<u>M.I.T. *Is* Guilty…of Being Nice</u>

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INTRODUCTION

Elizabeth Shin died on April 14th, 2000 as a result of severe neurological damage caused by setting herself aflame in her residence hall. Her death was tragic and so is the case brought by her parents against her university, M.I.T. They alleged twenty-five counts in their civil suit, and the Superior Court of Middlesex, Massachusetts made its decision on the summary judgment motions in July. Most of you are aware that nine of the 25 counts survived the summary judgment order, and will now be docketed for trial. This opens the door to settlement discussions, unless M.I.T. or the Shins insist on a trial. Cases like this typically settle at this point (and in fact, Shin did summarily settle, with no admission of liability by MIT).

SUMMARY JUDGMENT

Summary judgment is a legal mechanism for courts to dismiss claims where there are no genuine issues of material fact to be decided. In discussing this case with colleagues, there appear to be some misperceptions about Shin that bear explanation. First, it is not really correct that M.I.T. as an institution was dropped from the suit. There were five counts against M.I.T. relating to liability under Massachusetts' statutes for institutions engaged in "trade or commerce." The court ruled in favor of M.I.T. on these counts because as a university it did not fall under these statutes. The remaining 20 counts were against M.I.T. employees, including doctors, administrators and a housemaster. Nine of these 20 survived, and because each of these employees was within the course and scope of their employment, M.I.T. is still very much a litigant in this case.

NOT ABOUT FERPA

Second, there is a common public perception that this case is somehow about FERPA, and whether Elizabeth Shin's parents should have been notified of her condition. While there is a larger context in which FERPA is relevant to Shin, the lawsuit did not involve FERPA. In fact, it bears recollection that there is no private right of action under FERPA. Students and their parents cannot sue colleges for violating their FERPA rights. The Shins tried to make a claim for negligent misrepresentation that would have involved their notification rights, but this claim was dismissed by the court under the "trade and commerce" analysis referenced above.

For those not familiar with the facts of the case, let me address the parental notification issue by making it clear that the Shins were well aware that their daughter was suffering psychological distress, was ideating and had threatened suicide. Elizabeth's struggles did not begin at M.I.T. She suffered from mental health problems in high school, and was a cutter. At M.I.T., her parents were called at least twice to be notified of Elizabeth's distress. Her parents hospitalized her, took her out of M.I.T. for a time, and had her treated for depression and anxiety on breaks. They were not wholly in the dark.

BACKGROUND OF THE CASE

I think the best way to learn from this case in terms of our own practices is to walk through it together. M.I.T. was aware of Elizabeth's self-destructive behavior from February of 1999 (her freshman year) through April of 2000. The litany of incidents involving Elizabeth is extraordinary. In February of 1999, she overdosed on painkillers and spent a week in a psychiatric treatment facility. Nina Davis-Millis, Elizabeth's housemaster, notified Elizabeth's parents of this hospitalization. Davis-Millis is a defendant in the Shin's case. At the time of the overdose, Mr. Shin arranged for Elizabeth to begin treating with a psychiatrist from M.I.T.'s Health Services. Elizabeth and the psychiatrist met every two or three weeks, and M.I.T. immediately made academic extensions available to Elizabeth from Counseling and Support Services. In March of 1999, Elizabeth threatened suicide, and this was communicated by a Dean of Counseling and Support Services to Elizabeth's psychiatrist. Sporadic therapy ensued throughout the spring, and then Elizabeth spent the summer living at home with her parents.

When she returned for her Sophomore year, Elizabeth's difficulties resurfaced in early October, when she was referred to another psychiatrist at M.I.T.'s Health Services for ideation. The diagnosis included cutting without suicidal intent and passive suicidal ideation. Sessions with her psychiatrist became more frequent. In early November, Elizabeth sought out another Dean of Counseling and Support Services, to whom she reported intentional cutting. He referred Elizabeth for urgent psychiatric treatment. By early December, instructors were contacting the Deans to report that Elizabeth was buying sleeping pills with the intention to take them. This threat was conveyed to Elizabeth's housemaster and therapist.

In March of 2000, a student reported to the housemaster that Elizabeth was cutting herself and was extremely upset. Elizabeth was persuaded to seek medical attention, and went to the infirmary for observation. With tranquilizers calming her, she was sent back to her hall. The next day, a fellow student reported to the housemaster that Elizabeth was distraught, but this report was not communicated to any of the M.I.T. medical staff. However, the next day the housemaster contacted Mr. and Mrs. Shin to inform them that Elizabeth was back in the infirmary. The Shins took Elizabeth home to New Jersey for spring break. The pattern that should be clear here is one of immediate response by M.I.T. to Elizabeth's needs, and successful communication by those offering support to Elizabeth. Reading the documents surrounding this case, it is hard for me to imagine a more supportive, involved and engaged staff.

When she returned, Elizabeth met with a new psychiatrist (if you are counting, this is #3), who immediately prescribed anti-depressants and tranquilizers without checking Elizabeth's records or consulting with other treating psychiatrists, the court noted. It seems to me, though, that such records and conversations would only have served to confirm the diagnosis of depression and borderline personality disorder. Between the end of March and early April, reports of Elizabeth's deterioration increased, with the Deans and housemaster responding to the concerns of other students, and taking action to postpone Elizabeth's upcoming examinations. She had a severe depressive episode and her dosage of antidepressants was increased. A decision was made to try to find an outside therapist at this point. "Recurrent suicide gestures" were noted on March 30th, 2000. This was the fourth episode--as I count it--of attempted suicide, threats or ideation that was clearly known to M.I.T. administrators and health service providers. Many

universities would have thrown in the towel already, or would have done so at this point. Perhaps that is one of the lessons of this case.

But, M.I.T. prevailed, continuing to try to support Elizabeth. This is where they were too nice, in my opinion. Heroic, even. But with hindsight it is clear they were in way over their heads in terms of Elizabeth's needs and their own ability to monitor her and prop her up. No college should have to struggle this mightily to keep its students alive.

WHAT ABOUT AN INVOLUNTARY WITHDRAWAL?

If they had medically withdrawn Elizabeth at this point, M.I.T. might have faced suits from the Shins, under 504 for discrimination and under the ADA for failure to provide accommodations. I'd venture an educated guess that those suits would have been one-tenth the cost of defending this one, even if M.I.T. lost (and I think courts could see withdrawal at this point as very reasonable, given that colleges are not mental health facilities. The key to succeeding in court is to have built a very clear case before withdrawal for the conclusion that a student is a "direct threat" of immediate and grave harm to themselves or others).

It is at this point of "recurrent suicide gestures" that the Shins allege M.I.T. failed to respond adequately. M.I.T. had regular "deans and psychs" meetings to discuss students in distress. Despite recurrent suicide gestures on March 30th, for some reason Elizabeth's condition did not merit scheduling for that week's meeting, or even an emergency meeting. She was not the topic of the "deans and psychs" meeting until April 10th. In the meantime, the situation worsened. Elizabeth continued to request academic accommodations, and more exams were postponed. Here's another lesson learned, in my opinion. When your Dean is re-arranging all of your exams because you cannot cope, you are no longer a student (in the language of the ADA, it is reasonable at this point to say that student is not "otherwise qualified" and that the protections of the ADA do not apply). You need to be somewhere else, and hopefully you will be better off there.

A Dean of Counseling and Support Services, at Elizabeth's behest, kept communications open with Elizabeth's housemaster. Into early April, Elizabeth sought further support from another doctor and a social worker. The doctors began to explore outside treatment options more seriously. Two professors then contacted the housemaster, worried about Elizabeth's condition. The housemaster briefed the Dean.

THE FINAL THREAT

On April 8th, Elizabeth told a fellow resident that she was going to kill herself with a knife. This student called the police, who transported Elizabeth to the M.I.T. Medical Center. There, an on-call psychiatrist spoke to Elizabeth by phone from his home. After less than five minutes, he determined that Elizabeth was not acutely suicidal and instructed her to go back to her residence hall. Even if this was less than the level of engagement we might hope for, Elizabeth did not immediately kill herself. Two days later, on the morning of April 10th, two of her hallmates told the housemaster that Elizabeth planned to kill herself that day. Elizabeth even requested that one of the hallmates erase her hard drive on her computer. The housemaster took this seriously, and

called the on-call psychiatrist. The psychiatrist reassured the housemaster that when he talked to Elizabeth at the hospital, she had assured him she was fine. He instructed the housemaster to check on her, and they decided he would follow-up with her at 6:30am the next morning. Was Elizabeth really fine? Did this psychiatrist fail to take enough time to diagnose her? The Shins think so. But, maybe he was fooled by a very clever M.I.T. student.

At this point, the court agreed, a special relationship surely existed. While Elizabeth may not have been in custody, she had agreed not to harm herself, and was under watchful supervision. At 6:30am, the housemaster went to check on Elizabeth, "found all was quiet and decided not to wake her." From this description in the court's opinion, I raise a number of questions. How the housemaster made this determination is disturbing. We have an informal, non-custodial suicide watch underway. What did the housemaster do? Did she listen at the door? Dead people are quiet. Did she open the door and observe Elizabeth sleeping? Sleeping people and dead people look pretty similar. How did she know that all was okay, because she needed to know that. Elizabeth's welfare was now M.I.T.'s legal responsibility. What level of training do M.I.T.'s housemaster's have? I have a feeling this was just a lucky guess. Elizabeth called her housemaster at 9:45 that morning, ending the call with "You won't have to worry about me anymore," and the housemaster duly reported this to the Dean, who promised to discuss it at that afternoon's "deans and psychs" meeting.

That meeting took place at 11am. In my opinion, the Shins should have been aware of that meeting, and perhaps should have participated in it, unless there was evidence not contained in the court record that they might have been an impediment to Elizabeth's support. The result of that meeting was a decision to check Elizabeth into an outside facility the next day. At 9:00pm that night, the smoke alarm sounded in Elizabeth's room, and she died of burn-related injuries four days later.

The court may ultimately get to decide the remaining claims for gross negligence and wrongful death, unless the case settles. Here are some thoughts I have about this case, though I'm not sure I mean all of them. I just want them to make you think:

- Many colleges expel students for three alcohol violations. Yet, M.I.T. supported Elizabeth though many episodes. Where is the line between supporting and enabling? Why is a college the right place for a student with such dire needs?

- Elizabeth's friends, hallmates and professors saw that the situation was critical…why didn't her doctors? Why wasn't the housemaster at the "deans and psychs" meeting? Common sense and medical diagnosis should each have a place at the table, because none of us can predict future harm with much accuracy.

- There seems to have been no referral of Elizabeth for conduct violations. I wonder if that would have given M.I.T. more leverage to push her "voluntarily" into an outside treatment facility.

- A student on suicide watch should not be left in a residence hall. Apart from the inability to monitor what happens behind a closed door, suicide impacts an entire hall. It was not fair to

Elizabeth's hallmates to have this ever-present distraction. Allowing Elizabeth to remain in her residence hall potentially endangered her hallmates, as well.

- The best and biggest medical staff available is no guarantee. Elizabeth was referred almost every time she ideated, and saw a psychiatrist. Some colleges don't even have a campus psychiatrist.

- Was Elizabeth really taking her medications? The opinion does not mention it, and I suspect she was not. Some level of monitoring of that might have helped.

- Colleges don't generally owe students a duty of protection until we act to protect them. Once we extend the protective wing, we need to make sure that wing is strong enough to support that student. As we transition from the 2nd Restatement of Torts to the 3rd Restatement era starting in about 2010, it will be interesting to see how many courts adopt its shift toward the legal principle that schools have a special relationship with students.

- I continue to be very nervous about "no harm" agreements and behavioral contracts when used with students who may be a harm to self or others. By creating these agreements, we potentially incur a legal duty. We create a "special relationship," and yet we have limited ability to monitor and enforce compliance by the student. It is a one-sided agreement and we're taking a heck of a chance that the student is going to perform as agreed.

All information offered in this publication is the opinion of the author, and is not given as legal advice. Reliance on this information is at the sole risk of the reader.

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