IN THE SUPREME COURT OF PENNSYLVANIA
WESTERN DISTRICT

Docket No. 7 WAP 2019

LAURA L. MAAS, Administratrix of the Estate of
LISA CHRISTINE MAAS, deceased,

Appellee/Plaintiff,

v.

UPMC PRESBYTERIAN SHADYSIDE d/b/a WESTERN PSYCHIATRIC INSTITUTE & CLINIC; WESTERN PSYCHIATRIC INSTITUTE & CLINIC; MICHELLE BARWELL, M.D.; and WESTERN PSYCHIATRIC INSTITUTE & CLINIC ADULT COMMUNITY TREATMENT TEAM,

Appellants/Defendants.

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, PENNSYLVANIA MEDICAL SOCIETY, AND PENNSYLVANIA PSYCHIATRIC SOCIETY IN SUPPORT OF APPELLANTS

Appeal from the Order of the Superior Court entered June 29, 2018, at No. 185 WDA 2017, affirming the Judgment of the Court of Common Pleas of Allegheny County, entered November 9, 2016, at No. G.D. 09-18900.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici are the American Medical Association (AMA), Pennsylvania Medical Society (PAMED), and the Pennsylvania Psychiatric Society (PaPS). 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 all United States physicians, residents and medical students are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the science and art 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.

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 also represent the AMA Litigation Center, a coalition of the AMA and state medical societies to advance the views of organized medicine in the courts.

The Pennsylvania Psychiatric Society (PaPS), a district branch of the American Psychiatric Association is comprised of more than 1,500 physicians practicing the specialty of psychiatry in the Commonwealth. PaPS's mission is to fully represent Pennsylvania psychiatrists in advocating for their profession and their

patients, and to assure access to psychiatric services of high quality, through activities in education, shaping of legislation and upholding ethical standards. The doctor-patient relationship and the privileged communication shared within treatment is paramount to effective evidenced-based treatment.

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

Amici adopt and incorporate Appellants'/Defendants' Statement of the Case and Procedural History to the extent needed for the arguments stated herein. This case involves a tragic incident in which Mr. Terrence Andrews, who had been diagnosed with Paranoid Personality Disorder and Antisocial Personality Disorder, fatally stabbed Ms. Lisa Maas in her apartment, which was on the same floor of the apartment building in which Mr. Andrews lived. Previously, Mr. Andrews had been admitted to Mayview State Hospital for these and other conditions and was discharged in 2006. In an effort to integrate him into society, he began residing in the apartment building at the end of 2007/beginning of 2008 and attempted to gain employment. He was under the care of Defendants during this time.

Over the course of the several months he lived in the apartment building, Mr. Andrews expressed suicidal and homicidal ideations. At different times he offered different descriptions of whom his homicidal ideations were toward, including neighbors, his brother, friends, and "others, in general" who "piss me off." At no time, though, did Mr. Andrews express a specific ideation with respect to Ms. Maas or any plan or intent to carry out any of these ideations. When Defendants and other mental health professionals were aware of these ideations, they treated him, including admitting him to the hospital until the episodes passed and they concluded he was not a threat to himself or others. On the day in question, Mr. Andrews did not express any homicidal ideations, including with respect to Ms. Maas. Rather, a nurse who spoke with him by phone described him as being "in good spirits."

Thus, Defendants did not have specific knowledge before the attack to warn Ms. Maas. Nevertheless, the courts held Defendants had a legal duty to Ms. Maas to interrogate Mr. Andrews about his homicidal ideations and warn Ms. Maas of them.

ARGUMENT

This case strikes at the heart of the treatment system the General Assembly and this Court have developed over the past several decades for treating mentally ill patients, such as Mr. Andrews. In the Commonwealth, as in other states, mental health professionals are instructed to develop individual treatment plans for each patient based on that patient's input and consent with the fewest restrictions possible

on that patient's liberty. *See* 50 P.S. § 7107. To safeguard this process, which includes whether to aid a patient's integration into society or admit a patient to a mental health facility, the law affords the providers with legal protections. *See* 50 P.S. § 7114. The Commonwealth has long prioritized the sanctity of the patient-physician relationship because a bond of trust is needed to give the patient the greatest opportunity to successfully manage his or her mental illness.

The cornerstones for that trust, namely the provider's duty to the patient and patient confidentiality, are at risk in this case. Here, Mr. Andrews had been discharged from a facility and was placed in an apartment building in an attempt to integrate him into society. He was living on his own, trying to secure a job, and attempting to become a productive member of society. He expressed homicidal and suicidal ideations several times over the few months that he was living in the apartment. As this Court has fully appreciated, mental health patients such as Mr. Andrews regularly voice such thoughts but "few of which are acted upon." *Emerich v. Philadelphia Ctr. for Human Dev., Inc.*, 554 Pa. 209, 226, 720 A.2d 1032, 1040-41 (1998). The Court explained that a mental health professional should not disclose these ideations because doing so would "vitiate the therapists' efforts to build a trusting relationship necessary for progress." *Id.* The Court appreciated that, as a general matter, if a patient's conditions and ideations are broadcast to others, patients would be ostracized from the very communities they are seeking to join.

In *Emerich*, this Court provided a highly circumscribed situation in which this patient-physician bond can be broken to protect others: only when the danger to that other person is immediate, known and potentially lethal, and the target has been identified or is readily identifiable. 554 Pa. at 231-32, 70 A.2d at 1042-43. This Court joined others around the country in stating the clarity of these standards are critical for ensuring that mental health care providers put their patient's needs first and are not driven to impose greater restrictions on the mentally ill to protect themselves from liability in cases such as this one. *See id.*; *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976). Here, Ms. Maas's death is a tragedy; neither she nor her mother deserved this fate. But, the questions before this Court are of liability and the system the Commonwealth put in place to treat people like Mr. Andrews.

As Defendants explain, the lower courts have acknowledged the *Emerich* standards were not met here. Mr. Andrews never expressed specific, immediate homicidal ideations with respect to Ms. Maas or any identifiable person. To create liability here, the Superior Court blurred and lowered these standards. It held that mental health professionals have a duty to third parties to assess the severity of a patient's general homicidal ideations, interrogate the patient to determine whether he or she has the intent and plan to carry them out and if the target is a specific person or a person in an identifiable group, and warn anyone who may be in that identifiable

group. Further, although Mr. Andrews included a "neighbor" among his ideations, one's neighborhood is not sufficiently identifiable for issuing such a warning.

For these reasons, as further detailed below, *amici* urge the Court to overturn the Superior Court's ruling in this case. Allowing liability here would fundamentally change the legal framework for treating mentally ill patients. Managing a person's re-entry into society is delicate and risky, and mental health professionals should not impede that process by broadcasting a patient's condition to his or her community or issuing medically improper restrictions to protect themselves from liability.

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

For much of American history, people with mental illnesses 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.*

It was around this time that 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. The focal point of this model bill was the "psychiatrists' decision-making power on the issue of civil commitment." *Id*. at 32-33. 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 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, not through forced commitment. *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 involuntarily committed to a mental institution was a "massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), and that people with mental illnesses retain their due process rights to control their own destiny, *see O'Connor v. Donaldson*, 422 U.S. 563 (1975). Consequently, the state bears the burden of proving by clear and convincing evidence that a person is a present danger to him or herself, or others, and therefore must be involuntarily committed. *See Addington v. Texas*, 441 U.S. 418 (1979).

Otherwise, mental health care providers must 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 involuntary commitment. *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."); Justin M. Johnson & Theodore A. Stern, *Involuntary Hospitalization of Primary Care Patients*, Prim. Care Companion CNS Disord. 16.3 (2014) (Involuntary admissions should be "considered carefully and coercion used only in acute crises."). "[M]ental health treatment and services can only be effective when the consumer embraces it, not when it is coercive and involuntary." *Id.* [1]

[1] This effort to reduce involuntarily committing mental health patients worked. By the 1990s, involuntary commitments were reduced to only 30,000 people. *See* Testa & West, *supra* at 33.

Pennsylvania law now squarely emphasizes the due process rights of mentally ill patients, such as Mr. Andrews, and the need to find the least restrictive path for treating them. *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."). Mental health providers must establish a treatment plan for each patient "with cooperation, understanding and consent" of the patient, 50 P.S. § 7107, in or near the person's "own community," 55 Pa. Code § 5100.3(b). This Court and General Assembly have appreciated that key to integrating a patient into society is confidentiality; the law provides that "[p]sychologists shall safeguard the confidentiality of information about an individual that has been obtained in the course of teaching, practice or investigation." 49 Pa. Code § 41.61 (Principle 5(a)). Telling those who live around a patient of his or her mental illness and various ideations violates these codes, could cause instability, and, ultimately, incite the very behaviors that are of concern.

As this Court has also appreciated, choosing the least restrictive path and integrating mentally ill individuals such as Mr. Andrews into society is not without risk. In *Emerich*, the Court acknowledged that, even as out-patients, mentally ill individuals often have homicidal and suicidal ideations. *See* 554 Pa. at 226, 720 A.2d at 1040. These ideations do not automatically trigger warnings to potentially affected communities and/or involuntary commitment to a facility. As the state ethics code

states, homicidal ideations can be revealed only "when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities." 49 Pa. Code § 41.61 (Principle 5(b)(1)). Disclosure to a potential victim, such as Ms. Maas, is allowed only when the patient "has expressed a serious threat or intent to kill or seriously injure an identified or readily identifiable person or group of people and when the psychologist determines that the client is likely to carry out the threat of intent." *Id.*

Further, before issuing any alerts, mental health providers are supposed to "validate the clinical impression that the threat or intent of harm is likely to be carried out." *Id.* Without these rules, individuals such as Mr. Andrews would never be able to function in society, and there would be a return to mass involuntary confinement.

II. THE SUPERIOR COURT'S RULING TO LOWER LIABILITY STANDARDS WOULD IMPROPERLY INTERFERE WITH THE COMMONWEALTH'S WELL-CRAFTED REGULATORY REGIME

Given the risks of seeking the least restrictive means for treating mentally ill patients, the Commonwealth has given mental health care providers strong liability protections for their patients' acts. Providers making determinations as to whether a patient should be integrated into society, involuntarily admitted to a mental health facility, or coached to accept placement in a particular facility "shall not be civilly or criminally liable for such decision or for any of its consequences." 50 P.S. § 7114. Further, when a patient is living within society, as with Mr. Andrews, the Court does

not "require a mental health professional 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.

In *Emerich*, the Court followed the trend started by the Supreme Court of California that a therapist has a duty to warn a third party of a patient's dangerous propensities only when there is an immediate, known and serious risk of potential lethal harm to that person. *See Tarasoff,* 551 P.2d at 340. The patient must express a specific, imminent threat of serious bodily injury to someone who is identified or identifiable. The therapist must believe the patient has the intent and plan to commit the harm. And, warning the potential victim must be practical and effective. *Emerich*, 554 Pa. at 224-26, 720 A.2d at 1039-40. The Court cautioned that such circumstances "are extremely limited." *Id.* They do not include the "vague and imprecise threats [that] are made by an agitated patient as a routine part" of his or her care. *Id.* "[O]nly in those situations in which a specific and immediate threat is communicated can a duty to warn be recognized." *Id.* This standard has provided mental health providers in Pennsylvania and other states with clear guidance.

Because Mr. Andrews never communicated an immediate threat to anyone, including Ms. Maas, the Superior Court now suggests new standards for liability, namely whenever the patient's vague imprecise threats "escalated in frequency and specificity over time." Further, in such situations, the Superior Court seeks to force

the therapist to interrogate the patient to determine if he or she has the intent and plan to carry out his or her ideations and, if so, against whom. Such a duty contradicts this Court's acknowledgement in *Emerich* that "the nature of therapy encourages patients to profess threats of violence," 554 Pa. at 226, 720 A.2d at 1040, and the ethical obligation discussed above to be cautious and seek validation that such a situation has arisen. Further, this approach provides no clarity for when the duty to the potential victim arises. Here, at which point should it have been clear to Defendants that their duty shifted from treating Mr. Andrews to warning Ms. Maas?

Such a sliding scale for shifting loyalties exemplifies the concern the Court expressed in *Seebold v. Prison Health Servs., Inc.* against the liability standard being a "moving target." 618 Pa. 632, 657, 57 A.3d 1232, 1248 (2012). Other lower courts have embraced this Court's direction, concluding that allowing recovery against mental health providers "for harms caused by their patients except in the clearest of circumstances . . . would paralyze a sector of society that performs a valuable service to those in need of mental health care." *F.D.P. v. Ferrara*, 804 A.2d 1221, 1232 (Pa. Super. Ct. 2002). Further, as Defendants point out, the concept of a neighbor or neighborhood is highly amorphous. The Superior Court observed that there were only twenty people who live on the same apartment building floor, but this focus on that floor is driven by the hindsight knowledge that Ms. Maas lived there. If she lived

one floor above Mr. Andrews, would they argue that notification should have extended to those neighbors too? What if she lived in a neighboring building?

The truth is that Mr. Andrews' vague and imprecise ideations can turn into a specific and immediate threat to Ms. Maas only through the lens of hindsight. This Court must guard against any tendency to judge psychiatric decisions through hindsight or positive outcome bias: because Mr. Andrews killed Ms. Maas, the decision not to warn Ms. Maas in light of his various ideations must have been wrong. *See Kortus v. Jensen*, 237 N.W.2d 845, 851 (Neb. 1976) (providing initial research into hindsight biases in medical malpractices cases). "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)." 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) (observing the difficulty of obtaining a fair trial or disqualifying an opposing expert who will testify that he or she would have reached a different conclusion.). "The hindsight bias has particularly detrimental effects in the domain of medical decision making," such as the one at bar, that involve "important, highly consequential situations." Hal R. Arkes, *The Consequences of Hindsight Bias in Medical Decision Making*, 22(5) Curr. Directions in Psych. Sci. 356, 359 (2013).

If the providers here were concerned about such hindsight liability, the safest choice would have been forcibly admit Mr. Andrews into a mental health facility and not allow him an opportunity to integrate into society. As indicated, they would have been provided complete immunity from liability for doing so. *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"); David Starrett, M.D. et al, *Involuntary Commitment To Outpatient Treatment,* Am. Psych. Ass'n 26 (1987) (noting immunity is essential to providing providers the ability to treat patients with plans outside of involuntary in-patient holds); *cf. Gilhuly v. Dockery*, 615 S.E.2d 237, 239 (Ga. Ct. App. 2005) (Third party liability "forc[es] the physician to weigh the welfare of unknown persons against the welfare of his patient.").

However, the mental health professionals determined that Mr. Andrews no longer fit the criteria for such confinement, and there is no evidence that the providers here chose an outpatient care plan for Mr. Andrews for any reason other than their sincere assessment of their obligations under the law and what they thought best for him. Outside influencers, including liability, relatives, and insurers, 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."). At the time in question, they were in discussions with Mr. Andrews about moving him to an out-patient facility, but he wanted to live on his own or move into a specific facility.

Thus, in order to give effect to the legislature's decision to protect the rights of mentally ill individuals to self-determination, mental health providers must be given liability protections absent the clear circumstances specified in *Emerich*. Otherwise, providers will be incentivized to curtail patients' personal liberties or may choose not to work with patients who have homicidal or suicidal ideations.

III. INCENTIVIZING MENTAL HEALTH PROFESSIONALS TO PUT LIABILITY OVER PATIENT CARE WILL REDUCE OVERALL SAFETY

In addition to the legal arguments above, it also is in the best health care interest of patients, and ultimately the public, that mental health patients have a sense of self-determination in their treatment plans. Studies have shown that forcing treatment plans on patients could have long-term negative effects, as patients in Mr. Andrews' situation will refuse help out of fear of losing their civil rights. *See*, *e.g.*, Dinah Miller, M.D. & Annette Hanson, M.D., *Committed: The Battle over Involuntary Psychiatric Care* xviii (1st ed. 2016). In one survey, 77 percent of previously admitted patients will not take the risk of being institutionalized again, even if they know they pose a danger to themselves or others. *See id*.; *see also*

Johnson & Stern, *supra* (explaining that involuntary institutionalization makes them feel stigmatized and ostracized).

By contrast, patients report being most receptive to receiving the care they need when the therapist develops a "climate of trust, genuine interest, and understanding." *Id.* Critical to this trust is allowing the patient "to acknowledge a desire for help, and increase patient involvement and personal responsibility for his disease." Roberts, *supra*, at 7. Imposing liability and conflicting legal obligations into these situations would chill this process, exacerbate challenges in treating mental illness, and impede the substantial progress made to raise mental health awareness and encourage people to seek treatment.

Further, the "United States is suffering from a dramatic shortage of psychiatrists and other mental health providers." Stacy Weiner, *Addressing the Escalating Psychiatrist Shortage*, Ass'n of Am. Med. Colleges, Feb. 13, 2018 (stating "the shortfall is particularly dire in rural regions, many urban neighborhoods, and community mental health centers that often treat the most severe mental illnesses").[2] 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] Also, a 2017 report prepared for the

[2]https://news.aamc.org/patient-care/article/addressing-escalating-psychiatrist-shortage/.

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

National Council for Behavioral Healthcare estimates that demand for psychiatrists may outstrip supply by more than 15,000 psychiatrists by 2025. *See* Nat'l Council Med. Dir. Inst., *The Psychiatric Shortage: Causes and Solutions* 15 (Mar. 2017).[4]

This crisis is being felt here in Pennsylvania. More than 4.6 percent of the Commonwealth's 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.[5] Additionally, the Pennsylvania Department of Health has reported that 24 counties are Designated Health Professional Shortage Areas (HPSAs) for mental health providers, with 22 of the counties considered in high need. *See* Designated Mental Health Care Health Professional Shortage Areas, Pa. Dep't of Health (Sept. 2018).[6] Most of these counties are rural.

Expanding the scope of liability of mental health professionals would create an additional strain on this system by increasing the costs of patient care and causing some mental health professionals to relocate to places that have more effective medical negligence laws. Here, creating liability may result in compensation to Ms.

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[4]https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf.

[5]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

[6]https://www.health.pa.gov/topics/Documents/Health%20Planning/Designated%20Mental%20Health%20HPSAs%20List.pdf

Maas's family, but it will not lead to a safer community or better mental health care. It would have the opposite effect, putting more patients and others at greater risk.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Honorable Court reverse the Order of the Superior Court entered June 29, 2018.

Sincerely,

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April 24, 2019

CERTIFICATION 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).

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PROOF OF SERVICE

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 24th day of April 2019.

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