[Cite as *Yurkowski v. Univ. of Cincinnati*, 2013-Ohio-242.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Sharon Yurkowski, Admr. et al.,	:	
Plaintiffs-Appellants,	:	No. 11AP-974 (Ct. of Cl. No. 2007-04311)
v.	:	(REGULAR CALENDAR)
University of Cincinnati,	:	
Defendant-Appellee.	:	

D E C I S I O N

Rendered on January 29, 2013

Allen Law Firm, LPA, and *Mitchell W. Allen*, for appellants.

Michael DeWine, Attorney General, and *Anne Berry Strait*, for appellee.

APPEAL from the Court of Claims of Ohio.

BROWN, J.

{¶ 1} Plaintiffs-appellants, Sharon Yurkowski, individually and as administratrix of the estate of Peter J. Yurkowski, along with Daniel P. Yurkowski and Cara F. Yurkowski, Peter and Sharon's children, appeal from the judgment of the Court of Claims of Ohio in favor of defendant-appellee, University of Cincinnati, on appellants' claims for medical malpractice, wrongful death, and loss of consortium. For the following reasons, we affirm in part, reverse in part, and remand for further proceedings.

{¶ 2} Peter struggled with mental health issues in his youth, culminating in a suicide attempt at age 18. He recovered from that episode and married Sharon in 1985. The couple subsequently had two children, Daniel and Cara. Peter received a doctorate in pharmacy and, in 1992, began working as a clinical pharmacist at University Hospital

("UH") in Cincinnati. In addition to his clinical duties at the hospital, Peter traveled extensively throughout the country lecturing on pharmacology-related topics. He also participated in various community activities.

{¶ 3} Peter's mental health issues resurfaced in September 2000, when he became extremely anxious and began to suffer from psychosomatic illnesses that prevented him from traveling. Peter was admitted to the UH emergency room with symptoms of severe anxiety and depression. Because he did not want to be treated at the same hospital at which he was employed, he was subsequently transferred to Christ Hospital for inpatient treatment. He was released a few days later, but was again treated at Christ Hospital in December 2000.

{¶ 4} In January 2001, Peter had another psychiatric episode. Due to a shortage of beds at Christ Hospital, he was admitted to UH for inpatient treatment with Dr. James Curell. Dr. Curell, an associate professor of clinical psychiatry at the university and an attending psychiatrist on the inpatient adult psychiatry unit at UH, knew Peter professionally and was aware that he had been diagnosed at Christ Hospital with major depression and panic disorder. Dr. Curell adjusted the medications Peter had been prescribed at Christ Hospital and urged him to curtail his lecturing and community activities in order to relieve stress. Peter responded well to the adjustments, and thereafter saw Dr. Curell only on an outpatient basis for the next two and one-half years. Early in this period, Dr. Curell diagnosed Peter with bipolar 2 disorder; however, he subsequently abandoned that diagnosis and confirmed that Peter suffered from major depression and panic disorder.

{¶ 5} In June 2004, Peter began a series of inpatient hospitalizations and outpatient treatment due to his worsening psychiatric state and multiple suicide attempts. In total, Peter was admitted to UH for inpatient psychiatric treatment ten times between June 2004 and February 2005. Medical records from each admission include detailed evaluations, diagnoses, progress notes, treatment plans, and discharge summaries from Dr. Curell and his psychiatric treatment team. Peter's treatment regimen included a combination of various mood-stabilizing, anti-anxiety, and anti-depressant medications, group and individual psychotherapy sessions, and electroconvulsive therapy.

{¶ 6} In early February 2005, Dr. Curell sought a second opinion regarding Peter's treatment from psychiatrist Dr. Paul Keck, an expert in bipolar disorders and related psychopharmacology. After meeting with Peter and reviewing his medical and psychiatric history, Dr. Keck concurred with Dr. Curell's diagnosis of major depression and panic disorder and agreed that Peter did not suffer from bipolar 2 disorder. While Dr. Keck recommended adjustments to some of Peter's medications, including the addition of lithium, he did not recommend involuntary commitment to a mental health facility. Peter was subsequently discharged from UH.

{¶ 7} One day after his discharge, Peter obtained a bottle of lithium from the UH pharmacy and ingested a significant quantity of the drug. Following medical treatment related to the overdose, Peter was transferred to the UH inpatient psychiatric unit. In mid-February 2005, Peter reported to Dr. Curell that his wife was planning to divorce him, and that he would not be permitted to return to the marital home upon his release from UH.

{¶ 8} Peter remained in the inpatient psychiatric unit until March 22, 2005. During this period, Peter often expressed suicidal thoughts, and Dr. Curell contemplated transferring him to Summit Behavioral Health ("Summit"), a state psychiatric hospital, for long-term inpatient psychiatric treatment. However, in late February 2005, Peter began to improve, and Dr. Curell authorized him to leave UH for one day in order to secure a place to live upon his release. Upon his return to UH, Peter reported that he had located an apartment.

{¶ 9} On March 1, 2005, Peter was served with divorce papers, and by March 4, 2005, had "decompensated" to the point where Dr. Curell believed Peter to be "acutely dangerous" to himself. (Tr. 155.) Dr. Curell ordered that Peter be placed in restraints and adjusted his medication in the hope of preventing another psychiatric episode. At this point, Dr. Curell was convinced Peter should be transferred to Summit; his progress notes in early-to-mid March indicate that transfer was imminent. However, by March 18, 2005, Peter exhibited significant improvement. According to Dr. Curell, Peter denied suicidal ideation, completed paperwork related to his divorce, discussed returning to work, and requested that he be discharged to his apartment rather than to Summit. At this point, Dr. Curell, although "still suspicious" and "worried because of [Peter's] up-and-down

pattern," concluded that Peter would not benefit from long-term inpatient treatment at Summit. (Tr. 161.) Indeed, Dr. Curell believed that involuntary commitment would be so devastating to Peter's self-esteem that he would never recover.

{¶ 10} Dr. Curell candidly discussed with Peter his reservations about discharging him from inpatient treatment. He ultimately concluded that Peter's best chance at recovery was to return to employment and begin living independently. Dr. Curell discharged Peter on March 22, 2005, with the proviso that Peter contact him immediately upon experiencing anxiety or suicidal ideation. Dr. Curell's progress notes from that day indicate that Peter was engaged with the staff, had no anxiety issues or suicidal ideation, and was planning to return to work the next week.

{¶ 11} Peter attended outpatient treatment sessions with Dr. Curell on March 25, April 4 and 13, 2005. Dr. Curell's progress notes from those sessions indicate that, although Peter was sad about his impending divorce and remained "at risk," he had no depressive episodes or acute suicidal thoughts, had a bright and hopeful affect, had returned to work and moved into his apartment, and was taking his medications as prescribed. (Tr. 179.)

{¶ 12} Sharon and the children remained in close contact with Peter following his discharge. According to Sharon, Peter was sad about living apart from the family, but was not anxious or agitated and did not exhibit any suicidal behavior. On April 17, 2005, Sharon and Peter celebrated their daughter's birthday together and made plans to attend an event later in the week. The next day, Peter committed suicide by ingesting a lethal overdose of olanzapine, a prescription medication, and diphenhydramine, an over-the-counter antihistamine.

{¶ 13} Following Peter's death, appellants filed an action in the Warren County Court of Common Pleas against several defendants, including Dr. Curell. Dr. Curell asserted he was entitled to personal immunity pursuant to R.C. 9.86 and 2743.02. Consequently, appellants filed an action in the Court of Claims against Dr. Curell, University Psychiatric Services, University Hospital, Inc., The Health Alliance of Greater Cincinnati, and University of Cincinnati Physicians, Inc. Appellants subsequently filed an amended complaint for medical malpractice, wrongful death, and loss of consortium, naming only appellee as defendant. The Court of Claims matter was stayed pending an

immunity determination. The Court of Claims ultimately found that Dr. Curell was entitled to statutory immunity. Thereafter, the common pleas court action was dismissed, and the stay was vacated in the Court of Claims.

{¶ 14} The Court of Claims bifurcated the issues of liability and damages, and held a liability trial in January and April 2011. On October 6, 2011, the Court of Claims issued a decision, finding in favor of appellee. The court journalized its decision in a judgment entry filed the same day. Appellants timely appeal, asserting the following assignments of error:

> [I.] The Trial Court erred in applying the "Professional Judgment Rule" from *Littleton* [*v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86 (1988)] to this case rather than the correct, "Ordinary Care" standard from *Bruni* [*v. Tatsumi*, 46 Ohio St.2d 127 (1976)].
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> [II.] The Court erred in failing to apply to Defendant its Local Rules which prevent experts from testifying to items outside the opinions expressed in their reports.
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> [III.] The Court erred in allowing Defense expert to testify to hearsay items he had previously testified that he had no knowledge of and which were outside his area of expertise.
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> [IV.] The Court's decision was against the manifest weight of the evidence.
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> [V.] The Court erred in injecting itself into the litigation as a participant rather than a trier of fact.
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> [VI.] The Court erred in presuming that Defendant had complied with the standard of care where evidence of such compliance was absent in the record or testimony.
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> [VII.] The Court erred in failing to advise the parties, particularly Plaintiffs, of potential conflict of interest or bias.

{¶ 15} In their first assignment of error, appellants contend the trial court erred in applying the "professional judgment rule" from *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86 (1988) rather than the "ordinary care" standard from *Bruni v. Tatsumi*, 46 Ohio St.2d 127 (1976) to Dr. Curell's decision to release Peter from UH on March 22, 2005.

{¶ 16} In *Bruni*, the Supreme Court of Ohio held that, in order to prevail on a claim of medical malpractice or professional negligence, a plaintiff must establish by a preponderance of the evidence: (1) the standard of care recognized by the medical community, (2) the failure of the defendant to meet the requisite standard of care, and (3) a direct causal connection between the negligent act and the injury sustained. *Id.* at paragraph one of the syllabus. The appropriate standard of care must be proven by expert testimony, which must explain what a medical professional of ordinary skill, care, and diligence in the same medical specialty would do in similar circumstances. *Id.*

{¶ 17} In *Littleton*, the administratrix of a minor's estate brought a survivorship and wrongful death action against a hospital staff psychiatrist arising out of a voluntarily hospitalized patient's killing of her minor child following the patient's release from a psychiatric hospital. The administratrix maintained that the child's death proximately resulted from the psychiatrist's negligence in releasing the patient from the hospital.

{¶ 18} The court began its analysis utilizing the framework of the traditional duty-breach-proximate-cause analysis applicable to survivorship and wrongful death claims predicated upon ordinary negligence or medical malpractice. Noting the "complicating factor" that the case involved a mental health practitioner, the court resolved that "[u]sing the traditional concepts of tort law, we must decide how these concepts apply to such practitioners for the acts of a disturbed patient." *Id.* at 92.

{¶ 19} The court first addressed the duty element of a negligence claim. While acknowledging that the parties did not dispute that the psychiatrist owed a duty of care to the child, the court nonetheless deemed it important to delineate the basis and scope of such duty and to demonstrate how it was consistent with established tort principles. To that end, the court noted that there is no duty under Ohio law to control the conduct of another person so as to prevent that person from causing physical harm to a third-party unless a "special relation" exists between the actor and the person which imposes a duty upon the actor to control the person's conduct. The court further noted that such a "special relation" exists when the actor takes charge of a person whom the actor knows or should know is likely to cause bodily harm to others if not controlled. The court found that, because the psychiatrist had sufficient charge of the patient in the hospital setting,

such that a "special relation" was created, he had a duty to take reasonable precautions to protect the child from her mother's violent propensities.

{¶ 20} Following this discussion, the court acknowledged general rules pertaining to the *Bruni* standard of care. In particular, the court noted that "[t]he standard of care required of a medical doctor is dictated by the custom of the profession" and that "a psychiatrist, as a medical specialist, is held to the standard of care 'of a reasonable specialist practicing medicine or surgery in that same specialty in light of present day scientific knowledge in that specialty field.' " *Littleton* at 93, quoting *Bruni* at paragraph two of the syllabus. The court then noted the psychiatrist's contention that, in cases involving psychiatric decisions releasing voluntary mental patients from a hospital, courts should apply a "professional judgment rule" rather than the *Bruni* malpractice standard of ordinary care. The court characterized the "professional judgment rule" as one which shields a psychiatrist from liability "for releasing a patient who subsequently harms another if, after carefully examining all relevant data, the psychiatrist makes a professional medical judgment that the patient does not pose an immediate danger to others." *Id.* at 95.

{¶ 21} The court affirmed that the psychiatrist had advanced four arguments in support of adopting the professional judgment rule: (1) psychiatrists are unable to predict their patients potential for violence with any degree of accuracy, (2) there is no standard in the psychiatric profession with which to measure a psychiatrist's judgment of a patient's propensity for violence, (3) if a psychiatrist knows that he or she will face liability for failing to foresee a patient's future violent behavior, the predictable result will be a court-mandated end to "out-patient" treatment and a massive confinement of all patients who display even a remote possibility of violent behavior, and (4) the Ohio General Assembly, in delineating the liability standards pertaining to civil commitment, holds a psychiatrist to only a good faith standard of care for decisions to commit or discharge a mental patient. The court noted that the psychiatrist supported these arguments with citations to numerous articles from commentators in the field of psychiatry addressing such topics as (1) the difficulty in predicting violence leading to homicide, (2) problems in fulfilling the duty to protect, (3) the prediction of violent behavior and the duty to protect third parties, (4) the inability of psychiatrists to accurately predict dangerous behavior in

psychiatric patients, and (5) the psychotherapeutic duty to protect third parties from patients' violent acts.

{¶ 22} The court ultimately found persuasive the psychiatrist's arguments in support of adopting the professional judgment rule, stating:

> Though a psychiatrist's ability to predict violent behavior is probably better than a layperson's, and there does appear to be some consensus within the mental health community on the factors relevant to a diagnosis of violent propensities, diagnosing both the existence of violent propensities and their severity is still a highly subjective undertaking. Psychiatric evaluations of any given fact pattern are bound to vary widely. And once a determination is made that a patient possesses a propensity for violent behavior, deciding upon a course of treatment poses difficult questions. The patient's right to good medical care, including freedom from unnecessary confinement and unwarranted breaches of confidentiality, must be balanced against the need to protect potential victims. Courts, with the benefit of hindsight, should not be allowed to second-guess a psychiatrist's professional judgment.
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> On the other hand, a psychiatric patient is not required to assume the risk of improper treatment. Where there are professional standards of care a psychiatrist is required to conform to the standards at all times or suffer liability. Where there are no professional standards, a psychiatrist must exercise good faith judgment based on a thorough evaluation of all relevant factors. Professional standards will be used to determine which factors are relevant and whether an evaluation was thorough.

Id. at 97-99.

{¶ 23} The court ultimately held:

> [A] psychiatrist will not be held liable for the violent acts of a voluntarily hospitalized mental patient subsequent to the patient's discharge if (1) the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge, or (2) a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant

> factors, and a good faith decision was made by the psychiatrist that the patient had no violent propensity, or (3) the patient was diagnosed as having violent propensities and, after a thorough evaluation of the severity of the propensities and a balancing of the patient's interests and the interest of potential victims, a treatment plan was formulated in good faith which included discharge of the patient.

Id. at 99.

{¶ 24} In the instant case, the trial court applied the professional judgment rule to appellants' claim that Dr. Curell should not have discharged Peter from the psychiatric unit at UH on March 22, 2005. The court concluded that Dr. Curell "exercise[d] his professional judgment in good faith when he elected to discharge [Peter] on March 22, 2005." Appellants contend the trial court erred as a matter of law in applying the professional judgment rule because the rule only applies where there are no professional standards, such as between a physician and an unrelated third-party. In other words, appellants maintain that the professional judgment rule only applies when the release of a psychiatric patient results in harm to a third-party and not the patient himself. Appellants argue that the *Bruni* duty of ordinary care applies in situations where a psychiatric patient harms himself following release from a psychiatric facility.

{¶ 25} In applying the professional judgment rule, the trial court relied on this court's decision in *Brooks v. Ohio Dept. of Mental Health*, 10th Dist. No. 95API04-505 (Nov. 14, 1995), wherein we discussed the holding in *Littleton* and expanded it to include a psychiatric patient's attempted suicide following discharge from a psychiatric facility. We stated:

> While the test in *Bruni* is proper in a medical negligence case, the court in *Littleton v. Good Samaritan Hospital & Health Ctr.* (1988), 39 Ohio St.3d 86, recognized that, because of the unpredictability and uncertainty as to patients' actions upon release from a psychiatric facility, holding psychiatrists to the malpractice standard of ordinary care is too stringent. Therefore, the court in *Littleton* adopted the "professional judgment rule," wherein a psychiatrist would not be liable for releasing a patient who subsequently harms someone if, after carefully examining all of the relevant data, the psychiatrist makes a professional medical judgment that the patient does not pose a danger to others. The court found that "[w]here

> there are no professional standards, a psychiatrist must exercise good faith judgment based on a thorough evaluation of all relevant factors." *Id.* at 99. We believe the holding in *Littleton* can be expanded to include harm to oneself.

{¶ 26} Upon careful review of *Littleton,* we agree with appellants that the Supreme Court intended the professional judgment rule to apply in circumstances where there are no professional standards, such as where the release of a psychiatric patient results in harm to a third-party with whom the physician has no relationship. We conclude as much for several reasons.

{¶ 27} First, the discharged psychiatric patient in *Littleton* killed a third-party; she did not commit suicide. Thus, the issue of a psychiatrist's liability for release of a discharged patient who later commits suicide was not before the court. Second, the court began its analysis with a discussion of a psychiatrist's duty to control a patient's actions so as to prevent bodily harm to a third-party. Third, the court expressly characterized the professional judgment rule as one which shields a psychiatrist from liability "for releasing a patient who subsequently *harms another,* if after carefully examining all relevant data, the psychiatrist makes a professional medical judgment that the patient does not pose an immediate danger *to others.*" (Emphasis added.) *Id.* at 95. Fourth, in discussing the arguments advanced by the psychiatrist in support of implementing the professional judgment rule, the court referenced several articles authored by psychiatric experts that address the inherent challenges in accurately predicting a psychiatric patient's violent behavior as related to the duty to prevent harm to third parties. Fifth, in its discussion finding persuasive the psychiatrist's arguments in support of adopting the professional judgment rule and again in its actual holding in the case, the court specifically and repeatedly refers to a patient's "violent acts," "violent behavior," and "violent propensities." We perceive the court's concern about a patient's propensity for violence to be related to potential harm to other persons, not the patient himself. Indeed, the court expressly noted that the rights of a patient who exhibits violent propensities must be balanced against the need to protect "*potential victims.*" (Emphasis added.) *Id.* at 98, 99. Sixth, in his concurrence/dissent, Justice Douglas stated that, while he concurred in large part with the majority's adoption of the professional judgment rule, he was troubled by

the fact that the test failed to include a "limited duty to warn." *Id.* at 101. Logically, a "duty to warn" may be imposed only where there is the potential for harm to a third-party. For these reasons, we believe the *Littleton* court intended the professional judgment rule to apply to circumstances where, in the absence of professional standards, release of a psychiatric patient results in harm to a third-party.

{¶ 28} In *Brooks,* this court analyzed the issue of liability for discharge of a patient who subsequently attempted suicide under both the standard of care enunciated in *Bruni* and the *Littleton* professional judgment rule (in affirming the trial court's determination that "appellants failed to establish by a preponderance of the evidence that [the defendant] had deviated from any medical standard, or that it failed to exercise its judgment in good faith"). *Id.* The professional judgment rule, however, is to be used where there are "no professional standards." *Littleton* at 99. *See also Hubbard v. Laurelwood Hosp.*, 85 Ohio App.3d 607, 613 (11th Dist.1993) ("The professional judgment rule is to be used when standards cannot be determined."); *Jenks v. W. Carrollton,* 58 Ohio App.3d 33, 38 (2d Dist.1989) ("The traditional malpractice rule applies in situations in which standards of care may be determined. Where they cannot, the professional judgment rule offers the basis for determination of liability.").

{¶ 29} In *Cromer v. Children's Hosp. Med. Ctr. of Akron,* 9th Dist. No. 25632, 2012-Ohio-5154, ¶ 23, the court recognized that the *Littleton* court's analysis was predicated upon the relationship between a physician and third-party, as distinct from a physician-patient relationship, noting that, "[a]lthough the *Littleton* plaintiffs brought claims alleging medical malpractice, they did not allege that injuries to a patient had resulted from the quality of medical care provided by the defendant." Rather, "the *Littleton* plaintiffs sought to recover for the wrongful death of a third party, who had been killed by her mother, based on the alleged negligence of the mother's psychiatrist in failing to control her actions and prevent her from harming her child." *Id.* The court in *Cromer* observed that "[t]he alleged duty by the psychiatrist [in *Littleton*] was not to his patient, but to her daughter, with whom he had no physician-patient relationship." *Id.* Thus, "[f]oreseeability of injury was relevant in that medical malpractice case because the plaintiffs sought to establish the existence of a new duty by the treating physician, as Ohio

law did not recognize a duty on the part of a psychiatrist to control the conduct of his patient to protect third parties from injury." *Id*.

{¶ 30} Under the facts of *Brooks*, involving a physician-patient relationship (and not a claim of liability for harm to a third-party), there was competing expert testimony as to the applicable standard of care under *Bruni*, and the court found no deviation from that standard. Because *Littleton* holds that the professional judgment rule is applicable in circumstances where there are no professional standards, *Brooks'* application of *Littleton* to a case in which there were professional standards arising out of a physician-patient relationship is incongruent with the *Littleton* court's analysis.

{¶ 31} In the present case, experts for both parties testified as to the professional standards to be employed in a decision to release a psychiatric patient who later harmed himself; accordingly, the trial court should have applied the *Bruni* ordinary malpractice standard rather than the *Littleton* professional judgment rule to Dr. Curell's discharge decision. We therefore remand this matter to the trial court to determine whether Dr. Curell's decision to release Peter from UH on March 22, 2005 fell below the applicable standard of care. Based upon the foregoing, appellants' first assignment of error is sustained.

{¶ 32} Appellants argue in their second assignment of error that the trial court violated its own local rule in permitting appellee's expert, Dr. Mark Schechter, to offer opinions outside those expressed in his expert report filed prior to trial.

{¶ 33} L.C.C.R. 7(E) provides, in relevant part:

> **Expert witnesses.** Each trial attorney shall exchange with all other trial attorneys, in advance of the trial, written reports of medical and expert witnesses expected to testify. The parties shall submit expert reports in accordance with the schedule established by the court.
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> A party may not call an expert witness to testify unless a written report has been procured from said witness. It is the trial attorney's responsibility to take reasonable measures, including the procurement of supplemental reports, to insure that each such report adequately sets forth the expert's opinion. However, unless good cause is shown, all supplemental reports must be supplied no later than thirty days prior to trial. The report of an expert must reflect his

> opinions as to each issue on which the expert will testify. An expert will not be permitted to testify or provide opinions on issues not raised in his report.

{¶ 34} "L.C.C.R. 7(E) requires trial attorneys to exchange written reports of the expert witnesses they intend to call to testify at trial. An expert's report must reflect the expert's opinions as to each issue on which the expert will testify at trial, and the reports must be supplemented as necessary to insure that they comply with this requirement." *McMullen v. Ohio State Univ. Hosp.*, 10th Dist. No. 97API10-1301 (Sept. 22, 1998), *rev'd on other grounds,* 88 Ohio St.3d 332 (2000).

{¶ 35} We note initially that appellants do not provide this court with specific citations to opinions expressed by Dr. Schechter that allegedly fell outside those reflected in his report. Instead, appellants generally cite to 25 pages of transcript for examples of Dr. Schechter's alleged prohibited testimony. "[T]he burden of affirmatively demonstrating error on appeal rests with the party asserting error." *State ex rel. Petro v. Gold,* 10th Dist. No. 04AP-863, 2006-Ohio-943, ¶ 94. "It is not the duty of [an appellate] court to search the record for evidence to support an appellant's argument as to alleged error." *Id.* In any event, we consider appellants' argument in the interest of justice.

{¶ 36} Appellants contend that the opinions expressed by Dr. Schechter in his expert report were limited to the timeframe encompassing Peter's last hospitalization from February 8 to March 22, 2005 and the subsequent outpatient treatment sessions, and that Dr. Schechter was erroneously permitted to testify to matters involving treatment and hospitalizations occurring prior to that time period.

{¶ 37} We do not agree that Dr. Schechter's report was limited to the February 8 to April 13, 2005 timeframe. In his report, Dr. Schechter opined that "Dr. Curell and the staff of University Hospital complied with the standard of care, and that nothing they did or failed to do contributed to the overdose and death of Peter Yurkowski." In rendering that opinion, Dr. Schechter noted that he reviewed documentation related to Peter's hospitalizations and course of treatment prior to February 8, 2005, including Dr. Curell's office notes and UH discharge summaries beginning in 2001. He further stated that he reviewed the report of Dr. Robert Granacher, appellants' expert, which contained numerous opinions pertaining to Dr. Curell's allegedly substandard treatment of Peter

prior to February 8, 2005. Dr. Schechter addressed each of the criticisms Dr. Granacher leveled against Dr. Curell, finding all of them to be without merit.

{¶ 38} At trial, appellants objected to Dr. Schechter's testimony pertaining to the same matters on which his report opined in response to Dr. Granacher's report. In overruling appellants' objections, the trial court noted that Dr. Schechter's testimony merely reiterated his repudiation of the opinions Dr. Granacher rendered in his report. Thus, we cannot find that the trial court abused its discretion in allowing Dr. Schechter's testimony related to the time period prior to Peter's last hospitalization, as Dr. Schechter's report encompassed that time period. The second assignment of error is overruled.

{¶ 39} In their third assignment of error, appellants assert the trial court erred in permitting Dr. Schechter to testify, over objection, as to the toxicity of the prescription medication, olanzapine, found in Peter's system at the time of his death. Appellants contend that information pertaining to the medication's lethality was not included in Dr. Schechter's report, was outside Dr. Schechter's area of expertise, and was based on hearsay Dr. Schechter had gleaned from internet searches that were never admitted into evidence.

{¶ 40} The admission or exclusion of evidence, including expert testimony, is a matter within the trial court's discretion and will be reversed only for an abuse of that discretion. *Robertson v. Mt. Carmel E. Hosp.*, 10th Dist. No. 09AP-931, 2011-Ohio-2043, ¶ 27, citing *Valentine v. Conrad*, 110 Ohio St.3d 42, 2006-Ohio-3561, ¶ 9. The trial court admitted the testimony on grounds that it was offered to rebut Dr. Granacher's opinion that Dr. Curell breached the standard of care in discharging Peter with a lethal dose of olanzapine. Assuming, without deciding, that the trial court improperly admitted this testimony, this court cannot find that appellants were prejudiced by its admission. The trial court neither referenced nor based its decision upon this testimony. The third assignment of error is overruled.

{¶ 41} Appellants contend in their fourth assignment of error that the trial court's judgment in favor of the university was against the manifest weight of the evidence. In *Osgood v. Dzikowski*, 10th Dist. No. 08AP-105, 2008-Ohio-5065, ¶ 15-16, this court set forth the standard of review to be applied in civil cases in assessing whether a trial court's judgment is against the manifest weight of the evidence:

> "[W]here an appellant challenges a trial court's judgment in a civil action as being against the manifest weight of the evidence, the function of the appellate court is limited to an examination of the record to determine if there is any competent, credible evidence to support the underlying judgment." *Lee v. Mendel* (Aug. 24, 1999), Franklin App. No. 98AP-1404, 1999 Ohio App. LEXIS 3892, at *14. "Judgments supported by some competent, credible evidence going to all the essential elements of the case will not be reversed by a reviewing court as being against the manifest weight of the evidence." *Seasons Coal Co. v. Cleveland* (1984), 10 Ohio St.3d 77, 80, 10 OBR 408, 461 N.E.2d 1273.
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> "A trial court's findings of fact are presumed to be correct and will not be reversed as being contrary to the manifest weight of the evidence if there is competent and credible evidence supporting the finding." *Eagle Land Title Agency v. Affiliated Mtge. Co.* (June 27, 1996), Franklin App. No. 95APG12-1617, 1996 Ohio App. LEXIS 2766, at *5, citing *Wisintainer v. Elcen Power Strut Co.* (1993), 67 Ohio St.3d 352, 355, 617 N.E.2d 1136. "Further, the weight to be given the evidence and the credibility of the witnesses are primarily for the trier of fact to decide." *Id.* at *6, 617 N.E.2d 1136; see, also, *State v. Wilson*, 113 Ohio St.3d 382, 2007-Ohio-2202, 865 N.E.2d 1264, ¶ 24, citing *Seasons Coal*, supra, at 80-81, 461 N.E.2d 1273. "This presumption arises because the trial judge had an opportunity 'to view the witnesses and observe their demeanor, gestures and voice inflections, and use these observations in weighing the credibility of the proffered testimony.' " *Wilson*, supra, at 387, 865 N.E.2d 1264, quoting *Seasons Coal*, supra, at 80, 461 N.E.2d 1273. Mere disagreement over the credibility of witnesses or evidence is not sufficient reason to reverse a judgment. *Id.*

{¶ 42} Appellants contend that the manifest weight of the evidence does not support the trial court's conclusion that Dr. Curell did not deviate from the accepted standard of care in treating Peter. In support of their argument, appellants rely on the testimony of their expert witness, Dr. Granacher, who opined that Dr. Curell breached the applicable standard of care in nine separate ways, any one of which proximately led to Peter's death.

{¶ 43} Dr. Granacher first opined that Dr. Curell breached the applicable standard of care in failing to perform and document a suicide risk assessment prior to discharging

Peter on March 22, 2005. More specifically, Dr. Granacher testified that, prior to his discharge, Peter demonstrated several of the risk factors associated with suicide, and that had Dr. Curell performed a proper suicide risk assessment, he would not have discharged Peter, and, accordingly, Peter would not have committed suicide.

{¶ 44} Dr. Granacher's second critique related to Dr. Curell's alleged failure to provide an oversight plan for management of Peter's medications. According to Dr. Granacher, the applicable standard of care requires a psychiatrist to provide a plan for the management of a patient's psychiatric medications in cases where the patient has demonstrated an inability to manage his own medications. Dr. Granacher opined that, because Peter had previously attempted suicide via overdose, Dr. Curell fell below the standard of care in prescribing lethal doses of medication without monitoring the dispensing of that medication. Dr. Granacher opined that Dr. Curell should have either personally dispensed the medication to Peter or ensured that a family member did so.

{¶ 45} Thirdly, Dr. Granacher opined that Dr. Curell breached the standard of care in misdiagnosing Peter with major depression rather than bipolar disorder. Dr. Granacher averred that Dr. Curell's improper diagnosis led to the prescribing of anti-depressants which exacerbated Peter's bipolar disorder, ultimately resulting in his suicide.

{¶ 46} Dr. Granacher's fourth criticism was that Dr. Curell failed to maintain appropriate professional boundaries while treating Peter. Dr. Granacher opined that Dr. Curell breached the standard of care by allowing Peter to be admitted to UH under a pseudonym. According to Dr. Granacher, affording such special status to Peter compromised the physician-patient relationship and interfered with Dr. Curell's objectivity in treating Peter.

{¶ 47} Dr. Granacher fifthly criticized Dr. Curell for failing to develop an appropriate psychopharmacology plan. Dr. Granacher opined that Dr. Curell should have prescribed mood stabilizers rather than anti-depressants and should have ensured that Peter complied with his medication regimen. Dr. Granacher was particularly critical of Dr. Curell's decision to discontinue the lithium trial commenced during Peter's final hospitalization. Dr. Granacher opined that a six-day trial period was not sufficient to determine whether Peter would have benefited from the drug.

{¶ 48} Dr. Granacher's sixth critique related to Dr. Curell's failure to sufficiently integrate Sharon into Peter's treatment plan. Dr. Granacher opined that the standard of care in psychiatric cases mandates familial participation in the patient's treatment plan, including an understanding of the related psychopharmacology, the risks associated with suicide, and methods to assist both the psychiatrist and the patient in the treatment process.

{¶ 49} Dr. Granacher's seventh criticism was that Dr. Curell did not coordinate with a therapist to assist with Peter's outpatient treatment. Dr. Granacher opined that complex psychiatric cases such as Peter's require coordinated involvement between the primary treating psychiatrist and other mental health professionals.

{¶ 50} Eighthly, Dr. Granacher criticized Dr. Curell for failing to develop an effective outpatient treatment plan. Dr. Granacher opined that placing the onus on Peter to contact Dr. Curell if he felt suicidal was improper; rather, Dr. Curell should have required Peter to receive daily outpatient therapy and should have monitored Peter's attendance and progress.

{¶ 51} Lastly, Dr. Granacher criticized Dr. Curell for failing to provide a proper psychopharmacology treatment plan and suicide risk reduction plan following Peter's discharge on March 22, 2005. Dr. Granacher opined in particular that Dr. Curell's prescribing multiple doses of medication and permitting Peter to return to work at the pharmacy from which he had previously obtained a lethal quantity of drugs fell below the accepted standard of care, particularly given Peter's previous suicide attempts by overdose.

{¶ 52} In response, appellee presented contrary testimony from their expert witness. Dr. Schechter disagreed with Dr. Granacher's contention that Dr. Curell did not perform a proper suicide risk assessment prior to discharging Peter on March 22, 2005. According to Dr. Schechter, the applicable standard of care requires a psychiatrist to thoughtfully evaluate both objective and subjective suicide risk factors, and that such assessment need not be documented in a standardized checklist. Dr. Schechter opined that, while Peter's medical records did not include a single document entitled "suicide risk assessment" which denoted Dr. Curell's listing and weighing of the risk factors, the record contained voluminous documentation demonstrating that Dr. Curell performed ongoing

suicide risk assessments. Dr. Schechter averred that Dr. Curell documented Peter's clinical improvement in the week leading up to his discharge, noting particularly that Peter was future oriented, had diminished anxiety, and felt significantly less hopeless. Dr. Schechter also disagreed that the applicable standard of care required Dr. Curell to monitor the dispensing of Peter's medication either personally or through a family member.

{¶ 53} Dr. Schechter further opined that Dr. Curell did not breach the standard of care in not definitively diagnosing Peter with bipolar disorder, as the medical records did not clearly support such a diagnosis. Dr. Schechter noted specifically that Dr. Keck had determined that Peter did not have bipolar disorder.

{¶ 54} Dr. Schechter also opined that Dr. Curell's psychopharmacologic treatment plan met the standard of care, as he treated Peter's depression and anxiety with appropriate mood stabilizers, anti-depressants and electroconvulsive therapy, and made appropriate medication changes where necessary. In particular, Dr. Schechter averred that Dr. Curell's discontinuing the lithium trial after only six days did not breach the standard of care. Dr. Schechter testified that it would be speculative to assess the impact of lithium on the risk of suicide, and, because lithium is substantially toxic, the risk of potential toxicity in a person who had recently overdosed on the drug might outweigh any speculative benefits.

{¶ 55} Dr. Schechter also averred that Dr. Curell did not fall below the standard of care in failing to more fully integrate Sharon into Peter's treatment plans. Dr. Schechter noted that Dr. Curell met with Sharon on occasion and was consistently available to her via telephone. Dr. Schechter also opined that Dr. Granacher's criticism related to coordinating with a non-medical therapist following discharge was not valid because no literature or data existed regarding the efficacy of such a practice.

{¶ 56} Dr. Schechter further opined that Dr. Curell provided appropriate aftercare plans for Peter's March 22, 2005 discharge. Dr. Schechter noted that Peter's medical records indicated that, at the time of discharge, his mental health had significantly improved, and he exhibited the capacity to understand the outpatient treatment and crisis plans. Dr. Schechter further noted that Peter met with Dr. Curell nearly weekly after discharge, and that Dr. Curell's notes from those sessions do not suggest that Peter was

becoming increasingly suicidal. Dr. Schechter opined that a psychiatrist does not fall below the standard of care in discharging a patient who has demonstrated a capacity to understand outpatient treatment and safety plans and does not exhibit suicidal ideation.

{¶ 57} A plaintiff in a medical malpractice case bears the burden of presenting sufficient evidence to allow the trier of fact to conclude that the defendant breached the standard of care, and the issue of whether the defendant has employed the requisite care must be determined from the testimony of experts. *Bruni*. While appellants' expert provided opinion testimony that the care provided by Dr. Curell fell below the standard of care, and that such breach proximately resulted in Peter's suicide, there was also expert testimony provided by appellee's expert indicating that Dr. Curell met the standard of care in treating Peter. Both experts thoroughly explained the basis for their opinions, and the trial court carefully considered and outlined their testimony in its decision. It was within the province of the trier of fact to weigh the expert testimony and to resolve the conflicting opinions. The trial court expressly found the testimony of Dr. Schechter to be more credible and persuasive than the testimony of Dr. Granacher.

{¶ 58} Upon thorough review of the record, we conclude that there was competent, credible evidence which, if believed, would support the trial court's finding that Dr. Curell did not breach the accepted standard of care in his treatment of Peter. Therefore, such finding is not against the manifest weight of the evidence. The fourth assignment of error is overruled.

{¶ 59} In their fifth assignment of error, appellants contend the trial court erred in injecting itself into the litigation as a participant rather than a trier of fact.

{¶ 60} Pursuant to Evid.R. 614(B), a trial court "may interrogate witnesses, in an impartial manner, whether called by itself or by a party." Because Evid.R. 614(B) permits the trial court discretion to decide whether or not to question a witness, appellate courts must review the trial court's questioning under an abuse of discretion standard. *Brothers v. Morrone-O'Keefe Dev. Co. LLC*, 10th Dist. No 05AP-161, 2006-Ohio-1160, ¶ 10, citing *State v. Johnson*, 10th Dist. No. 03AP-1103, 2004-Ohio-4842, ¶ 10.

{¶ 61} A trial court is obligated to control the proceedings before it, to clarify ambiguities, and to take steps to ensure substantial justice. *Brothers*, citing *State v. Stadmire*, 8th Dist. No. 81188, 2003-Ohio-873, ¶ 26. Accordingly, a trial court should not

hesitate to pose pertinent and even-handed questions to witnesses. *Id.*, citing *Klasa v. Rogers*, 8th Dist. No. 83374, 2004-Ohio-4490, ¶ 32. Further, a trial court enjoys even greater freedom in questioning witnesses during a bench trial because the court cannot prejudicially influence a jury with its questions or demeanor. *Brothers*, citing *Klasa*.

{¶ 62} Evid.R. 614(B), however, requires the trial court to question impartially and thus tempers a trial court's ability to question a witness. *Brothers* at ¶ 12. However, absent " ' "any showing of bias, prejudice, or prodding of a witness to elicit partisan testimony, it will be presumed that the trial court acted with impartiality [in propounding to the witness questions from the bench] in attempting to ascertain a material fact or to develop the truth." ' " *Id.*, quoting *State v. Baston*, 85 Ohio St.3d 418, 426 (1999), quoting *Jenkins v. Clark*, 7 Ohio App.3d 93, 98 (2d Dist.1982).

{¶ 63} Although appellants allege that the trial court repeatedly and improperly questioned the witnesses, appellants cite only one specific example of such conduct. During cross-examination, appellants' counsel, citing Dr. Curell's testimony that in retrospect he did not know whether the decision to discharge Peter on March 22, 2005 was correct, asked Dr. Schechter if he still believed Dr. Curell correctly discharged Peter. Dr. Schechter responded that he understood Dr. Curell's consternation, given that Peter committed suicide within a month after discharge. Dr. Schechter averred that, "I hope there isn't a psychiatrist in the world who wouldn't look back after a suicide of a patient and think I wonder if there's something else I could have done. I can't speak to it being the right or wrong decision partly because I don't know if another decision would have saved [Peter's] life. That would be purely speculative on my part. So I wish I knew the answer to that, but I don't." (Tr. 1158.)

{¶ 64} The trial court then asked Dr. Schechter whether he was familiar with the term "hindsight bias." (Tr. 1158.) When Dr. Schechter responded in the negative, the court explained it as "when you have a result there's a tendency to then oversimplify earlier bits of information and be critical of them." (Tr. 1159.) Appellants' counsel objected to the line of questioning, arguing that the court's introduction of the term "hindsight bias" "add[ed] information that was not in the question I asked." (Tr. 1159.) The court overruled the objection, and Dr. Schechter continued his testimony, incorporating the term "hindsight bias" into his explanation. In particular, Dr. Schechter

averred that Dr. Curell's candid admission that Peter's eventual suicide caused him to doubt his decision to discharge him was a common reaction among psychiatrists to losing a patient to suicide, as they often second guess each decision made during the treatment process.

{¶ 65} The court twice stated that it posed the question in an effort to clarify and understand Dr. Schechter's testimony. Contrary to appellants' contentions, nothing in the substance or tenor of the trial court's colloquy with Dr. Schechter suggests bias on the part of the court in favor of Dr. Schechter or appellee. Appellants thus have failed to overcome the presumption of impartiality. The fifth assignment of error is overruled.

{¶ 66} Appellants argue in their sixth assignment of error that the trial court erred in presuming that Dr. Curell complied with the applicable standard of care absent evidence in the record demonstrating such compliance. In support of this argument, appellants cite a lengthy colloquy between the trial court and appellants' counsel which purportedly demonstrates the court's "improper predisposition or bias" against appellants.

{¶ 67} During cross-examination of Dr. Schechter on the issue of whether Dr. Curell had properly performed a suicide risk assessment prior to discharging Peter on March 22, 2005, appellants' counsel questioned Dr. Schechter about his making assumptions about Dr. Curell's thought process that were not necessarily borne out in Dr. Curell's documentation. In an apparent attempt to illustrate the impropriety in making such assumptions, appellants' counsel asked Dr. Schechter if, as a psychiatrist, he made assumptions about his patients' thought processes. Dr. Schechter averred that his testimony about Dr. Curell's decision to release Peter was based upon his clinical experience and expertise in reading medical records, and that such expertise allowed him to make certain inferences about Dr. Curell's decision.

{¶ 68} Immediately thereafter, appellants' counsel asked Dr. Schechter to specify in future responses whether or not he was making assumptions about Dr. Curell's decisions. At this point, the trial court interceded, stating:

> I'm having a problem understanding the question, because quite frankly, you're asking him, do you assume your patients think certain things when you don't know what's in their

> mind, and then you try to translate that to whether he is making assumptions about what Dr. Curell's thinking.
>
> It's a totally different situation. He [is] a psychiatrist of long-standing in the community. Skilled, apparently. I mean, the man has run this entire program down there. And he knows -- there's no suggestion he does not know what he's supposed to be doing in treating a patient. So I think it is not unfair to assume that when he is looking at various risks that are tabulated, that are listed, that, in fact, you have to assume - - I think it's not unfair for this doctor to say, I assume another qualified physician is doing what he's supposed to be doing and I see in the documentation the very things that he's supposed to be considering.
>
> And so I - - I'm guessing at this point that what we're talking about is a different situation from when you look at a patient that you don't know and is standing, staring at the wall. No, I don't imagine anybody knows what that's person's thinking, unless they articulate it, or act it out in some fashion.
>
> But if you have a trained professional - - I mean, I assume you prepared for trial. You didn't tell me you did. You're here. You're trying your case. I assume then as a trained professional, you did that. And then as I see you functioning, I can tell that you * * * prepared for trial. So, yes, I'm assuming that you prepared, but it's also being borne out because of your training and experience and history. But it's also being borne out by what I see you doing.
>
> And I hear this doctor saying that Dr. Curell is a trained physician in this area and presumably would know what he's doing, and now I see that, in fact, he does, because look at this documentation, right down the path that I would take, although I, perhaps, would have documented it more carefully.
>
> So I think we're talking about two different things when you asked him to talk about a patient's mind and reviewing whether a physician did something or not. It seems to me that way.

(Tr. 1065-67.)

{¶ 69} Contrary to appellants' contention, the foregoing discussion does not evidence a presumption by the trial court that Dr. Curell complied with the applicable standard of care or that the trial court was biased against appellants. Rather, the trial court was pointing out the difference between an expert witness making assumptions about the thought process of an experienced psychiatrist in making treatment decisions and a physician's assumptions about a patient's thought process. The sixth assignment of error is overruled.

{¶ 70} In their seventh assignment of error, appellants contend the trial judge erred in failing to advise the parties of a potential conflict of interest or bias. Appellants assert the trial judge violated Canon 1 and Rule 2.11 of the Code of Judicial Conduct in failing to disclose to the parties that his wife is a practicing psychologist. Appellants contend the trial judge's exhibition of "more knowledge, familiarity and specific views about the nuances of the mental health arena," presumably due to his wife's occupation, manifested in a clear bias and prejudice in favor of the university and against appellants.

{¶ 71} Canon 1 of the Code of Judicial Conduct requires a judge to "uphold and promote the *independence, integrity, and impartiality* of the judiciary," and to "avoid *impropriety* and the appearance of *impropriety*." (Emphasis sic.) Rule 2.11 lists four relevant specific circumstances in which a judge must disqualify himself or herself because of a spousal affiliation. The judge must disqualify himself or herself if the judge's spouse (1) is "[a] party to the proceeding, or an officer, director, general partner, managing member, or trustee of a party," (2) "act[s] as a lawyer in the proceeding," (3) "has more than a *de minimis* interest that could be substantially affected by the proceeding," or (4) "has an *economic interest* in the subject matter in controversy or in a party to the proceeding." (Emphasis sic.) Rule 2.11(A)(2)(a), (b), (c), and (A)(3), respectively.

{¶ 72} Appellants do not assert that any of the four listed circumstances in Rule 2.11 pertaining to spousal affiliation apply here. Indeed, appellants do not argue that the judge's spouse was a party to the proceeding or was an officer, director, general partner, managing member or trustee of the university, acted as a lawyer in the case, or had any interest, economic or otherwise, in the case. Appellants simply argue that the trial judge should have recused himself because his spouse is a professional in the field of psychiatry,

and the case concerned whether Dr. Curell met the standards of care applicable to that discipline. However, none of the specified grounds for disqualification require recusal because the judge's spouse is a professional in a field related to the subject matter of the case.

{¶ 73} Appellants appear to rely exclusively on Rule 2.11(A)(1), which provides that a judge must recuse himself or herself if the judge "has a personal bias or prejudice concerning a party," and comment 5 to Rule 2.11, which provides that a "judge should disclose on the record information that the judge believes the parties or their lawyers might reasonably consider relevant to a possible motion for disqualification, even if the judge believes there is no basis for disqualification."

{¶ 74} "A judge is presumed to be fair and impartial." *In re Disqualification of Kilpatrick*, 47 Ohio St.3d 605, 606 (1989). Upon a thorough review of the record, we conclude that the trial judge approached every aspect of this case from an unbiased and objective viewpoint. We, therefore, discern no reason for the trial judge to have either disclosed his wife's profession or recused himself from the proceedings. The seventh assignment of error is overruled.

{¶ 75} Having overruled appellants' second through seventh assignments of error, but having sustained appellants' first assignment of error, we hereby affirm in part and reverse in part the judgment of the Court of Claims of Ohio and remand this matter to that court for further proceedings in accordance with law and consistent with this decision.

Judgment affirmed in part and reversed in part; cause remanded.

CONNOR, J., concurs.
KLATT, P.J., dissents.

KLATT, P.J., dissenting.

{¶ 76} Because the Supreme Court of Ohio's decision in *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86 (1988), and this court's decision in *Brooks v. Ohio Dept. of Mental Health*, 10th Dist. No. 95API04-505 (Nov. 14, 1995), strongly support the trial court's application of the "professional judgment rule" to

appellants' claim of wrongful discharge of a patient from a psychiatric hospital, I respectfully dissent.

{¶ 77} In *Littleton*, the court determined under what circumstances a psychiatrist can be held liable for the violent acts of a voluntarily hospitalized psychiatric patient following the patient's release from the hospital. In *Littleton*, the adminstratrix of a minor child brought a survivorship and wrongful death action against a hospital staff psychiatrist after a voluntarily-hospitalized patient killed her minor child following the patient's release from a psychiatric hospital. The administratrix argued that the psychiatrist committed malpractice by violating the standard of care in discharging the patient.

{¶ 78} The *Littleton* court acknowledged that as a general rule, "[a] psychiatrist, as a medical specialist, is held to the standard of care 'of a reasonable specialist practicing medicine or surgery in that same specialty in the light of present day scientific knowledge in that specialty field.' " *Littleton* at 93, quoting *Bruni v. Tatsumi*, 46 Ohio St.2d 127 (1976), paragraph two of the syllabus. However, the *Littleton* court found that the general malpractice standard articulated in *Bruni* does not appropriately address the highly subjective and individualized nature of a psychiatrist's assessment of a patient's risk for violent behavior following the patient's discharge from a psychiatric facility. The court reached this conclusion based upon four arguments advanced by the defendant: (1) psychiatrists are unable to predict their patient's potential for violence with any degree of accuracy; (2) there is no standard in the psychiatric profession with which to measure a psychiatrist's judgment of a patient's propensity for violence; (3) if a psychiatrist knows that he or she will face liability for failing to foresee a patient's future violent behavior, the predictable result will be a court-mandated end to "out-patient" treatment and a massive confinement of all patients who display even a remote possibility of violent behavior; and (4) the General Assembly, in determining the liability standards pertaining to civil commitment, holds a psychiatrist to only a good-faith standard of care for decisions to

commit or discharge a mental patient. The *Littleton* court expressly found these arguments persuasive. *Id*. at 97.[1]

{¶ 79} Therefore, instead of a conventional malpractice standard, the court adopted the "professional judgment rule." Under this rule, a psychiatrist will not be liable for releasing a patient with violent propensities, who subsequently commits a violent act, as long as the psychiatrist thoroughly evaluated the severity of the violent propensities, and after balancing all the interests involved and in good faith, formulated a post-release treatment plan. *Littleton* at syllabus. The court stated:

> We find the arguments in support of adopting the professional judgment rule persuasive. Though a psychiatrist's ability to predict violent behavior is probably better than a layperson's, and there does appear to be some consensus within the mental health community on the factors relevant to a diagnosis of violent propensities, diagnosing both the existence of violent propensities and their severity is still a highly subjective undertaking. Psychiatric evaluations of any given fact pattern are bound to vary widely. And once a determination is made that a patient possesses a propensity for violent behavior, deciding upon a course of treatment poses difficult questions. The patient's right to good medical care, including freedom from unnecessary confinement and unwarranted breaches of confidentiality, must be balanced against the need to protect potential victims. Courts, with the benefit of hindsight, should not be allowed to second-guess a psychiatrist's professional judgment.

Id. at 97-98.[2]

{¶ 80} The majority decision suggests that the professional judgment rule only applies when the victim is a third party—not when the patient is the victim. I disagree. Although the victim in *Littleton* was a third party, the court's analysis is not so limited. The *Littleton* court's rationale is based, in substantial part, on the difficulty of predicting

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[1] I note that the *Littleton* court was persuaded that there were no defined standards in the psychiatric profession with which to measure a psychiatrist's judgment of a patient's propensity for violence after discharge. The court reached this conclusion despite the fact that the administratix presented expert testimony that purported to identify a standard of care for the discharge of a potentionally violent psychiatric patient.

[2] I also note that the *Littleton* court distinguished a wrongful discharge claim from a claim based upon alleged improper treatment ("a psychiatric patient is not required to assume the risk of improper treatment"). *Id*. at 99.

the violent acts of a discharged patient—not whether the victim of that violence was a third party or the patient himself. Moreover, to the extent this issue was ever in doubt, we expressly resolved it in *Brooks*, wherein we applied the professional judgment rule in a case involving the alleged wrongful discharge of a psychiatric patient where the discharged patient attempted suicide. The court in *Brooks* stated:

> While the test in *Bruni* is proper in a medical negligence case, the court in *Littleton v. Good Samaritan Hospital & Health Ctr.* (1988), 39 Ohio St.3d 86, recognized that, because of the unpredictability and uncertainty as to patients' actions upon release from a psychiatric facility, holding psychiatrists to the malpractice standard of ordinary care is too stringent. Therefore, the court in *Littleton* adopted the "professional judgment rule," wherein a psychiatrist would not be liable for releasing a patient who subsequently harms someone if, after carefully examining all of the relevant data, the psychiatrist makes a professional medical judgment that the patient does not pose a danger to others. The court found that "[w]here there are no professional standards, a psychiatrist must exercise good faith judgment based on a thorough evaluation of all relevant factors." *Id.* at 99. We believe the holding in *Littleton* can be expanded to include harm to oneself.

{¶ 81} The *Brooks* court went on to expressly find that the trial court did not err when it determined that the plaintiffs failed to prove the discharge violated the professional judgment rule. The *Brooks* court expressly relied on *Littleton* when it applied the professional judgment rule to precisely the type of claim at issue in the case at bar.

{¶ 82} The majority decision is directly at odds with *Littleton* and this court's decision in *Brooks*. For the foregoing reasons, I respectfully dissent from the majority decision. I would affirm the trial court's judgment in its entirety.

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