [omission] [or] [____(condition)] is a 'cause' of [injury] [harm] [____(other)] if [unbroken by an independent intervening cause,] it contributes to bringing about the [injury] [harm] [____(other)] [, and if injury would not have occurred without it]. It need not be the only explanation for the [injury] [harm] [____(other)], nor the reason that is nearest in time or place. It is sufficient if it occurs in combination with some other cause to produce the result. To be a 'cause', the [act] [or] [omission] [or] [____(condition)], nonetheless, must be reasonably connected as a significant link to the [injury] [harm].").

In cases involving suicide, a doctor's negligence must be the cause of the patient's suicide before any liability attaches to the doctor's acts.⁹⁵ Courts have held that failure to properly diagnose or treat a psychiatric condition will be considered the cause of a patient's injury or death if it is shown that proper diagnosis and treatment could have corrected or controlled the patient's condition.⁹⁶ Even if the court concludes that the injury was caused by the act of the defendant, the foreseeability of the injury plays an important role in determining the scope of potential liability or the "proximate cause."⁹⁷

4. Proximate Cause

Although careless or reckless behavior may have caused an injury, the courts will not stretch liability beyond the reasonable and foreseeable consequences of an action.⁹⁸ Proximate cause is often considered a limitation device because "[t]he [element] suggests that even if the defendant had a duty to exercise reasonable care, engaged in careless conduct, and the carelessness was the cause-in-fact of the plaintiff's injuries, there may be some factual settings in which imposing liability would nonetheless be inappropriate because it pushes liability too far."⁹⁹ Courts consider what injury, if any, was foreseeable to the defendant and apply liability accordingly. Doing so essentially limits liability to the risks that made the conduct unreasonable in the first place.¹⁰⁰

In determining whether a physician or psychiatrist breached his duty of care, resulting in the suicide of his patient, courts have conclusively held that the suicide itself must have been foreseeable in order to hold the doctor liable.¹⁰¹ Some courts have found that, depending on the level of depression and suicidal thoughts exhibited by a patient, it would be foreseeable that patients seeking psychiatric care because of suicidal thoughts or tendencies would in fact commit suicide.¹⁰² However, others argue that determining whether a patient is likely to kill himself is the

95. See Kussman, *supra* note 90, § 5 (citing *Farwell v. Un*, 902 F.2d 282 (4th Cir. 1990); *Vinchiarello v. Kathuria*, 558 A.2d 262 (Conn. App. Ct. 1989)).

96. *Schuster v. Altenberg*, 424 N.W.2d 159, 162 (Wis. 1988).

97. New Mexico courts and the New Mexico Uniform Jury Instruction 13-305 do not address the issues of causation or "cause in fact" and proximate cause separately. Rather, the New Mexico Uniform Jury Instruction combines both concepts as causation and they are treated as a single element in a tort claim. See UJI 13-305 NMRA 2005 (quoted in full *supra* note 94). However, this Note along with various scholars' works separate cause in fact and proximate cause for clarity because both elements are critical for establishing causation. See, e.g., *VETRI ET AL.*, *supra* note 65, at 76-77.

98. See *VETRI ET AL.*, *supra* note 65, at 77.

99. *Id.*; see also *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99, 99 (N.Y. 1928) ("If no hazard was apparent to the eye of ordinary vigilance, an act innocent and harmless, at least to outward seeming, with reference to her, did not take to itself the quality of a tort because it happened to be a wrong, though apparently not one involving the risk of bodily insecurity, with reference to some one else.").

100. *VETRI ET AL.*, *supra* note 65, at 550.

101. See, e.g., *Keebler v. Winfield Carraway Hosp.*, 531 So. 2d 841, 844-45 (Ala. 1988); *Cowan v. Doering*, 522 A.2d 444, 449 (N.J. Super. Ct. App. Div. 1987); see also *Husted v. Echols*, 919 S.W.2d 43 (Tenn. Ct. App. 1995).

102. James J. McCabe et al., *Suicide Deemed Foreseeable Result of Failure to Treat Properly*, MED. MALPRACTICE L. & STRATEGY, May 1997, available at 14 No. 7 MEDMALLST 3 (Westlaw); see also *Winger v. Franciscan Medical Ctr.*, 701 N.E.2d 813, 820 (Ill. App. Ct. 1998) (citing *Cowan*, 522 A.2d at 449-50) ("Where it is reasonably foreseeable that a patient by reason of his mental or emotional illness may attempt to injure himself, those in charge of his care owe a duty to safeguard him from his self-damaging potential. This duty contemplates the reasonably foreseeable occurrence of self-inflicted injury regardless of whether it is the product of the patient's volitional or negligent act.").

pivotal question for psychiatrists treating suicidal patients and that foreseeability should therefore be a central consideration for the courts.¹⁰³

5. The Defenses of Contributory Negligence and Comparative Fault

If the plaintiff proves all of the above elements and establishes a *prima facie* case of negligence, the defendant then has the opportunity to assert defenses that could bar or limit the plaintiff's recovery.¹⁰⁴ The defendant has the burden of proving the applicability of each asserted defense. Contributory negligence and comparative fault¹⁰⁵ are two such defenses, and they arise when the plaintiff's own action contributed to the injury.¹⁰⁶ The negligence of the plaintiff can be established by proving, by a preponderance of the evidence, that the plaintiff failed to meet the standard of care and that his action caused the resulting injury.¹⁰⁷

In 1981 New Mexico adopted pure comparative fault in the case of *Scott v. Rizzo*.¹⁰⁸ The supreme court adopted the opinion directly from the court of appeals¹⁰⁹ and in doing so brought an end to the application of contributory negligence, substantially changing tort law in New Mexico. Contributory negligence had served to completely bar recovery for plaintiffs if their own unreasonable conduct contributed in any substantial way to the injuries they suffered.¹¹⁰ The defense operated as an all-or-nothing proposition¹¹¹ often resulting in inequity and injustice, and for this reason, many jurisdictions, including New Mexico, moved to the less harsh defense of comparative fault.¹¹²

The premise of comparative fault is that where both the plaintiff and the defendant are at fault, and both contribute to the injury, "they should share the responsibility rather than have it fall entirely on one party or the other."¹¹³ Under comparative fault, the supreme court hoped to accomplish a more equitable apportionment of fault between the negligent parties, including a proportional allocation of damages resulting from the loss or injury.¹¹⁴ The jury would be responsible for making the ultimate judgment concerning the allocation of liability.¹¹⁵ In adopting the defense, the court declared, "Pure comparative negligence denies recovery for one's own fault; it permits recovery to the extent of another's fault; and it holds all parties fully responsible for their own respective acts."¹¹⁶ While the court intended

103. See R. Collin Middleton, *Determining Professional Negligence When Patients Commit Suicide*, MED. MALPRACTICE L. & STRATEGY, Jan. 2002, available at 19 No. 3 MEDMALLST 5 (Westlaw).

104. VETRI ET AL., *supra* note 65, at 689.

105. "Comparative fault" is also referred to by many courts, including the New Mexico Supreme Court, as "comparative negligence." See, e.g., *Scott v. Rizzo*, 96 N.M. 682, 684, 634 P.2d 1234, 1236 (1981).

106. VETRI ET AL., *supra* note 65, at 690.

107. *Id.*

108. 96 N.M. at 690, 634 P.2d at 1242.

109. *Id.* at 683, 634 P.2d at 1235.

110. VETRI ET AL., *supra* note 65, at 690.

111. *Scott*, 96 N.M. at 684, 634 P.2d at 1236.

112. *Id.* at 685-86, 634 P.2d at 1237-38.

113. VETRI ET AL., *supra* note 65, at 691.

114. See *Scott*, 96 N.M. at 688, 634 P.2d at 1240.

115. *Id.* (noting that the state's trial judges should submit special interrogatories to facilitate the entry of a judgment as to the jury's determination).

116. *Id.* at 690, 634 P.2d at 1242.

comparative fault to change the apportionment of liability and damages in New Mexico, it has also impacted the court's duty analysis.¹¹⁷

B. Duty in New Mexico

New Mexico tort law has adapted, and arguably expanded, the concept of duty considerably over the last decade.¹¹⁸ When the court decided *Calkins v. Cox Estates* in 1990, the majority of the New Mexico Supreme Court stressed the importance of foreseeability in determining whether a duty was owed, stating that foreseeability was "integral" to the issue of duty.¹¹⁹ In *Calkins*, the court considered whether a landlord should be held liable for the death of a tenant child who wandered from a hole in the playground fence and was hit by a car 945 feet away.¹²⁰ *Calkins* established that for a defendant to owe a duty, the plaintiff must have been foreseeable and the duty must be supported by public policy.¹²¹ By looking to statutes and common law, the court found that policy supported imposition of a duty based on the landlord-tenant relationship which would require landlords to protect their tenants from known hazards on the property.¹²²

The court then turned to the issue of foreseeability, stating that "if it is found that a plaintiff, and injury to that plaintiff, were foreseeable, then a duty is owed to that plaintiff by the defendant."¹²³ Because the young boy was a tenant and the playground was meant for use by tenant children, the court held that it was reasonably foreseeable that the child would be harmed as a result of the landlord's failure to maintain the playground fence.¹²⁴ With both elements met, the majority found the defendant landlord liable for the boy's injuries.

The dissent took a different view on the importance of foreseeability in determining the existence of a duty. Justice Ransom's dissent stressed public policy over foreseeability, arguing that "[t]he crux of the duty analysis is not a factual foreseeability determination, but rather it is a legal policy determination."¹²⁵ While recognizing that duty and foreseeability are integrated concepts, the dissent emphasized Dean Prosser's definition of duty as "an obligation to which the law will give recognition and effect"¹²⁶ and proffered the idea that the law should give such recognition in accordance with public policy rather than foreseeability.¹²⁷ Based on this analysis, Justice Ransom found that "[a]s a matter of public policy" it would be

117. See *infra* Part III.C.

118. Quinn M. Bumgarner-Kirby, Note, *The Continuing Debate over Tort Duty in New Mexico: The Role of Foreseeability and Policy in Herrera v. Quality Pontiac*, 34 N.M. L. REV. 433, 433 (2004).

119. 110 N.M. 59, 61, 792 P.2d 36, 38 (1990).

120. *Id.*

121. *Id.* at 62, 792 P.2d at 39.

122. *Id.* at 63-64, 792 P.2d at 40-41 (citing NMSA 1978, § 47-8-20(A)(3) (1989) (obliging an owner to keep common areas of the premises in a safe condition)).

123. *Id.* at 62, 792 P.2d at 39 (quoting *Ramirez v. Armstrong*, 100 N.M. 538, 541, 673 P.2d 822, 825 (1983), *overruled in part on other grounds by Folz v. State*, 110 N.M. 457, 460, 797 P.2d 36, 39 (1990)).

124. *Id.* at 65, 792 P.2d at 42.

125. *Id.* at 67, 792 P.2d at 44 (Ransom, J., dissenting).

126. *Id.* at 67-68, 792 P.2d at 44-45 (quoting WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 53, at 324 (4th ed. 1971)).

127. See *id.* at 68, 792 P.2d at 45.

unreasonable to require a landlord to prevent children from leaving the property and being faced with potential "remote" dangers one-fifth of a mile away.¹²⁸

While the majority did not share this opinion in *Calkins*, in 1995, Justice Ransom wrote the court's opinion in *Torres v. State*,¹²⁹ and in doing so transformed New Mexico's duty analysis.¹³⁰ In *Torres*, the New Mexico Supreme Court questioned whether law enforcement officials who investigated a murder in New Mexico could owe a duty to out-of-state victims later killed by the same murderer.¹³¹ Overturning the court of appeals, the court held that such a duty does exist.¹³² In coming to its conclusion, the court stated, "Policy determines duty. With deference always to constitutional principles, it is the particular domain of the legislature, as the voice of the people, to make public policy."¹³³ The court found that through the Tort Claims Act¹³⁴ the legislature had imposed a duty on law enforcement officials to reasonably investigate crimes and had permitted claims based on breach of that duty.¹³⁵ In placing emphasis on the voice of the legislature, the court did not focus on other policy considerations relied upon by the lower court.¹³⁶ Perhaps most importantly, the court held that the issue of foreseeability of the victims was a question for the jury and would become a question of law only when the victim would be unforeseeable to any reasonable mind.¹³⁷ Because the court could not conclude that the victims were unforeseeable as a matter of law,¹³⁸ it reversed the court of appeals' decision and remanded the case for a jury trial on the issue of foreseeability.¹³⁹

The tension between the policy emphasis in *Torres* and the stress on foreseeability in *Calkins* was left unresolved by the supreme court until 2003.¹⁴⁰ With *Herrera v. Quality Pontiac*, the court again reassessed the state's jurisprudence for determining whether a duty exists.¹⁴¹ In a highly controversial decision,¹⁴² the court determined that Quality Pontiac, a car dealership, owed a duty to the plaintiff when a thief stole an unlocked car with the keys inside from the dealership's lot and caused an accident in which the plaintiff was injured.¹⁴³ The court's argument

128. *Id.*

129. 119 N.M. 609, 894 P.2d 386 (1995).

130. See Bumgarner-Kirby, *supra* note 118, at 438 (arguing that with *Torres v. State*, the supreme court departed from the *Calkins* framework for analyzing duty).

131. *Torres*, 119 N.M. at 614–15, 894 P.2d at 391–92.

132. *Id.* at 615–16, 894 P.2d at 392–93.

133. *Id.* at 612, 894 P.2d at 389.

134. NMSA 1978, § 29-1-1 (1994) (stating that it is the duty of every officer "to investigate all violations of the criminal laws of the state which are called to the attention of any such officer or of which he is aware").

135. *Torres*, 119 N.M. at 612, 894 P.2d at 389 (citing NMSA 1978, § 29-1-1 (1994)).

136. *Id.* at 613, 894 P.2d at 390.

137. *Id.* (citing *Calkins v. Cox Estates*, 110 N.M. 59, 61–62, 792 P.2d 36, 38–39 (1990)).

138. *Id.* at 614, 894 P.2d at 391.

139. *Id.* at 616, 894 P.2d at 393.

140. See Bumgarner-Kirby, *supra* note 118, at 440 ("[T]he court's statement that foreseeability is a jury question unless it is absent as a matter of law represented a major departure from *Calkins*, which had held that foreseeability of the plaintiff was always a question for the court. Because *Torres* did not signal that it was making a change in the law, a reader who was unfamiliar with *Calkins* would not be aware that a change was occurring. Moreover, although the holdings regarding who is to decide foreseeability are in direct opposition, the *Torres* court did not overrule *Calkins*. Thus, after *Torres*, both methods for determining foreseeability were arguably still available." (footnote omitted)).

141. See *Herrera v. Quality Pontiac*, 2003-NMSC-018, 73 P.3d 181.

142. Bumgarner-Kirby, *supra* note 118, at 434.

143. *Herrera*, 2003-NMSC-018, ¶ 37, 73 P.3d at 196.

rested on the foreseeability of such accidents given the high rate of car theft in Albuquerque, New Mexico.¹⁴⁴ While the ruling used policy to support the imposition of such a duty,¹⁴⁵ the majority reverted to foreseeability concepts from *Calkins*, stating that “[i]ntegral to both [duty and proximate cause] is a question of foreseeability.”¹⁴⁶

While the majority in *Herrera* determined that there was a duty, principally because of the foreseeability of the injury,¹⁴⁷ the concurring opinion considered abandoning the foreseeability question altogether, relying instead on policy issues and legislative intent.¹⁴⁸ Justice Bosson’s concurrence echoed the *Torres* holding; Justice Bosson stated, “As Justice Ransom has repeatedly reminded us, the overarching question for any court is whether issues of sound legal and social policy trump foreseeability and preclude imposing a duty in a particular case.”¹⁴⁹ The majority’s analysis did not comport with this framework, and instead demonstrated a potential reversion back to *Calkins*, with emphasis on foreseeability. Although the *Herrera* opinion emphasized the foreseeability of injury over public policy for determining duty, the court has not maintained this particular approach.

Tafoya v. Rael,¹⁵⁰ decided in 2008, demonstrates that the *Herrera* decision had by no means overturned *Torres* and the court’s emphasis on policy. In the *Tafoya* opinion, the duty analysis began with a reference to *Torres* and the strong statement that “[i]t is well established that the existence of a tort duty in a given situation is a question of policy. . . .”¹⁵¹ In *Tafoya*, the supreme court considered whether New Mexico policy favored imposing a duty on a general contractor who negligently hired a subcontractor to dig a trench, knowing that the subcontractor was neither licensed nor qualified to do the work.¹⁵² As *Tafoya*, the subcontractor, dug the trench, he did so without following approved standards; the trench collapsed, burying him and causing his death.¹⁵³ Although there was case law before *Tafoya* that provided a basis for the liability of contractors to third parties caused by unqualified independent contractors, no case had specifically dealt with the liability of the contractor to the same unqualified independent contractor.¹⁵⁴

In accordance with *Torres*, the court looked first to the legislature to determine if it had already provided guidance on the issue. The court found that with the Construction Industries Licensing Act, the legislature indeed had provided statements of policy.¹⁵⁵ The court stated that the statute “indicate[s] a strong legislative choice for the protection of the public to require construction contractors to be

144. *Id.* ¶ 22, 73 P.3d at 191.

145. *Id.* ¶ 31, 73 P.3d at 194.

146. *Id.* ¶ 8, 73 P.3d at 186 (alteration in original) (quoting *Calkins v. Cox Estates*, 110 N.M. 59, 61, 792 P.2d 36, 38 (1990)).

147. *Id.* ¶¶ 19–25, 73 P.3d at 190–92.

148. *See id.* ¶ 41, 73 P.3d at 196 (Bosson, J., specially concurring).

149. *Id.* ¶ 41, 73 P.3d at 196 (citing *Solon v. WEK Drilling Co.*, 113 N.M. 566, 572–73, 829 P.2d 645, 651–52 (1992) (Ransom, C.J., specially concurring); *Torres v. State*, 119 N.M. 609, 612–13, 894 P.2d 386, 389–90 (1995)).

150. 2008-NMSC-057, 193 P.3d 551.

151. *Id.* ¶ 14, 193 P.3d at 554.

152. *Id.* ¶ 1, 193 P.3d at 552.

153. *Id.* ¶ 5, 193 P.3d at 552–53.

154. *Id.* ¶ 15, 193 P.3d at 554–55.

155. *Id.* (citing the Construction Industries Licensing Act, NMSA 1978, §§ 60-13-1 to -59 (2001)).

licensed and qualified to do the work they are hired to perform.”¹⁵⁶ The court intended to choose the “course of action [that would] best enhance such a policy.”¹⁵⁷ Although the court recognized that Tafoya had willingly put himself into a dangerous situation and was likewise responsible for his own death, the court did not find that this removed liability from the contractor. After considering both sides of the argument,¹⁵⁸ the court held that the contractor owed a duty to the independent contractor to take appropriate measures to avoid unqualified and unlicensed workers from performing dangerous work that requires a license.¹⁵⁹

Tafoya, like *Herrera*, demonstrates the New Mexico Supreme Court’s recent inclination toward finding a duty. Additionally, the interplay between foreseeability and policy is apparent in the two opinions. However, while both opinions expose the apparent tension between foreseeability and policy in the New Mexico courts, they also reveal an important change in the court’s approach to analyzing public policy in order to determine whether a duty should be imposed.

C. Comparative Fault as a Policy Consideration for Determining Duty in New Mexico

In its decision to hold a car dealership liable for leaving the keys in the ignition of an unlocked car, the supreme court in *Herrera v. Quality Pontiac* conceded that it could be unjust to hold the dealership entirely liable for injuries that were caused by the criminal acts of a third party.¹⁶⁰ However, application of comparative fault, the court believed, would maintain the equity of their decision.¹⁶¹ Under New Mexico’s comparative fault system, fault would be fairly apportioned between the tortfeasors because “each individual tortfeasor [would] be held responsible only for his or her percentage of the harm.”¹⁶² The court integrated the defense of comparative fault into its policy analysis, entitling that section of the opinion “The Policy Component of Duty: Adoption of Comparative Fault.”¹⁶³ Although the court’s analysis did not rest entirely on comparative fault,¹⁶⁴ it plainly stated that the *Herrera* decision “would be consistent with contemporary notions of public

156. *Id.* ¶ 17, 193 P.3d at 555.

157. *Id.*

158. *Id.* ¶¶ 17–25, 193 P.3d at 555–57. The court considered the contractor’s argument that no duty should be imposed because unlicensed individuals, knowing that they would be barred from recovery if they were injured, would be more inclined to become licensed or decline jobs for which they were not qualified. *Id.* ¶ 18, 193 P.3d at 555. On the other hand, if a duty were imposed, the court believed that general contractors might be less likely to hire unqualified contractors if they were aware of the potential liability. *Id.* ¶ 19, 193 P.3d at 555–56.

159. *Id.* ¶ 26, 193 P.3d at 557.

160. *Herrera v. Quality Pontiac*, 2003-NMSC-018, ¶ 29, 73 P.3d 181, 193.

161. *Id.* ¶¶ 26–27, 73 P.3d at 193.

162. *Id.* ¶ 28, 73 P.3d at 193.

163. *Id.* ¶ 26, 73 P.3d at 193 (internal quotation marks omitted).

164. *Id.* ¶¶ 26–32, 73 P.3d at 192–94. The court listed policy factors to consider in policy analysis including

the foreseeability of harm, the certainty of injury from the wrongful act, the closeness of the connection between the wrongful acts and the plaintiff’s injuries, the moral blameworthiness of the wrongful act, the policy of preventing future harm, the burden on potential defendants, the consequences to the community from the imposition of a new duty, and the availability and cost of insurance against the risk of harm.

Id. ¶ 30, 73 P.3d at 193–94.

policy, most importantly, comparative fault.”¹⁶⁵ Essentially, the court concluded that because the partial defense of comparative fault existed in New Mexico and could be applied in *Herrera*, the duty in question was appropriate. With this holding, the *Herrera* court relaxed the policy standard necessary for finding a duty by allowing the application of a possible defense, comparative fault, to be used as a policy consideration for duty.¹⁶⁶

Likewise, in *Tafoya v. Rael*, although the court made various substantial policy arguments in support of imposing a duty,¹⁶⁷ the court also applied comparative fault in its analysis to demonstrate that holding the defendant liable would not be unfair.¹⁶⁸ The court acknowledged that by voluntarily performing the work, Tafoya’s own negligence contributed to his death. However, it resolved this concern with the application of comparative fault, stating that the contractor who employed Rael would only be liable for the portion of damages attributable to his own conduct.¹⁶⁹ As in *Herrera*, the application of comparative fault was considered by the *Tafoya* court in connection to determining whether or not a duty was owed.

Interestingly, while such a defense should be analytically relevant “only after the plaintiff has established a prima facie case of negligence against the defendant,”¹⁷⁰ the cases discussed in this section show that the court has used the existence of comparative fault to support the finding of a duty, an element of negligence. Since the supreme court employed comparative fault as a policy argument in various cases, including *Herrera*, the court of appeals has been asked to expand upon the supreme court’s reasoning.

In *Chavez v. Desert Eagle*, the court of appeals provided an explanation for the application of comparative fault in duty analysis.¹⁷¹ There, the court determined that public policy did not support the imposition of a duty upon alcohol distributors when their alcohol was served at a casino where a patron became intoxicated, drove, and caused an accident that injured a motorist.¹⁷² The court held that by failing to connect the distributor’s actions to the actual service of alcohol, the plaintiff did not establish that the injuries were foreseeable to the defendant.¹⁷³ Likewise, in looking to policy, the court believed that the legislature intended to limit liability in cases involving the sale or service of alcohol to those who exercised control over that service or consumption.¹⁷⁴

However, the plaintiff argued that comparative fault supported finding a duty because the distributor would only be liable to the extent of his fault. In response, the court wrote that “the concept of comparative fault does not create new duties” and that “while the adoption of comparative fault in New Mexico means that it

165. *Id.* ¶ 31, 73 P.3d at 194.

166. See Bumgarner-Kirby, *supra* note 118, at 456.

167. *Tafoya v. Rael*, 2008-NMSC-057, ¶¶ 16–20, 193 P.3d 551, 555–56.

168. *Id.* ¶¶ 22–24, 193 P.3d at 556–57.

169. *Id.* ¶¶ 21–22, 193 P.3d at 556.

170. Cf. VETRI ET AL., *supra* note 65, at 690 (discussing the related defense of contributory negligence).

171. *Chavez v. Desert Eagle Distrib. Co.*, 2007-NMCA-018, ¶ 32, 151 P.3d 77, 87.

172. *Id.* ¶ 31, 151 P.3d at 87.

173. *Id.* ¶ 23, 151 P.3d at 85.

174. *Id.* ¶ 31, 151 P.3d at 87.

would not be against public policy to find a duty owed, it does not necessarily follow that the imposition of such a duty is supported by public policy.”¹⁷⁵

Essentially, the court of appeals held that although a duty cannot be imposed exclusively because of the existence of comparative fault, the court’s policy analysis may include acknowledgment that because of comparative fault the parties would not face excessive liability. *Chavez* demonstrates how the lines between the elements of a tort claim can become conflated. After cases including *Chavez*, *Herrera*, and *Tafoya*, the New Mexico courts have established that the application of comparative fault can be considered in the court’s policy analysis. As such, the defense plays a role in the court’s determination as to whether a duty exists.¹⁷⁶ The next section will demonstrate that in cases involving the suicide of a psychiatric patient, the issue of whether to apply comparative fault is central.

D. Comparative Fault in Cases Involving a Patient’s Suicide

Many courts throughout the United States have been reluctant to allow the defense of comparative fault or contributory negligence in suits involving a psychiatrist’s failure to prevent a patient from injuring or killing himself.¹⁷⁷ Often, these courts have concluded that the comparative fault of the patient should not be considered in cases where the psychiatrist’s duty includes preventing the very act that caused the patient’s injury.¹⁷⁸ However, other courts have found that by preventing this defense, psychiatrists could potentially face a higher burden of legal liability than would be imposed on other physicians.¹⁷⁹

Courts that reject the use of the defense have argued that juries will likely allocate most, if not all, of the fault to the intentional actor—the patient—and that doing so would reduce the incentive for the negligent actor—the psychiatrist—to act with due care.¹⁸⁰ Allowing the defense of comparative fault, they argue, poses practical difficulties in allocating fault between negligent and intentional acts.¹⁸¹ These courts question whether asking a jury to compare the patient’s fault to the physician’s fault could result in a complete dismissal of any liability for psychiatrists whose patients commit suicide, no matter how gross or reckless their negligence.¹⁸²

Conversely, courts that allow the defense of contributory negligence or comparative fault find that not doing so would make the psychiatrist the “absolute insurer” of suicidal patients.¹⁸³ Putting physicians in that position, they argue, would

175. *Id.* ¶ 32, 151 P.3d at 87.

176. See *Tafoya v. Rael*, 2008-NMSC-057, ¶ 22, 193 P.3d 551, 556; *Herrera v. Quality Pontiac*, 2003-NMSC-018, ¶¶ 26–32, 73 P.3d 181, 192–95.

177. See Gary K. Smith & William D. Domico, *The Psychiatrist’s Liability: Suicide and Comparative Fault*, MED. MALPRACTICE L. & STRATEGY, Oct. 1999, available at 16 No. 12. MEDMALLST 4 (Westlaw).

178. *E.g.*, *McNamara v. Honeyman*, 546 N.E.2d 139, 146 (Mass. 1989); *Cowan v. Doering*, 545 A.2d 159, 164 (N.J. 1988).

179. Smith & Domico, *supra* note 177.

180. *Cf. Veazey v. Elmwood Plantation Assocs.*, 650 So. 2d 712, 719 (La. 1994) (discussing apartment complex’s liability for rape of tenant).

181. *Turner v. Jordan*, 957 S.W.2d 815, 821–23 (Tenn. 1997) (discussing comparative fault of doctor in patient’s attack on nurse).

182. See *McNamara*, 546 N.E.2d at 146–47.

183. *Hobart v. Shin*, 705 N.E.2d 907, 911 (Ill. 1998).

encourage hospitals and physicians to avoid treating suicidal patients because of the liability and risk associated with their mental illness.¹⁸⁴

The Supreme Judicial Court of Massachusetts has addressed this issue, holding in *McNamara v. Honeyman* that, at least with respect to self-abusive acts arising out of conduct for which the patient was hospitalized, the patient's comparative fault may not be considered as a defense for the psychiatrist's negligence.¹⁸⁵ While the court did not hold that a mentally ill person can never be comparatively negligent, it stated that "there can be no comparative negligence where the defendant's duty of care includes preventing the self-abusive or self-destructive acts that caused the plaintiff's injury."¹⁸⁶ The court found that deciding otherwise would render the duty to protect against the patient's self-harm entirely meaningless.¹⁸⁷

The Illinois Supreme Court came to the opposite conclusion, this time applying contributory negligence.¹⁸⁸ In *Hobart v. Shin*, the court determined that a supervising physician was entitled to raise a patient's contributory negligence as an affirmative defense.¹⁸⁹ Public policy, the court believed, would not condone ruling otherwise because health care providers would then be reluctant to take on suicidal patients considering the risk and liability associated with treating them.¹⁹⁰ The court concluded that it was also the duty of the decedent to use ordinary care for her own safety,¹⁹¹ and as such, the instruction involving contributory negligence was appropriate.¹⁹²

The dissenting opinion in *Hobart v. Shin*, following a trend in tort law, focused on the use of a "capacity-based" standard in determining whether the patient's own negligence could be employed as a defense.¹⁹³ The standard would permit application of a reduced standard of self-care for mentally disturbed plaintiffs.¹⁹⁴ It is meant to "recognize[] that a mentally disturbed plaintiff is not capable of adhering to a reasonable person's standard of self-care, but at the same time holds that plaintiff responsible for the consequences of conduct that is unreasonable in light of the plaintiff's capacity."¹⁹⁵ Essentially, the reduced standard would aim to hold mentally disturbed plaintiffs responsible for exercising care only to the extent that they are capable.¹⁹⁶

Various courts have supported application of a reduced capacity standard in similar cases, but it has been applied narrowly.¹⁹⁷ In *Cowan v. Doering*, the New Jersey Supreme Court acknowledged the importance of applying the capacity

184. *Id.*

185. *McNamara*, 546 N.E.2d at 146.

186. *Id.*; see also Robert K. Jenner, *Overcoming Contributory and Comparative Negligence in Suicide and Self-Inflicted Harm Cases*, ANNUAL CONVENTION REFERENCE MATERIALS (Assoc. of Trial Lawyers of America), July 2000, available at Ann.2000 ATLA-CLE 1985 (Westlaw).

187. *McNamara*, 546 N.E.2d at 146-47.

188. *Hobart*, 705 N.E.2d at 913.

189. *Id.*

190. *Id.* at 911.

191. *Id.* at 910-11.

192. See *id.* at 913.

193. *Id.* (Freeman, C.J., concurring in part and dissenting in part).

194. *Id.* (citing *Cowan v. Doering*, 545 A.2d 159, 163 (N.J. 1988)).

195. *Id.* (quoting *Cowan*, 545 A.2d at 163) (emphasis omitted).

196. *Id.* at 913-14.

197. See KEETON ET AL., *supra* note 69, § 32, at 178 (stating that the majority of courts favor use of a capacity-based standard for the contributory negligence of mentally disturbed plaintiffs); see also De Martini

based standard in cases in which a mentally disturbed plaintiff acts negligently, contributing to her own injury.¹⁹⁸ However, the court found that the defense of contributory negligence, and thus application of the reduced capacity standard, were not applicable in that case.¹⁹⁹

In *Cowan*, the plaintiff was admitted to the emergency ward of a hospital to be monitored after overdosing on prescription medication in her second known suicide attempt.²⁰⁰ After she was visited in the Intensive Care Unit by a doctor with whom she had previously engaged in a sexual relationship, and whose decision to end the relationship arguably led to her suicide attempt, Ms. Cowan jumped from the window of her hospital room and suffered serious injuries, which became the basis of her claim.²⁰¹ At trial before the appellate division, the defendants offered expert testimony that the suicide attempts were “of a very low degree of severity” and that they were “attempts at manipulation.”²⁰² The defendants therefore sought the defense of contributory negligence.²⁰³

The New Jersey Appellate Division refused to allow the defense, stating that the “plaintiff committed the very act that defendants were under a duty to prevent.”²⁰⁴ In opposition, the defendants argued that the lower court had “fashioned a rule in which a mentally disabled plaintiff is relieved from any responsibility for the consequences of his or her own conduct without any requirement that the plaintiff be incapable of exercising self-care.”²⁰⁵ The New Jersey Supreme Court disagreed, finding that the appellate court had accurately explained and considered the reduced capacity standard and had properly concluded that it was not applicable in this case.²⁰⁶ The supreme court stated that “[t]his issue . . . does not present itself in this case because the plaintiff’s inability to exercise reasonable self-care attributable to her mental disability was itself subsumed within the duty of care defendants owed her.”²⁰⁷

Although the court expressed a desire to apply the reduced standard of care to the plaintiff’s actions in similar cases, it was not willing to allow the defense of contributory negligence in *Cowan*.²⁰⁸ The opinion demonstrates the court’s reluctance to allow contributory negligence or comparative fault to be considered, even when the acts of the plaintiff will be judged according to a reduced standard of care. Nevertheless, *Cowan* provides a method for application of the reduced capacity standard in future cases.²⁰⁹ The standard may be particularly applicable in cases that do not involve hospitalized and institutionalized patients because courts could

v. Alexander Sanitarium, Inc., 13 Cal. Rptr. 564, 567–68 (Cal. Dist. Ct. App. 1961); *Mochen v. State*, 352 N.Y.S.2d 290, 293–94 (N.Y. App. Div. 1974).

198. *Cowan*, 545 A.2d at 163. However, the case does not involve the liability of a psychiatrist and may be distinguishable on those grounds.

199. *Id.*

200. *Id.* at 161.

201. *Id.* (“The injuries to her back required the insertion of two steel rods, which limit her movements, make her unable to lift anything over ten pounds, and cause her pain and suffering.”).

202. *Id.* at 162.

203. *Id.* at 161.

204. *Cowan v. Doering*, 522 A.2d 444, 450 (N.J. Super. Ct. App. Div. 1987).

205. *Cowan*, 545 A.2d at 162.

206. *Id.* at 163.

207. *Id.*

208. *Id.*

209. *See id.* at 163–64.

determine that a psychiatrist's duty does not subsume his patient's duty of self-care in the outpatient setting.²¹⁰

IV. ANALYSIS

A. Should a Psychiatrist Owe a Duty to His Patient to Prevent Him from Committing Suicide?

Whether a psychiatrist owes a duty to prevent the suicide of his patient was an issue of first impression for the New Mexico Court of Appeals in *Haar v. Ulwelling*.²¹¹ Although the court determined that Dr. Ulwelling did not owe a duty because the special doctor-patient relationship had been terminated, the opinion did not effectively state whether New Mexico law supports the imposition of a duty for a psychiatrist to prevent the suicide of his patient. As discussed previously, the New Mexico Supreme Court has instructed that the answer to this unresolved issue requires an analysis of foreseeability and policy.²¹²

1. The Foreseeability of Suicide

While the issue of foreseeability is not central to this Note, it should be an important consideration in any New Mexico court's analysis. Competing theories exist as to whether the suicide of a mentally ill patient seeking psychiatric treatment is foreseeable.

Between twenty and fifty million Americans suffer from depression, and between nineteen and thirty-three million of those experience major depression; it is the most significant mental illness associated with suicide.²¹³ In one year, about 30,000 Americans commit suicide.²¹⁴ Therefore, separating psychiatric patients seen for depression from those who will or are likely to commit suicide is a critical determination for psychiatrists. Risk factors and predictors aid psychiatrists in their treatment,²¹⁵ however, many argue that there are no reliable scientific means to indicate if a certain patient's suicide is imminent.²¹⁶

Still, many courts have held that suicide is a foreseeable result of a psychiatrist's failure to properly treat a severely depressed or suicidal patient.²¹⁷ New Mexico courts would likely come to the same conclusion. The New Mexico Supreme

210. See *infra* Part IV.A.3.

211. 2007-NMCA-032, ¶¶ 13, 16, 154 P.3d 67, 70.

212. See *supra* Part III.B.

213. Middleton, *supra* note 103 (noting that the number of Americans who suffer from major depression is equivalent to seven to twelve percent of the population).

214. *Id.*

215. *Id.* Risk factors compiled from various studies for those that will successfully complete a suicide indicate that unmarried, unemployed males in their thirties and forties suffering from depression and schizophrenia posed the highest risk. *Id.* Likewise, for patients, risk factors include being white, having a history of suicide attempts, and experiencing either humiliation or the loss of a "key person," as well as being in a hospital or having been discharged within the last twelve months. *Id.*

216. *Id.* ("[T]hese risk factors are not predictive. A 1983 study examined 4,800 consecutive patients admitted to a Veterans Administration hospital. Using risk factors, the population was narrowed to 800 with increased suicide risk. However, only 30 of those actually killed themselves. The risk criteria thus were false predictors of suicide in the vast majority of cases. More startling was that 37 of the 4,800 patients not selected by the risk factors to be at increased risk in fact did kill themselves.").

217. See cases cited *supra* note 101.

Court, in *Herrera v. Quality Pontiac*, stressed that “[f]oreseeability is a critical and essential component of New Mexico’s duty analysis because ‘no one is bound to guard against or take measures to avert that which he [or she] would not reasonably anticipate as likely to happen.’”²¹⁸ The court asked if Quality Pontiac knew or should have known that a theft was likely to occur and if the dealership’s actions of leaving the keys in an unlocked car “enhanced or increased the risk.”²¹⁹ The court then argued that given the high rate of car theft in New Mexico, combined with the facts that thieves are more likely to steal cars to which they have “ready access” and that stolen cars are more likely to be involved in accidents, the court concluded that the injuries would be foreseeable to the defendant.²²⁰

Considering the high rates of suicide in America,²²¹ including the added risk for those who request psychiatric treatment,²²² a similar application of the above analysis would demonstrate that a psychiatrist should know that the potential for a patient’s suicide could be enhanced by the psychiatrist’s actions. Just as the *Herrera* court held that plaintiffs injured in accidents caused by car theft were within the “zone of danger” created by the dealerships actions, a court would conclude that a psychiatrist’s patient likewise exists within that zone.

2. Public Policy Considerations for Imposing a Duty to Prevent the Suicide of a Patient

While the foreseeability of suicide for patients seeking psychiatric treatment for depression lends itself to the imposition of a duty,²²³ policy considerations are likewise central to the court’s determination. The New Mexico Supreme Court has declared that policy is “the particular domain of the legislature.”²²⁴ Thus, in line with *Torres*, a court should first look to the Medical Malpractice Act²²⁵ to determine if the imposition of a duty is supported by policy considerations. The Act, which encompasses malpractice claims made against psychiatrists, has a stated purpose of promoting “the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico.”²²⁶ Essentially, the Act serves to limit damages and decrease a health provider’s liability by setting caps on the amount of damages recoverable by plaintiffs in New Mexico.²²⁷ In doing so, the Act demonstrates the legislature’s desire to limit health care provider liability. Arguably, imposing a duty on psychiatrists to prevent

218. *Herrera v. Quality Pontiac*, 2003-NMSC-018, ¶ 20, 73 P.3d 181, 190–91 (quoting *Bogart v. Hester*, 66 N.M. 311, 316, 347 P.2d 327, 330 (1959)) (alteration in original).

219. *Id.* ¶ 22, 73 P.3d at 191.

220. See *supra* text accompanying notes 143–44.

221. See Suicide.org, Suicide Statistics, <http://www.suicide.org/suicide-statistics.html#2005> (last visited June 13, 2009). Suicide is the eleventh leading cause of death for all Americans. *Id.* In 2004, 32,439 Americans successfully killed themselves leading to a rate of 11.1 suicide deaths per 100,000 people. *Id.*

222. See Middleton, *supra* note 103, text accompanying n.5 (stating that “[b]eing a psychiatric patient” is an additional risk factor for suicide).

223. See *id.*

224. *Torres v. State*, 119 N.M. 609, 612, 894 P.2d 386, 389 (1995).

225. NMSA 1978, §§ 41-5-1 to -29 (1992).

226. *Id.* § 41-5-2 (1976).

227. *Id.* § 41-5-6 (1992); see *supra* text accompanying note 49. Section 41-5-6(A) states that “[e]xcept for punitive damages and medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed six hundred thousand (\$600,000) per occurrence.”

the suicide of their patients would be contrary to the Act as it would extend liability for psychiatrists.

However, while the Medical Malpractice Act caps damages and limits liability, the larger intention of the Act is to "promote the health and welfare of the people of New Mexico."²²⁸ Thus, maintaining a standard of care for health care professionals would also be an important policy consideration.

Beyond the Medical Malpractice Act, policy concerns specific to mental health and suicide issues should also be considered by a court faced with the question of whether a psychiatrist owes a duty to prevent the suicide of a patient. Among the most critical policy considerations that have been expressed by various courts is the concern that imposing a duty to prevent suicide would discourage psychiatrists from treating severely depressed and suicidal patients because of the associated liability.²²⁹ Such a result would be contrary to public policy as it could deny patients important treatment and potentially endanger the public in general by preventing the mentally ill from receiving proper care and supervision.

However, opposing arguments contend that not imposing a duty would be "tantamount to strict non-liability."²³⁰ According to this argument, once a treating psychiatrist determines that his patient exhibits suicidal tendencies he could intentionally fail to treat the condition without any legal consequences.²³¹ Public policy intended to preserve life and health would be contrary to such a decision.

Considering these competing policy arguments, the courts should consider how best to balance the goals of imposing a duty while maintaining reasonable standards for psychiatrists. This balance could be met by imposing a duty in particular situations including inpatient, but not outpatient, treatment.

Over the past ten years, New Mexico tort law has greatly expanded the concept of duty.²³² Just as the New Mexico Court of Appeals in *Haar v. Ulwelling* presupposed such a duty in their analysis, given a similar case, the court should officially impose it. With *Herrera v. Quality Pontiac*, *Torres v. State*, and *Tafoya v. Rael*, the New Mexico Supreme Court has demonstrated a strong inclination to impose a duty as a matter of law and allow questions of breach, causation, and damages to be determined by the jury. Given the foreseeability that patients seeking psychiatric care could commit suicide and the policy concerns in support of holding psychiatrists to a standard of care, the courts should impose a duty under the given circumstances. However, the New Mexico courts should be cognizant of the disparate level of control available to psychiatrists treating inpatient versus outpatient clients. The court should distinguish between these circumstances when determining if a duty is owed.

228. NMSA 1978, § 41-5-2.

229. See *supra* notes 188–89 and accompanying text.

230. Jenner, *supra* note 186 (internal quotation marks omitted).

231. *Id.*

232. See *supra* Part III.B.

3. Duty of Psychiatrists Treating Outpatient Patients

Most courts, including New Mexico, hold that a special relationship is a prerequisite before a duty to prevent self-harm or suicide can be considered.²³³ The level of control that one party has over the other within the special relationship has been critical to New Mexico courts in their duty analysis both for cases involving suicide and cases considering the duty of physicians.²³⁴ Because the level of control granted to a psychiatrist can differ dramatically between inpatient and outpatient relationships,²³⁵ the status of the patient should be central to the courts' reasoning.

Many courts have found an affirmative duty on the part of a psychiatrist or physician to prevent the suicide of a patient in cases involving institutionalized or hospitalized patients.²³⁶ Nearly all courts have held that psychiatric hospitals have a duty to exercise reasonable care to protect their patients from their known mental condition.²³⁷ This holding is appropriate because patients often enter a psychiatric hospital because they are concerned that they might kill themselves. In such cases, patients are asking the hospital to take custody over them to prevent them from doing just that.²³⁸

However, malpractice claims are more ambiguous when the patient is an outpatient and commits suicide outside of a hospital or institution.²³⁹ Not only does the psychiatrist have considerably less control over the actions of his patient,²⁴⁰ but the patient's status as an outpatient often represents a determination that inpatient treatment was not warranted. A psychiatrist is often asked to consider if the drawbacks of hospitalization, including the expense and unwillingness of insurance companies to cover inpatient treatment, exceed the possible benefits given the circumstances and condition of his patient.²⁴¹ Hospitalizing a patient is one of many treatment options and requires strong "evidence [of a] likelihood of serious harm to the client or others."²⁴²

Additionally, the possible implications of treating inpatient and outpatient suicides equally could be dramatic. In addition to the concern that psychiatrists would be discouraged from treating the mentally ill, several other issues should be considered for their potential impact on inpatient psychiatric treatment in New Mexico and throughout the country.

233. See, e.g., *King v. Smith*, 539 So. 2d 262, 264 (Ala. 1989); *Weiss v. Rush N. Shore Med. Ctr.*, 865 N.E.2d 555, 557 (Ill. App. Ct. 2007); *Maloney v. Badman*, 938 A.2d 883, 887–88 (N.H. 2007) (assuming on appeal that dicta about special relationships is controlling).

234. See *Lester v. Hall*, 1998-NMSC-047, ¶ 7, 970 P.2d 590, 592–93; *Wilschinsky v. Medina*, 108 N.M. 511, 513, 775 P.2d 713, 715 (1989); *Johnstone v. City of Albuquerque*, 2006-NMCA-119, ¶ 14, 145 P.3d 76, 82; see also *Weitz v. Lovelace Health Sys., Inc.*, 214 F.3d 1175, 1181–82 (10th Cir. 2000).

235. *Weitz*, 214 F.3d at 1182.

236. See, e.g., *McNamara v. Honeyman*, 546 N.E.2d 139, 146 (Mass. 1989); *Cowan v. Doering*, 545 A.2d 159, 162–63 (N.J. 1988).

237. See *Jenner*, *supra* note 186.

238. *Middleton*, *supra* note 103.

239. See *Williams*, *supra* note 4, at 310.

240. See *Weitz*, 214 F.3d at 1182; see also *Farwell v. Un.*, 902 F.2d 282, 289 (4th Cir. 1990) ("Obviously, in a particular case, such a stringent duty [to ensure that a patient follows through with voluntary hospitalization] could only be discharged by a physician's assuming actual physical custody of the patient or, at the very least, mounting such continuous and close physical surveillance that effective physical intervention could occur at any time it thereafter seemed necessary.").

241. *Middleton*, *supra* note 103.

242. NMSA 1978, § 43-1-11 (1989).

Imposing a duty upon psychiatrists to prevent or take reasonable steps to prevent the suicide of outpatients could encourage doctors to commit more patients in order to reduce their risk. Although increased hospitalization of the mentally ill could have both positive and negative effects, there are practical problems with this result, particularly in New Mexico where the state already suffers from an insufficient number of inpatient beds and minimal institutional funding.²⁴³ Across the country, the shortages of inpatient beds are causing hospitals to deny admission to individuals with severe psychiatric disorders.²⁴⁴ Additionally, studies show that the shortage leads to a variety of problems including overcrowding in hospital emergency rooms, increased homelessness, use of jails and prisons as de facto psychiatric institutions, as well as an overall increase in violent crime.²⁴⁵ A policy that leads to increased patient commitment, particularly for the purpose of decreasing psychiatrist liability whether or not commitment is necessary, would therefore not be acceptable.²⁴⁶

In light of these public policy considerations, a New Mexico court considering whether a psychiatrist has a duty to prevent a suicidal patient from killing himself should find that a duty exists when the special relationship, including the level of control that the psychiatrist has over the patient, is substantial. Generally, such a relationship should not be found to exist between psychiatrists and patients treated on an outpatient basis.

B. Should Comparative Fault Be Applicable in Cases Involving the Suicide of a Psychiatric Patient?

Because the court granted summary judgment in *Haar v. Ulwelling*, the issue of available defenses was not reached. However, if a New Mexico plaintiff established a prima facie case of negligence (which would include the court finding a duty) against a psychiatrist for failing to prevent the suicide of his patient, the court would need to determine if the psychiatrist could raise the defense of comparative fault.²⁴⁷

In adopting comparative fault, the supreme court intended to create a more equitable apportionment of fault in which the parties would each be responsible for their own unreasonable conduct.²⁴⁸ However, the circumstances of a psychia-

243. See E. FULLER TORREY ET AL., THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS 10, http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf. New Mexico is listed under "serious bed shortage" carrying only 22.3 beds per 100,000 population. Fifty public psychiatric beds per 100,000 population is considered the minimum number required. *Id.* at 8. See also Alan Judd & Andy Miller, *Mental Health Catch-Up Costly*, ATLANTA J.-CONST., July 6, 2008, available at <http://www.ajc.com/health/content/metro/stories/2008/07/06/mental.html> (stating that in 2005, New Mexico ranked forty-eighth among the states and the District of Columbia in per-person spending on state psychiatric hospitals at only \$11.33).

244. Torrey, *supra* note 243, at 5–6.

245. *Id.* at 11–14.

246. There is the argument that distinguishing between inpatient and outpatient treatment when determining if a duty is owed could lead psychiatrists to avoid committing patients in an effort to avoid additional liability. Non-commitment of patients who would otherwise benefit from inpatient treatment raises other malpractice issues that are beyond the scope of this article and will not be discussed here.

247. Additionally, if the court determined that the comparative fault of the patient should be considered, its application could also play a role in determining whether a duty should be imposed. See *supra* Part III.C.

248. See *supra* Part III.A.5.

trist-patient relationship complicate the application of this defense because the doctor's standard of care arguably includes using reasonable care to prevent the patient from the precise unreasonable act in question.²⁴⁹ But refusing to allow application of the defense would create a situation that results in all-or-nothing liability for the psychiatrist, which is precisely what the court hoped to end by replacing contributory negligence with comparative fault.

The New Mexico Court of Appeals, distilling the definitions used by secondary authorities, *Black's Law Dictionary* definitions, and other case law, defined suicide as "a voluntary, deliberate and intentional self-destruction by someone of sound mind."²⁵⁰ Additionally, New Mexico's jury instructions include the duty of the patient, asserting that "every patient has a duty to exercise ordinary care for the patient's own health and safety. A patient who fails to do so is negligent."²⁵¹ Both within and beyond tort law, it is self-evident that people have a duty to care for themselves. Based on that duty, "[a] person who voluntarily and intentionally subjects himself to an unreasonable risk of personal injury or death [and] violates the duty imposed upon all persons to use ordinary care for their own safety" should be considered at fault.²⁵²

However, allowing the fault of the suicidal patient to be considered could also lead to unfair results in medical malpractice cases because it does not hold the doctor to his standard of care. Arguably, a psychiatrist treating a mentally ill patient has a standard of care that includes looking out for and protecting the patient against his own mental illness. The psychiatrist's duty would therefore subsume the patient's duty of self-care by seeking to prevent foreseeable, self-inflicted harm.²⁵³

Additionally, the patient standard of care expressed in the Uniform Jury Instruction is potentially inapplicable under these circumstances because cases involving the care of a suicidal patient are distinguishable from many medical malpractice cases in which, generally, the patient shares the goals of the doctor and hospital to recover and get well. Rather, in cases involving suicide, it has been established that, "while the doctor is working to assist the patient to suppress suicidal tendencies, the patient, by nature of his illness, may be working at cross-purposes to his doctor's suggestions and may not be interested in following instructions [for self-care]."²⁵⁴

Likewise, the accepted New Mexico definition for suicide does not include self-destructive acts of either the mentally ill or of those who are not "of sound mind," and may, therefore, be inapplicable.²⁵⁵ Acts resulting from mental illness, if done in a state of insanity, would arguably not be classified as suicide under the court's definition and would not be considered intentional.²⁵⁶

249. See *McNamara v. Honeyman*, 546 N.E.2d 139, 146 (Mass. 1989).

250. *Solorzano v. Bristow*, 2004-NMCA-136, ¶ 14, 103 P.3d 582, 586.

251. UJI 13-1110 NMRA.

252. *Williams*, *supra* note 4, at 305.

253. *Jenner*, *supra* note 186 ("[T]reatment for mental illness is unique amongst illnesses in that it often consists of keeping the patient from volitional, self-destructive behavior, be it suicidal or high-risk in nature. Experts for both plaintiffs and defendants usually will acknowledge that the standard of care requires psychiatrists to protect patients from their own behavior, intentional or accidental.").

254. *Peoples Bank v. Damera*, 581 N.E.2d 426, 429 (Ill. App. Ct. 1991), *declined to follow on other grounds* by *Hobart v. Shin*, 705 N.E.2d 907, 911 (Ill. 1998).

255. See *Solorzano*, 2004-NMCA-136, ¶ 14, 103 P.3d at 586.

256. See *id.*; see also 83 C.J.S. *Suicide* §2 (Supp. 2008).

The court hoped that by adopting comparative fault, it would “den[y] recovery for one’s own fault; [permit] recovery to the extent of another’s fault; and [hold] all parties fully responsible for their own respective acts.”²⁵⁷ Based on this principle, the issue for the court becomes whether a patient who has attempted or committed suicide can be considered at fault. Generally, when this question has been posed, the state of mind of the patient becomes relevant,²⁵⁸ and the trend has been to adopt a reduced capacity standard for determining the fault of the patient.²⁵⁹

C. Implications of Asserting Comparative Fault: Application of a Reduced Capacity Standard

Applying a reduced capacity standard strikes a balance by taking into consideration the patient’s mental capacity while still holding him accountable for his actions.²⁶⁰ Considering that the purpose of comparative fault is to apportion damages fairly between parties in direct proportion to their respective negligence,²⁶¹ the capacity-based standard is compelling.²⁶² To the extent that the patient is making reasoned, intentional, and deliberate decisions that result in injury, the patient should be held comparatively liable.²⁶³ However, should the patient’s capacity be diminished to the point that he is unable to understand or appreciate his actions, fault or negligence should not be attributed to the injured party.²⁶⁴ If the patient’s capacity is so diminished that he cannot understand his actions, the act would not fall under the definition of suicide as defined by New Mexico law²⁶⁵ and would likewise not be considered an intentional act for which fault should be assigned to the patient.

To this point, New Mexico, along with many other states, has not applied a reduced capacity standard of care for the mentally ill in general medical negligence cases.²⁶⁶ New Mexico should join the minority of jurisdictions that do employ the

257. See *Scott v. Rizzo*, 96 N.M. 682, 690, 634 P.2d 1234, 1242 (1981).

258. *Solorzano*, 2004-NMCA-136, ¶ 11, 103 P.3d at 585; see also *Psychiatric Inst. of Wash. v. Allen*, 509 A.2d 619, 627 n.11 (D.C. 1986) (“We also reject the Institute’s contention that it was entitled to an instruction on contributory negligence. When an injured party suffers from a mental infirmity, as in this case, the defendant is not entitled to such an instruction unless there is evidence that the injured party was capable of exercising reasonable care for his own safety and failed to do so.”).

259. See *KEETON ET AL.*, *supra* note 69, § 32, at 178 n.39.

260. See *Williams*, *supra* note 4, at 315.

261. See *infra* Part III.A.5.

262. *Williams*, *supra* note 4, at 315–16 (“The capacity-based approach has certain appeal because the purpose of fault-based tort law is to discourage unreasonable behavior. To the extent that a person has the mental capacity at some level to prevent injury to himself, it makes sense to hold him to the standard of care that a person with that mental capacity could reasonably exercise. Should that capacity be too diminished to allow for reasoned thought, apportioning fault to the injured person fails to advance the goal of tort law.”).

263. See *McNamara v. Honeyman*, 546 N.E.2d 139, 146 (Mass. 1989) (“Mentally ill people who are capable of forming an intent and who actually do intend an act that causes damage will be held liable for that damage.” (citing *McGuire v. Almy*, 8 N.E.2d 760, 763 (Mass. 1937)); *Weathers v. Pilkinton*, 754 S.W.2d 75, 78 (Tenn. Ct. App. 1988) (“Can we say that an action for wrongful death may be maintained where the decedent himself ended his life in a deliberate, calculated, and voluntary act of suicide; where he had an understanding of the physical nature and effect of his act, and . . . a willful and intelligent purpose to accomplish it? In such a case the decedent himself would not have had a cause of action against his doctor for his own (the decedent’s) voluntary act. Consequently, no cause of action would pass to the surviving spouse.” (internal quotation marks and citation omitted)).

264. *Weathers*, 754 S.W.2d at 78–79.

265. See *supra* text accompanying note 250.

266. See *UJI 13-1110 NMRA*.

reduced capacity standard for cases involving mentally ill and suicidal patients. Given the purpose behind adoption of comparative fault²⁶⁷ and the policy implications associated with holding psychiatrists liable for the suicide of their patients,²⁶⁸ comparative fault should be applicable in cases involving suicide. However, because the state of mind of mentally ill patients affects their ability to make reasoned decisions, a lower standard of care would often be applicable.

V. CONCLUSION

Although the New Mexico Court of Appeals applied the law fairly to the facts of *Haar v. Ulwelling*, the court did not provide substantial guidance for New Mexico practitioners (both legal and medical) about their legal duties and liability. When the court is again asked to consider whether a psychiatrist owes a duty to prevent the suicide of his patient and what defenses, if any, are available to a negligent psychiatrist, the purposes of tort law would be best extended if the court considered the above analysis and approach.

The court should impose a duty on a psychiatrist to prevent the suicide of a patient when the special relationship, particularly the level of control that the psychiatrist has over the patient, is substantial. Often, this substantial level of control would exist in inpatient but not outpatient relationships.

If the court determines that a duty to prevent suicide does exist and the plaintiff succeeds in establishing a prima facie case of negligence, the court should permit the psychiatrist to assert the defense of comparative fault. However, because the level of fault attributable to the patient depends on his state of mind, the court should adopt and apply a reduced capacity standard to properly judge the comparative fault of the patient.

267. See *supra* Part III.A.5.

268. See *supra* Part IV.A.2.