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93 MAP 2023 and additional consolidated case(s)

IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

Docket Nos. 93 MAP 2023, 94 MAP 2023

STEVEN MATOS, AS ADMINISTRATOR OF
THE ESTATE OF JESSICA L. FREDERICK, DECEASED,

v.

GEISINGER MEDICAL CENTER; MICHAEL H. FITZPATRICK, M.D.;
AND RICHART T. DAVIES, JR., PA-C

AND

ALLEY MEDICAL CENTER; DAVID Y. GO, M.D.;
AND KYLE C. MAZA, PA-C,

Appeal of: Alley Medical Center, David Y. Go, M.D., and Kyle C. Maza, PA-C (93 MAP 2023)

Appeal of: Geisinger Medical Center; Michael H. Fitzpatrick, M.D.; and Richard T. Davies, Jr., PA-C (94 MAP 2023)

BRIEF OF *AMICI CURIAE* OF THE AMERICAN MEDICAL ASSOCIATION AND PENNSYLVANIA MEDICAL SOCIETY IN SUPPORT OF DEFENDANTS-APPELLANTS

On Appeal from the Order of the Superior Court entered March 10, 2023, at Nos. 1189 MDA 2021 and 1190 MDA 2021, affirming the June 15, 2021 Order and Opinion of the Columbia County Court of Common Pleas (Norton, G.) at No. 2013-cv-1067, denying Defendant's request for summary judgment.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici are the American Medical Association (AMA) and Pennsylvania Medical Society (PAMED). Maintaining clarity in the determination of when a person has been evaluated for voluntary inpatient care under the Mental Health Procedures Act and, accordingly, which rules govern third party claims for harm caused by mental health patients is of utmost importance to AMA and PAMED.

The AMA is the largest professional association of physicians, residents and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially physicians, residents and medical students in the United States are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including Pennsylvania, and in every medical specialty, including those that serve mental health patients.

PAMED is a Pennsylvania non-profit corporation that likewise represents physicians of all specialties and is the largest physician organization in the Commonwealth. PAMED regularly participates as *amicus curiae* in Pennsylvania appellate courts in cases raising important health care issues.

The AMA and PAMED appear on their own behalves and as representatives of the AMA Litigation Center. The Litigation Center is a coalition among the AMA

and the medical societies of every state. The Litigation Center is the voice of America's medical profession in legal proceedings across the country. The mission of the Litigation Center is to represent the interests of the medical profession in the courts. It brings lawsuits, files *amicus* briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians.

Pursuant to Pennsylvania Rule of Appellate Procedure 531(b)(2), *amici* state that no counsel for any party authored this brief in whole or in part and no entity or person, aside from *amici curiae*, their members, and counsel, made any monetary contribution to fund the preparation or submission of this brief.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

This appeal arises out of a tragic situation, the killing of a person who was close to someone with mental health struggles. As detailed in the Superior Court's ruling, Mr. Wise had a history of mental health difficulties from a brain injury caused by an ATV crash when he was six years old. *See Matos v. Geisinger Med. Ctr.*, 297 A.3d 899, 901 (Pa. Ct. App. 2023). The record indicates that, from 2000-2011, Wise had episodes of substance abuse, at one point was admitted to Geisinger for mental health treatment, received outpatient treatment for bipolar disorder at Alley, and served time in jail for harming the mother of his children. *See id.* at 901-02.

During the time at issue in this case, January 2011, Wise was living with his girlfriend, Jessica Frederick. A close friend of his had died, and he presented at

Geisinger's emergency room for mental health-related issues. *See id.* As the lower court noted, among other things, Mr. Wise was instructed to "call Tapline if he was suicidal or homicidal or felt worse." *Id.* at 902. Three days later, Mr. Wise presented at Alley for mental health issues, this time, with his father. The plan upon leaving Alley was to spend the "foreseeable future" at his father's residence in Colorado. *Id.* That night, Ms. Frederick asked, and Wise's father agreed, that Wise could spend one more night with Ms. Frederick. That night, Wise killed Ms. Frederick.

Ms. Frederick's estate has invoked the Mental Health Procedures Act (MHPA) in suing Geisinger, Alley, and the physicians who treated Wise at each facility. The estate alleges that Wise voiced a desire to be voluntarily admitted for inpatient mental health treatment at each facility and that, doing so, triggered the MHPA. Whether he actually asked to be voluntarily admitted is in dispute. Regardless, the estate continued that once the MHPA is triggered, defendants owed a duty of care to Ms. Frederick and others who could be harmed by Wise and subjects them to liability if they engaged in gross negligence and/or willful misconduct in failing to diagnose and admit Wise for inpatient treatment. The question for this court is whether the MHPA was, in fact, triggered and governs this claim.

ARGUMENT

Under traditional liability law, including for the treatment of mentally ill patients, health care providers are not liable to third parties a patient might harm. *See*

Emerich v. Philadelphia Ctr. for Human Dev., Inc., 554 Pa. 209, 231-32, 720 A.2d 1032, 1042-43 (1998). There are two limited exceptions: the providers must have been able to determine that the plaintiff presented an immediate threat or that the third party was identified or readily identifiable as a target of the patient. *See id*. Neither of these exceptions apply here. There is no allegation that when Mr. Wise left either of the two facilities in this lawsuit that he posed an immediate threat to anyone or that Ms. Frederick was identified or readily identifiable as a person Mr. Wise might harm. Thus, there is no third-party duty or liability. In trying to circumvent this law, Ms. Frederick's estate is seeking to invoke the MHPA. This statute, though, provides immunity, not a cause of action, and does not govern the type of treatment Mr. Wise received—voluntary outpatient mental health care.

As this Court has recognized, the General Assembly enacted the MHPA to provide liability protections to physicians and facilities that treat mentally ill patients to "assure the availability of adequate treatment to persons who are mentally ill." 50 P.S. § 7102; *see Leight v. Univ. of Pittsburgh Physicians*, 243 A.3d 126, 130 (Pa. 2020) (discussing MHPA's history). When a physician or facility provides treatment governed by this statute, they are given immunity from liability, including when the *Emerich* exceptions would otherwise apply. 50 P.S. § 7114. The General Assembly, though, did not provide these added protections to physicians who act with "willful misconduct or gross negligence." *Id*. In those situations, common law liability still

applies. As indicated, under the common law, Defendants had no duty to protect third parties from Mr. Wise—facts that should end the litigation. The MHPA did not *create* a right of action for third parties outside of the *Emerich* exceptions, even for willful misconduct or gross negligence. Yet, that is what creative lawyers are starting to argue—both in *Leight* and in this case. They are trying to trigger the MHPA, a statute that provides Defendants with *immunity from liability*, in an effort to create a lawsuit that would not exist at common law. The MHPA does no such thing.

This appeal, though, is focused on a more preliminary question: does the MHPA even govern this case? The answer, for the same reasons articulated in *Leight*, is "no." As this Court explained, the MHPA establishes rights and procedures in only three situations: involuntary inpatient, involuntary outpatient, and voluntary inpatient treatment. *See* 243 A.3d at 130. "[T]he voluntary treatment of outpatients falls outside the scope of the MHPA." *Id.* And, in *Leight* and here, the patients received only voluntary outpatient treatment. In *Leight*, the Court determined that the *involuntary* inpatient provisions had not been triggered even though the paperwork had been started, finding the MHPA's prerequisites for when such care is initiated were clear and had not been met. *Id*. at 141. It cautioned that triggering the statute too early or creating vague standards for when the MHPA applies "would lead to an unreasonable result." *Id.* Under the allegations, "physicians would have to speculate as to the point at which their conduct might be subject to liability," their

liability could be improperly expanded, and providers could be liable for "any thought or act" related to a covered service. *Id.* These outcomes would be detrimental to physicians and patients alike. *See id*. at 142.

Here, the question is whether *voluntary* inpatient care was initiated, namely did Wise "submit himself to examination and treatment" for inpatient care. 50 P.S. § 7201. Despite the Court's admonitions against triggering the MHPA too early, the Superior Court held that such submission occurs whenever a person goes to a covered facility and raises potential inpatient treatment—not whether they actually submitted to an exam or treatment. 291 A.3d at 909, 910 (holding the prerequisites were "satisfied when Wise submitted himself to approved facilities"). Determining whether a patient meets the threshold for examination and inpatient care, including on a voluntary basis, is a medical determination[1]—not one based on the thoughts or acts, however expressed, of patients or family members. Under the lower court's ruling, even when there is absolutely no clinical reason for conducting an exam, if the facilities or physicians do not conduct an inpatient exam or admit a patient for treatment when asked, they can be liable to third parties, even when the patient was not a threat and no third party was identified or reasonably identifiable as being in

[1] *See* American Psychiatric Association, Position Statement on Voluntary and Involuntary Hospitalization of Adults with Mental Illnesses (2020) (stating that voluntary hospitalization should not be offered when inappropriate), at https://www.psychiatry.org/getattachment/46011d52-de5d-4738-a132-f5aaa249efb5/Position-Voluntary-Involuntary-Hospitalization-Adults.pdf.

harm's way. *Id.* at 910. The Court should hold that submitting oneself "to examination and treatment" for inpatient care means an "examination or treatment" was actually initiated. That did not occur here, so the MHPA does not apply.

In making these arguments, *amici* do not, in any way, discount the impact of Mr. Wise's horrendous act. Ms. Frederick did not deserve her fate; her killing was a profound tragedy. But, the questions before this Court are of liability, and the laws of the Commonwealth do not create the liability Plaintiff seeks. For these reasons, as discussed below, *amici* respectfully urge the Court to reverse the ruling below.

I. THE LEGAL FRAMEWORK FOR TREATING PATIENTS WITH MENTAL ILLNESSES HAS BEEN DEVELOPED OVER DECADES TO CAREFULLY BALANCE THE RIGHTS OF THE MENTALLY ILL WITH THE NEED TO PROTECT THE PUBLIC

Mr. Wise, like many people with mental ailments, was trying to live a productive life integrated into society while seeking care for his mental ailments when needed. In the Commonwealth, as in other states, health care providers are to treat such patients with the fewest restrictions possible on their liberty, including when the patient or family member raises the possibility of inpatient care. *See* 50 P.S. § 7107; *see also Leight*, 243 A.3d at 130 (stating the General Assembly stressed that "in all instances, the least restrictive approach consistent with adequate treatment should be utilized"). The Commonwealth, like most states, prioritizes giving people like Wise the greatest opportunity to successfully manage their mental

ailments while maintaining their participation in society—not removing them from society, either involuntarily or voluntarily.[2]

This approach represents a beneficial, though sharp divergence from the past. For much of American history, people with mental ailments were put in prisons, shelters for the poor, or asylums. Society's view "was that persons with mental illness lacked the capacity to make decisions." Megan Testa, M.D. & Sarah West, M.D., *Civil Commitment in the United States*, Psychiatry Vol. 7 No. 10, 32 (2010). They were denied the basic right to liberty, as judges would lock them up and families could purchase the confinement of unwanted relatives. *See id*. By the 1950s, the rolls at state asylums swelled to more than 500,000 people. *See id.*

Around this time, the outlook toward mental health started to change, leading to fundamental shifts in the public policies toward patients. In 1951, the National Institute of Mental Health published the "Draft Act Governing Hospitalization for the Mentally Ill" to facilitate procedures, like those currently used in Pennsylvania, to protect the due process rights of mental health patients. Congress enacted the Mental Health Study Act in 1955 to establish the Joint Commission on Mental Illness and Health. *See* E. Fuller Torrey, M.D., *Out of the Shadows, Confronting*

[2] Even when a person is voluntarily admitted, they lose some autonomy; the facility can detain the patient for up to 72 hours after he or she asks to be dismissed and can seek to convert voluntary admission to involuntary admission when warranted. *See* 50 P.S. § 7202, 7206.

America's Mental Illness Crisis, appendix (1997). In 1963, President Kennedy signed the Community Mental Health Centers Act to facilitate treating individuals in their communities. *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960's*, 9 Ohio. St. J. Crim. L. 53, 53 (2011).

The United States Supreme Court, in a series of rulings in the 1970s, supported this effort, finding that mental health patients did not lose their constitutional rights. The Court recognized that being admitted to a mental institution could result in a "massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), and people with mental illnesses retain their due process rights to control their own destiny, *see O'Connor v. Donaldson*, 422 U.S. 563 (1975). As a result, mental health providers were to use the "least restrictive treatment" in caring for their patients. *See Lake v. Cameron*, 267 F. Supp. 155 (D.C. Cir. 1967).

Courts and legislatures around the country, including here in Pennsylvania, followed these developments by establishing legal regimes to focus mental health treatment on community-based outpatient programs. Patient advocacy groups and the medical community welcomed this sea change in legal and social attitudes because they believed that out-patient treatment plans were generally better for the mentally ill than removing them—involuntarily or voluntarily—from society. *See* Mental Health America, *Position Statement 22: Involuntary Mental Health*

Treatment (2013) ("Persons with mental health conditions can and should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery.").

Pennsylvania law now squarely emphasizes the need to find the least restrictive path for treating mental health patients, including Wise. *See* 55 Pa. Code § 5100.3(b) ("It is the policy of the Commonwealth to seek to assure that adequate treatment is available with the least restrictions necessary to meet each client's needs."). The Court and General Assembly have appreciated that continued participation in society by such individuals is not without risk. In *Emerich*, the Court recognized that even when outpatients have homicidal and suicidal ideations, they must not be sent automatically for inpatient care. Without these rules, individuals such as Wise would not be able to function in society, risking to a return to mass confinement.

II. MANY PEOPLE WITH MENTAL ILLNESSES REMAIN IN SOCIETY, WITH TREATMENT UNDER THE MHPA RESERVED FOR ONLY THOSE MEETING SPECIFIC CRITERIA

Consistent with this history, Pennsylvania law favors voluntary outpatient treatment and specifies the processes and standards for considering whether to transition someone to involuntary inpatient, involuntary outpatient, or voluntary inpatient care. 50 P.S. § 7103. In order for a person to seek voluntary inpatient care, which is at issue here, the person must "submit himself to examination and

treatment," which includes filing an application seeking such an examination. *See* 50 P.S. § 7201, 7202. "Before a person is accepted for voluntary inpatient treatment, an explanation shall be made to him of each treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject together with a statement of his rights." 50 P.S. § 7203. He or she must then provide written consent to be admitted and sign, along with the physician, the report of the evaluation and proposed treatment plan. None of this occurred here.

In fact, no clinical decision was ever made that Wise was even a candidate for voluntary inpatient examination or treatment. At most, and again this is disputed, Wise and his father raised the potential for inpatient care. What's clear is that the process for voluntarily admitting Wise for such treatment never started, which is comparable to the situation in *Leight* where the process for involuntary inpatient treatment had not been started because the paperwork was not completed. This Court has acknowledged that actions in an outpatient setting "that fall short of satisfying" the MHPA's requirements "do not transform" outpatient care into inpatient care. *Leight*, 243 A.3d at 141. The Court stated that adhering to this "bright line" rule is consistent with both the plain language of the MHPA, which is just as true here as in *Leight*, and "serves both the physician and the mental health patient." *Id*. at 142.

The lower court's interpretation of the MHPA rule that a person can submit himself for an inpatient examination and treatment to mean that any patient or family

member could trigger the MHPA merely by making an assertion regarding inpatient care "would create a gray area in which physicians would have to speculate as to the point at which" the statute has been triggered. *Id*. at 141. This would be true "no matter how inconsequential [or] tangentially related" the person's statement, act or thought about inpatient care. *Id*. It also would not matter if the statement was unreliable or inconsistent with the patient's actual condition, or that no medical basis existed for submitting the patient for such an exam. To be sure, deciding not to submit someone for an inpatient examination is an inexact science and certainly not free from risks, particularly given the requirement to choose the least restrictive treatment options. *See Farago v. Sacred Heart Gen. Hosp.*, 562 A.2d 300, 304 (1989). Accordingly, when a patient such as Mr. Wise is living in society and presents at a hospital, the Court does not require health care providers "to be liable for a patient's violent behavior because he fails to predict such behavior accurately." *Emerich*, 554 Pa. at 225, 720 A.2d at 1040.

The truth is that, here, Ms. Frederick's death could have been predicted only through the lens of hindsight, and this Court must guard against any tendency to judge mental health treatment decisions through hindsight bias. *See Kortus v. Jensen*, 237 N.W.2d 845, 851 (Neb. 1976) (discussing hindsight biases in medical cases); *cf.* Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 Tort & Ins. L. J. 895, 905 (2007)

("In the context of medical litigation, the existence of these biases suggest that it may be difficult for finders of fact to evaluate fairly (e.g., without reference to whether the decision, in retrospect, turned out to be the right choice)."); Hal R. Arkes, *The Consequences of Hindsight Bias in Medical Decision Making*, 22(5) Curr. Directions in Psych. Sci. 356, 359 (2013) ("The hindsight bias has particularly detrimental effects" in "important, highly consequential situations.").

If Defendants were focused on hindsight liability, the strategic choice would have been to examine and admit Wise to a mental health facility and not allow him an opportunity to remain integrated in society. Doing so would have triggered the MHPA and provided them with limited immunity. *See* Winsor C. Schmidt, *Critique of the American Psychiatric Association's Guidelines for State Legislation on Civil Commitment of the Mentally Ill*, 11 New. Eng. J. Crim. & Civ. Confinement 11, 24 (1985) (observing immunity "militat[es] against the otherwise inherent tendency to limit patient freedom"). Plaintiff, as well as others, may prefer removing people with certain mental health struggles from society, but that is not the law in Pennsylvania or other states. As this Court explained in *Leight*, expanding the scope of the MHPA "to include merely informal considerations" regarding inpatient care—here, a comment by a patient or family member—"would encourage the over commitment of patients to avoid potential liability" and "discourage health care workers from treating patients who exhibit mental ailments." 234 A.3d at 142.

Here, there is no indication the providers made their decisions for any reason other than their sincere assessment of their obligations under the law and what they thought best for Mr. Wise. Outside influencers, including liability, must not invade this decision. *See* James R. Roberts, M.D., *The Risks of Discharging Psych Patients Against Medical Advice*, Emergency Medicine News, Vol. 38 Iss. 7 (July 2016) ("Many practical and logistical pressures are placed on psychiatric patients from family, police, lack of shelter or personal resources."). Otherwise, health care providers would be incentivized to curtail patients' personal liberties or may choose not to work with patients who demonstrate mental ailments out of fear of lawsuits.

III. INCENTIVIZING HEALTH CARE PROVIDERS TO ADMIT PATIENTS TO GUARD AGAINST LIABILITY WILL REDUCE OVERALL SAFETY

It also is in the best health care interest of patients, and ultimately the public, that individuals with mental ailments have access to outpatient care, which can give them a sense of self-determination and skills for living in society. Patients in Wise's situation should be encouraged to discuss their situations openly with physicians, not censor themselves out of fear they may trigger the MHPA by raising the possibility of inpatient care. Studies have shown that 77 percent of previously admitted patients will not risk being admitted again, even if they know they pose a danger to themselves or others. *See, e.g.*, Dinah Miller, M.D. & Annette Hanson, M.D., *Committed: The Battle over Involuntary Psychiatric Care* xviii (1st ed. 2016).

Under the lower court's ruling, any indication patients provide that they are "submitting" themselves for inpatient examination would force the physicians to start that process, and patients may lose control over what happens after that.

Creating such a liability system that would incentivize inpatient admission, therefore, would have larger repercussions. Currently, one in five adults experiences a mental illness, and one in twenty-five adults live with a serious mental illness. *See* Nat'l Alliance on Mental Illness, *Mental Health by the Numbers*.[3] In Pennsylvania, more than 4.6 percent of the population, or nearly 590,000 people, have a serious mental illness. *See* State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health, The NSHUH Report, Substance Abuse and Mental Health Services Admin., Feb. 28, 2014.[4] Expanding the scope of liability of health care professionals would strain the mental health care system by increasing the costs of patient care. Here, creating liability may result in compensation to Ms. Frederick's estate, but it will not lead to a safer community or better mental health care. It could very easily have the opposite effect, putting more patients and others at greater risk. The determination of whether to consider a person for inpatient care must remain a medical determination made by the attending physicians.

[3]https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf.

[4]https://www.samhsa.gov/data/sites/default/files/sr170-mental-illness-state-estimates-2014/sr170-mental-illness-state-estimates-2014/sr170-mental-illness-state-estimates-2014.htm

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Honorable Court reverse the Order of the Superior Court entered March 10, 2023.

Sincerely,

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December 15, 2023

CERTIFICATIONS OF COMPLIANCE

Pursuant to Pennsylvania Rule of Appellate Procedure 2135(d), I hereby certify that this Brief of *Amici Curiae* complies with the word count limits of Pennsylvania Rule of Appellate Procedure 531(b)(3).

I further certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

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Pursuant to Pennsylvania Rule of Appellate Procedure 121(d), I hereby certify that two (2) copies of this Brief of *Amici Curiae* were served upon the following counsel of record via both electronic mail and U.S. Mail, first class, postage pre-paid, on this 15th day of December 2023:

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IN THE SUPREME COURT OF PENNSYLVANIA

Steven Matos, Individually and as Administrator of the Estate of Jessica L. Frederick, Deceased	:	93 MAP 2023
	:	94 MAP 2023
v.	:	
Geisinger Medical Center; Michael H. Fitzpatrick, M.D.; Richard T. Davies, Jr., PA-C; Alley Medical Center; David Y. Go, M.D. and Kyle C. Maza, PA-C		
Appeal of: Alley Medical Center, David Y. Go, M.D., and Kyle C. Maza, PA-C		

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I hereby certify that this 15th day of December, 2023, I have served the attached document(s) to the persons on the date(s) and in the manner(s) stated below, which service satisfies the requirements of Pa.R.A.P. 121:

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