[J-21-2020]
IN THE SUPREME COURT OF PENNSYLVANIA
WESTERN DISTRICT

SAYLOR, C.J., BAER, TODD, DONOHUE, DOUGHERTY, WECHT, MUNDY, JJ.

KATHRYN F. LEIGHT AND JOHN L. LEIGHT, HER HUSBAND,	:	No. 35 WAP 2019
Appellants	:	Appeal from the Order of the Superior Court entered December 31, 2018 at No. 1912 WDA 2017, affirming the Order of the Court of
v.	:	Common Pleas of Allegheny County entered December 15, 2017 at No. GD12-9942.
UNIVERSITY OF PITTSBURGH PHYSICIANS, UPMC, UNIVERSITY OF PITTSBURGH OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION, SUSAN SHICK, AND PHILLIP L. CLARK, ADMINISTRATOR OF THE ESTATE OF JOHN F. SHICK, DECEASED,	:	ARGUED: May 19, 2020
Appellees	:	

OPINION

JUSTICE TODD **DECIDED: DECEMBER 22, 2020**

In this discretionary appeal, we consider the viability of a cause of action by a third party against, *inter alia*, physicians under the Mental Health Procedure Act ("MHPA" or "Act").[1] For the reasons explained below, we find that physicians are not liable under the MHPA for considering, but not formalizing the prerequisites for, an involuntary emergency examination. Accordingly, we affirm the order of the Superior Court.

[1] 50 P.S. §§ 7101-7503.

This appeal arises from a tragic shooting incident on March 8, 2012, wherein John F. Shick, a 30-year-old adult, living independently, killed one person and injured several others at Western Psychiatric Institute and Clinic ("WPIC") in Pittsburgh. The injured persons included WPIC receptionist, Appellant Kathryn Leight. Subsequently, Ms. Leight and her husband John Leight (collectively, "Appellants"), filed a complaint against various defendants as described *infra*.

By way of background, the General Assembly enacted the MHPA in 1976. The purpose of the MHPA is to establish procedures to effectuate the Act's policy — assuring the availability of adequate treatment to those who are mentally ill. 50 P.S. § 7102. The legislature, through the MHPA, and in conformity with principles of due process, sought to assure the availability of voluntary and involuntary treatment "where the need is great and its absence could result in serious harm to the mentally ill person or to others." *Id*. Indeed, treatment under the MHPA can be broadly conceptualized as two types, voluntary and involuntary. The General Assembly stressed that treatment on a voluntary basis is preferable to involuntary treatment, and, in all instances, the least restrictive approach consistent with adequate treatment should be utilized. *Id*. Critical to the resolution of the instant appeal, and as discussed below in greater detail, the scope of the MHPA is limited, as it establishes rights and procedures only for the involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for the voluntary inpatient treatment of mentally ill persons. Thus, the voluntary treatment of outpatients falls outside the scope of the MHPA.

In furtherance of the policy of the MHPA, the General Assembly also provided limited immunity for certain individuals providing care to the mentally ill. Specifically, 50 P.S. § 7114 protects from civil and criminal liability those individuals and institutions that provide treatment to mentally ill patients, and, thus, promotes the statutory goal of

ensuring such treatment remains available. *Dean v. Bowling Green-Brandywine*, 225 A.3d 859, 869 (Pa. 2020). This immunity protection, however, does not insulate individuals from liability for acts of willful misconduct or gross negligence. 50 P.S. § 7114.

Generally speaking, a medical professional has no duty under the common law to control the conduct of a patient or warn or protect a third party from a threat by a patient in his or her care, except under certain limited circumstances. *See generally Maas v. UPMC Presbyterian Shadyside*, ___ A.3d ___, 2020 WL 4106611 (Pa. filed July 21, 2020); *Emerich v. Philadelphia Center for Human Development, Inc.*, 720 A.2d 1032 (Pa. 1998). However, in tort cases, a duty may be imposed, not only by the common law, but also through statute. Based upon Section 114, our Court has found an affirmative duty exists under the MHPA which requires mental health professionals and institutions to avoid willful misconduct or gross negligence in the treatment of mental health patients, and imposes civil liability for a breach of that duty. *Goryeb v. Commonwealth, Department of Public Welfare*, 575 A.2d 545, 548-49 (Pa. 1990) (finding a party participating in a decision to examine, treat, or discharge a mentally ill patient under the MHPA who commits willful misconduct or gross negligence can be liable for such decision or for any of its consequences); *see also Sherk v. Dauphin*, 614 A.2d 226, 232 (Pa. 1992) (plurality).

Finally, as this appeal arises in the context of preliminary objections, as explained below in greater detail, we must accept the allegations contained in the complaint, as amended, to understand the circumstances giving rise to this appeal and to analyze Appellants' claims under the MHPA. With this background, we consider the appeal *sub judice*.

In their complaint, Appellants asserted, in relevant part, that Shick began experiencing behavior that suggested he was suffering from severe mental illness in February 2005, when Shick, then 24 years old, was residing in New York City. He was

involuntarily committed and released on multiple occasions, with his final release while living in New York in June 2008. Thereafter, in April 2009, Shick was admitted to the chemistry program at Portland State University in Oregon as a doctoral student and graduate teaching assistant for the fall 2009 semester, and moved to Portland. While in Oregon, Shick was involuntarily committed in December 2009, and ultimately released in May 2010. He was expelled from the University.

In March 2011, Shick was accepted into Duquesne University's doctoral program in the Department of Biological Sciences in Pittsburgh, and was granted a graduate teaching assistantship. Approximately three months later, in June 2011, Shick established a patient-primary care physician relationship with University of Pittsburgh Physicians ("UPP"), and, specifically, with UPP doctors at University of Pittsburgh Medical Center's ("UPMC") Shadyside Family Health Center ("Shadyside Family"). Shick provided Shadyside Family with authorizations to obtain his prior treatment records, which revealed he had suffered from severe mental illness. At Shadyside Family, Shick initially complained to Dr. Thomas Weiner of neck and ankle pain, elevated cholesterol, and depression, for which Dr. Weiner prescribed, *inter alia*, physical therapy. Thus began an ongoing series of visits through the fall of 2011, during which Shick asserted various ailments – including headaches; neck, shoulder, chest, back, and ankle pain; belching; vomiting; and depression – for which Dr. Weiner prescribed a number of tests, treatments, and remedies.

On October 21, 2011, Dr. Weiner first recorded his impression that Shick's complaints of pain might be due to mental illness, that another psychiatric diagnosis besides depression was very likely, and that he may benefit from a psychiatric referral at some point. On November 4, 2011, Shadyside Family staff set up an appointment for Shick to be evaluated by WPIC personnel. Five days later, on November 9, 2011, Shick

underwent a psychiatric diagnostic evaluation by a WPIC licensed clinical social worker. At the evaluation, Shick denied prior psychiatric treatment and denied his prior history of psychiatric symptoms, but explained that a psychologist friend had told him that he was bipolar and acknowledged that he had been discharged from the doctoral program at Duquesne as the result of harassment charges due to his unacceptable interactions with women.

After various interactions with medical personnel at Shadyside Family, and a referral for Shick to visit the UPMC gastrointestinal clinic, on November 26, 2011, Dr. Weiner called and spoke with Shick to advise him of abnormal blood work, and noticed Shick's "pressured speech." Appellants' Second Amended Complaint at ¶ 204. As a result, Dr. Weiner encouraged him to be treated by a psychiatrist, which, at that time, Shick rejected. Two days later, however, on November 28, 2011, Shick underwent the recommended evaluation by UPP psychiatrist Jatinder Babbar, M.D., at WPIC. At the evaluation, Shick denied prior psychiatric treatment, avoided questions, exhibited disorganized thinking, and denied suicidal or homicidal ideations. Dr. Babbar called Shick's mother, Susan Shick, who advised the physician that Shick had five prior psychiatric admissions, including the admission in Portland in 2010. As, according to Shick's mother, the medication Abilify and individual psychiatric therapy had been effective in the past, Dr. Babbar strongly encouraged Shick to start that medication and begin therapy, which Shick refused to do. At that time, Dr. Babbar diagnosed Shick as schizophrenic and noncompliant with his medications.

On November 29, 2011, Dr. Weiner sent an email to UPP psychiatrist Stephanie Richards, M.D., who was on the staff of Shadyside Family, explaining his observations regarding Shick's behavior. After visits to various gastroenterology physicians, on December 23, 2011, Shick was seen by Dr. Weiner about his elevated potassium level.

Shick stated his belief that he had the ability to control his own potassium level. Shick also complained of regular severe headaches and pain, which he was unable to characterize. Shick then accused Dr. Weiner of "being like his mother" in asking about the pain, and said he could articulate his pain only in essay form, which he would provide to Dr. Weiner in February, for Dr. Weiner to edit. Appellants' Second Amended Complaint at ¶ 226. Dr. Weiner recommended that Shick begin taking anti-psychotic medication, and Shick responded in a grandiose and dismissive fashion. Dr. Weiner recognized that the physical pain complaints were "most likely" psychosomatic due to Shick's schizophrenia, and then referred him to Dr. Richards, and again recommended anti-psychotic medications, which Shick refused, while continuing to deny his schizophrenia and prior treatment for it. Appellants' Second Amended Complaint at ¶ 228.

On January 25, 2012, Shick was first evaluated by UPP primary care physician Dr. James Jarvis, of Stull, Jarvis and Spinola Internal Medicine Associates-UPMC. Shick complained of ankle pain, two ischemic strokes, diabetes, pancreatic and liver diseases and peptic ulcer disease, indicated his belief that Simvastatin provided him pain relief, and requested a prescription for the pain treatment drug Tramadol. Dr. Jarvis, after checking his chart, recognized that Shick's overriding issue was clearly psychiatric in nature, and refused to treat him, referring him to the doctors who had already ordered numerous tests. After Shick refused to undergo a prescribed CT scan, Dr. Weiner noted that Shick was "floridly psychotic," but, ultimately, Dr. Weiner did "not think [Shick] meets criteria for [involuntary commitment] but [was going to discuss the matter with a psychiatrist, and that Shick] believes he suffered an 'ischemic stroke' and this was due to inadequate statin dose." Appellants' Second Amended Complaint at ¶ 276.

Thereafter, Shick was treated by Dr. Ya'aqov Abrams from Squirrel Hill Family Health Center with complaints of vomiting and abdominal pain, and requested specific

testing for treatment of his self-diagnosed pancreatitis and diabetes. Dr. Abrams, using an authorization executed by Shick and information provided by him, had available for review copies of Shick's prior medical records from a Portland physician, Dr. Iverson, which reflected a diagnosis of depression. Thereafter, Shick began a series of visits to the UPMC Presbyterian Hospital emergency department and to various physicians, complaining of numerous physical ailments. On February 8, 2012, Shick returned to see Dr. Abrams with complaints of diabetes and demanding certain medication. Dr. Abrams explained that his lab results did not confirm Shick's suspicion of diabetes, and, instead, suggested Shick see a psychiatrist, and offered him a referral. Shick became angry and left the office.

The next day, February 9, 2012, Shick returned to Shadyside Family to see Dr. Jason Kirby, demanding testing. Dr. Kirby's impression was that Shick was acutely psychotic and delusional, noting that he refused psychological evaluation or medications, but that he should be monitored for possible commitment. Dr. Kirby spoke with Shadyside Family's director, UPP family practitioner Gregory Gallick, D.O., who, in turn, spoke with Philip Phelps, UPMC's Director of Behavioral Science curriculum, about involuntary mental health evaluation, treatment, and commitment; Phelps advised Dr. Gallick that Shick was not a candidate.

The next day, February 10, Shick appeared at Shadyside Family to have blood drawn for testing, and brandished a baseball bat in a threatening manner, upsetting a nurse. Dr. Weiner contacted resolve Crisis Services ("resolve") a mental health crisis intervention service, advised resolve's Jeffery McFadden that Shick had come into Shadyside Family that morning brandishing a baseball bat, and was becoming increasingly psychotic and intimidating during recent visits, including one episode in which Shick was removed from the practice by UPMC security. McFadden dispatched a mobile

team from resolve to take Shick to WPIC for a mental health wellness check and possible commitment. The mobile team went to Shick's home and attempted to assess him, but he refused, advising that they were not welcome and shutting the door to his apartment.

On February 17, 2012, at 11:35 a.m., Dr. Weiner called resolve and spoke with clinician Nedra Williams, asking to have involuntary commitment papers for Shick faxed to him. The clinician informed Dr. Weiner that WPIC does not fax involuntary commitment papers, and suggested that Dr. Weiner go to WPIC to fill out the forms. An hour later, one of the Shadyside Family staff members called and spoke with resolve clinician Amanda Dunmire, requesting information on the involuntary commitment process, and how a doctor would complete an involuntary commitment form – that information was provided.

On February 20, 2012, Shick was evaluated by UPP orthopedic foot and ankle surgeon Dr. Victor Prisk. Shick admitted to depression but denied any other psychiatric problems, but, curiously, wrote the word "green" on his intake sheet. Appellants' Second Amended Complaint at ¶ 331. Upon examination and review of Shick's medical records, Dr. Prisk recognized that Shick had uncontrolled schizophrenia and needed psychiatric care. Dr. Prisk made an effort to contact personnel he referred to as "the case managers" for psychiatric help, but noted they were unable to come. Appellant's Second Amended Complaint at ¶ 333.

Later that same day, Dr. Kirby spoke with resolve clinician Valerie Krieger, seeking assistance in having Shick involuntarily committed. However, Dr. Kirby never attempted to file a commitment petition. One week later, on Tuesday, February 28, Dr. Kirby sent Shick a letter on behalf of Shadyside Family notifying him that the practice would no longer provide medical care to him, effective 30 days from that date. On March 7, 2012, Shick called for and received emergency care at his residence for shortness of breath,

vomiting blood, and parasites in his intestines and eyes. Shick was taken to UPMC Presbyterian Hospital's emergency department, where he repeated that history, demanded pain medication, refused to discuss his medications with the examining physicians, and left.

The next day, March 8, 2012, Shick went to WPIC. He brought with him loaded Makarov and Beretta 9mm semiautomatic handguns and extra ammunition he had purchased a year earlier. In the WPIC lobby, he shot and injured Ms. Leight, who was seated at the receptionist's desk, and shot several other people, killing one of them, before he was shot and killed by an armed University of Pittsburgh ("Pitt") police officer stationed nearby. Ms. Leight suffered gunshot wounds, resulting in internal injuries, including a pneumothorax, and respiratory failure, as well as severe post-traumatic stress disorder.

Based on these incidents, Appellants filed a complaint in the Allegheny County Court of Common Pleas against Phillip L. Clark, Administrator of the Estate of John Shick, UPP, Pitt, UPMC, and Susan Shick. Relevant to this appeal, Appellants alleged claims against UPP and Pitt (collectively, "Appellees") for the failure of Appellees' physicians to begin the commitment process. Notably, Appellants did not assert common law negligence; rather, they asserted only a claim under the MHPA for Appellees' alleged gross negligence in "participat[ing] in a decision that a person be examined or treated under this act." 50 P.S. § 7114.

Thereafter, Appellees filed preliminary objections, alleging that, under the MHPA there was no duty to warn or protect Appellant Kathryn Leight and no duty owed to her.[2]

[2] UPMC, Clark, administrator of the Shick estate, and Susan Shick were ultimately dismissed from the case in prior orders. Thus, the current appeal involves only UPP and Pitt.

Following a hearing, Judge R. Stanton Wettick, Jr. of the Allegheny County Court of Common Pleas entered an order sustaining in part and overruling in part the preliminary objections. Significant for our purposes, the trial court dismissed Appellants' MHPA claims, concluding, *inter alia*, that the MHPA does not apply to Shick, who was being treated on a voluntary outpatient basis.

Specifically, before the trial court, Appellants argued that, from the observations expressed by the physicians employed by Appellees, the physicians knew or should have known that Shick was severely mentally ill and in need of immediate treatment; yet, none of them took any steps to have Shick involuntarily examined and committed. That is, Appellants alleged that the physicians breached a duty of care owed to Shick and members of the public by their failure to begin the commitment process by submitting a written application for immediate involuntary examination and treatment to the county administrator pursuant to 50 P.S. § 7302. The trial court determined that Appellants' claims were governed by 50 P.S. § 7114, which imposes liability for willful misconduct or gross negligence in decision-making regarding, *inter alia*, the examination or treatment of a mentally ill individual. The trial court then turned to 50 P.S. § 7103, which pertains to the scope of the MHPA, and which establishes rights and procedures for all involuntary treatment for mentally ill persons, whether inpatient or outpatient, and voluntary inpatient treatment of mentally ill persons. The trial court concluded that the MHPA does not apply to the alleged negligence of health care workers who provide voluntary outpatient treatment, and, thus, did not apply to Shick's situation, citing, *inter alia*, *DeJesus v. United States of America Dept. of Veterans*, 479 F.3d 271 (3d Cir. 2007) (determining that the MHPA does not apply to voluntary outpatient treatment), and *McKenna v. Mooney*, 565

A.2d 495 (Pa. Super. 1989) (finding, in wrongful death and survival actions, that a psychiatrist's actions fell outside the MHPA because he provided only voluntary outpatient treatment).

Additionally, the trial court found that Section 7114(a) does not apply to the physicians who never sought an emergency examination or emergency treatment because these physicians were not participating in a decision that Shick be examined or treated. According to the trial court, because the physicians never initiated the process for seeking an involuntary emergency examination, no decision was ever made as to whether Shick should have been involuntarily examined and received involuntary treatment. Based upon Sections 7103, 7114, and 7302, the trial court reasoned that, since the alleged gross negligence involved *voluntary outpatient treatment*, all of Shick's treatment fell outside the scope of the MHPA; thus, it sustained Appellees' preliminary objections.[3]

On appeal, a unanimous three-judge panel of the Superior Court affirmed the dismissal of all of Appellants' MHPA claims. *Leight v. University of Pittsburgh Physicians et al.*, 202 A.3d 103 (Pa. Super. 2018). Writing for the court, Judge John L. Musmanno concluded that based upon a plain reading of the MHPA, the statute applies to the type of treatment set forth in Section 103, which does not include voluntary outpatient care. The court noted that Shick had received only voluntary treatment and, although various

[3] After Appellants sought clarification and certification to immediately appeal the trial court's order, the court amended its order, dismissed all claims, except for the premises liability claims against Pitt, and denied the motion for certification. The parties then engaged in discovery regarding ownership and control of security at WPIC. Thereafter, Appellants filed a motion to discontinue the remaining claims against Pitt and UPMC so that they could appeal the dismissal of the MHPA claims. The trial court granted the motion.

physicians had considered involuntary treatment, no application under Section 302 was filed and no decision was made as to a course of treatment. Relevantly, the court found that "the mere thought or consideration of initiating an involuntary examination during voluntary outpatient treatment" was not encompassed by the express scope of the MHPA, and did not qualify as involuntary care. *Leight*, 202 A.3d at 117 (citing *Fogg v. Paoli Mem'l Hosp.*, 686 A.2d 1355 (Pa. Super. 1996) (providing that where patient presented himself for treatment at emergency room, but was not examined or treated by anyone in the field of mental health, and no decision regarding his treatment was made, the hospital's action did not fall within the MHPA). Accordingly, the court concluded that Appellants could not sustain a viable cause of action under the MHPA, and that the trial court properly granted Appellees' preliminary objections.

Appellants filed a petition for allowance of appeal, which we granted. The issue to be considered, as stated by Appellants is:

> Under the Mental Health Procedures Act, 50 P.S. § 7101, et seq., as interpreted by this Court in *Goryeb v. Com. Dept. of Public Welfare*, 575 A.2d 545 (Pa. 1990), can physicians who recognize that their patient is severely mentally ill and a clear and present danger to others, decide that he requires emergency involuntary examination under Section 302 of the Act, take affirmative steps to cause the examination to occur, but then grossly negligently fail to complete the process, be liable for injuries caused when their dangerous, mentally ill patient then engages in a mass shooting?

Leight v. University of Pittsburgh Physicians, 217 A.3d 791 (Pa. 2019) (order). Our analysis involves a question of statutory interpretation, which is a pure question of law. Thus, our standard of review is *de novo,* and our scope of review is plenary. *Buffalo Township v. Jones*, 813 A.2d 659, 664 n.4 (Pa. 2002). Moreover, as we are considering an order of the trial court sustaining preliminary objections in the nature of a demurrer,

the question is whether, on the facts averred, there is no basis for recovery under the law. *Dittman v. UPMC*, 196 A.3d 1036, 1043-44 (Pa. 2018). Any doubts as to whether the demurrer should be sustained should be resolved in favor of reversing the order. Finally, the Court must accept as true all material facts as set forth in the complaint, and any inferences reasonably deducible therefrom. *Id*.

Appellants first argue that the lower courts erred in finding that the absence of "voluntary outpatient" treatment in the MHPA's scope language in Section 103 indicated that physicians providing voluntary outpatient medical treatment were not liable for their grossly negligent involuntary examination decisions. 50 P.S. § 7103. Appellants assert that the lower courts' interpretation of Section 103's language regarding the scope of the MHPA overrode the specific delineations of duty and liability in Sections 302 and 114. 50 P.S. §§ 7302, 7114. Specifically, Appellants observe that an "involuntary emergency mental health examination" under Section 302 gives physicians and other enumerated professionals the right to effectuate an emergency involuntary examination, for potential commitment and treatment, of severely mentally ill individuals who are a clear and present danger to themselves or others. *See* 50 P.S. § 7302. Thus, Appellants contend such examinations constitute involuntary treatment under the MHPA. Appellants further point to Section 114, which, as noted above, establishes limited civil immunity for physicians and others engaging in involuntary examination decisions, in the absence of willful misconduct or gross negligence. According to Appellants, this Court interpreted the interaction between these provisions in *Goryeb*, *supra*. Appellants submit that, under *Goryeb*, when an individual participates in a decision that a person be examined, committed, treated, or discharged pursuant to the MHPA, that individual shall be liable for

injuries to third parties if they commit willful misconduct or gross negligence in making such decision. *Goryeb*, 575 A.2d at 548-49; *see also Sherk*, 614 A.2d at 232.

Appellants stress that, because an involuntary emergency medical health examination is, by definition, involuntary under the MHPA, a failure to act with regard to such examinations falls within the scope of Section 103, and involuntary mental health examinations cannot be transformed into voluntary outpatient treatment. This, according to Appellants, is why the trial court's reasoning that a physician providing outpatient medical treatment cannot be liable under the MHPA is flawed.

Appellants then discuss numerous decisions, asserting that none of them supports the proposition that a physician providing outpatient medical treatment cannot be liable for the consequences of their grossly negligent decisions regarding the involuntary mental health examinations of their patients. Appellants thus maintain that, consistent with the clear and unambiguous language of the MHPA, a physician should be held accountable for their determination of whether a mentally ill person should be involuntarily examined, and that such decision-making is within the scope of the Act.

Appellants also refute the lower tribunals' reasoning that, because the physicians never initiated the process for seeking an emergency examination – that is, never signed a commitment petition document – no decision was ever made as to whether Shick should be involuntarily examined. Here, Appellants assert that the physicians were grossly negligent in initially determining that Shick should be involuntarily examined for potential commitment and treatment, but then failing to file an application for an evaluation under Section 302. Moreover, because the case was not allowed to proceed to discovery, Appellants argue that it could not be determined whether Dr. Weiner's call to "resolve" to

involuntarily commit Shick would have met the certification standard under Section 302. Thus, Appellants submit that it cannot reasonably be concluded that Appellees' physicians failed to participate in decisions to initiate the involuntary examination process — it is not the absence of paperwork, but the grossly negligent decision and resultant inaction that, according to Appellants, provided the basis for Section 114 liability.

Finally, Appellants point to over 20 "thoughts and considerations" regarding the initiation of an involuntary examination of Shick, which they believe establish that his involuntary commitment was not a mere passing thought or vague consideration, but that "necessary action was obvious and apparent," and, thus, Appellees were grossly negligent in failing to complete the process. Appellants' Brief at 33, 60.

Appellees counter by stressing that, as voluntary outpatient treatment is excluded from the scope of the MHPA, 50 P.S. § 103, Appellants cannot assert a cause of action under the MHPA, which expressly applies to only inpatient treatment and involuntary outpatient treatment. That is, because the alleged gross negligence asserted by Appellants never involved inpatient treatment, and during the relevant times Shick was never examined under the MHPA, all treatment was voluntary outpatient treatment, and, thus, outside of the Act.

Related thereto, Appellees contend that *Goryeb* and *Sherk*, relied upon by Appellants, are inapt, as they involved decisions to discharge patients who were already receiving involuntary inpatient care at a mental health facility, and, thus, the care provided fell within the scope of the MHPA. This, according to Appellees, is distinguishable from the matter *sub judice*, as Shick at all times was treated on a voluntary outpatient basis, and such treatment was not provided by mental health care professionals at a mental

health facility or in conjunction with mental health treatment, but for medical issues unrelated to mental health.

Appellees allege that Appellants are simply attempting to bring their action within the scope of the MHPA based upon Shick's physicians' failure to take steps to have Shick involuntarily committed under the MHPA – that is, according to Appellants, the doctors' discussion of initiating the procedure for involuntary commitment renders their claims within the MHPA. Appellees assert that this cannot be tantamount to participation in involuntary mental health examination decisions. Indeed, Appellees stress that voluntary outpatient care cannot become involuntary without a court order. 50 P.S. §§ 304, 305.

Appellees maintain that, with respect to an involuntary emergency examination, a decision is not made under the MHPA until an application, warrant, or certification is filed under Section 302. Appellees submit that preliminary assessment of an outpatient's potential need for involuntary commitment – which would include the failure to begin the involuntary commitment process by completing the forms necessary to commence an involuntary mental health examination – does not fall under the MHPA, and thus does not support a cause of action thereunder. Specifically, Appellees stress that Section 114 of the MHPA was intended to expand availability of mental health treatment by immunizing from criminal and civil liability medical providers who assist in and facilitate such care. While an individual or institution may be liable under Section 114 to third parties harmed by a patient when that individual or institution was grossly negligent in examining a patient, treating a patient, discharging a patient, or committing a patient, Appellees contend that, absent such acts, Section 114 liability is not triggered.

According to Appellees, liability for a "decision" that a person be examined or treated under Section 114 refers to the act of *initiating* the commitment process through one of the formal written procedures, as well as to subsequent inpatient treatment decisions. Appellees emphasize such decision-making is not merely a "state of mind, nor a thought or consideration," nor "an intention to take action at a later time," but requires performing the written procedures enumerated in the statute to bring about an involuntary examination. Appellees' Brief at 30. Specifically, Appellees point out that the MHPA delineates three methods for involuntary emergency mental health examination: (1) certification by a physician; (2) warrant by a county administrator; or (3) application by a physician, peace officer, or other person authorized by the county administrator. 50 P.S. § 7302. Thus, Appellees submit that, without a completed certification, warrant, or application, the mere *consideration* of executing authorization under the MHPA cannot constitute an involuntary examination decision. It is only after the filing of such a document that an individual becomes a participant in the examination process, triggering potential liability under Section 114. Appellees stress that these prerequisites for examination are especially important, given the resultant forcible deprivation of the individual's liberty.

Appellees assert that Appellants' highlighting of mere examination-related "thoughts" proves that Shick was never examined or treated under the MHPA. As no steps were taken to initiate an emergency mental health examination under Section 302(a), Appellees contend, the MHPA cannot apply. Indeed, Appellees suggest that it is only upon the deprivation of liberty that a cause of action arises under the MHPA.

Finally, Appellees urge that Appellants' theory, if accepted, would create a new duty inconsistent with the plain language and intent of the MHPA, and that it would conflict with public policy. Specifically, Appellees argue that recognizing a duty in the instant action would have drastic consequences for medical providers. While acknowledging the shocking and tragic events that culminated in the shooting, according to Appellees, the imposition of limitless liability on all health care providers, based upon an alleged failure to institute involuntary mental health treatment proceedings, would further burden an overtaxed profession, expose health care providers who do not practice mental health care to liability, encourage the unnecessarily restrictive treatment of patients, and deter patients from receiving therapeutic treatment.

The American Medical Association, Pennsylvania Medical Society, Pennsylvania Psychiatric Society, and Pennsylvania Coalition for Civil Justice Reform jointly filed an *amicus* brief in support of Appellees. *Amici* argue that the legal framework for treating patients with mental illnesses has been developed over several decades to balance the rights of the mentally ill with the need to protect the public, and 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." *Amici* Brief at 9 (quoting 55 Pa. Code § 5100.3(b)). *Amici* note that, to seek voluntary inpatient care, a person has to file an application seeking an examination and must provide written consent to be admitted into a program. In this case, Shick did not cooperate or consent to a voluntary examination. Furthermore, with respect to involuntary examination and treatment, no decision was made that Shick presented a clear and present danger to himself or another person, 50 P.S. § 7301(a), and the process for involuntarily committing him to inpatient treatment

was never initiated. *Amici* warn that one cannot judge involuntary treatment decisions through hindsight and that Appellants' interpretation of the MHPA would reduce overall safety, incentivize involuntary commitment, and discourage working with patients who demonstrate mental ailments.

As noted, this appeal raises a question of statutory interpretation. Thus, our interpretation of the MHPA is dictated by the Statutory Construction Act, 1 Pa.C.S. §§ 1501-1991. Our General Assembly, unlike our federal counterpart, has expressly provided direction regarding how to discern its statutory intent. Pursuant to the Statutory Construction Act, the overriding object of all statutory interpretation "is to ascertain and effectuate the intention of the General Assembly" in enacting the statute under review. 1 Pa.C.S. § 1921(a). If statutory language is "clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit." *Id*. § 1921(b). Thus, when the words of a statute have a plain and unambiguous meaning, it is this meaning which is the paramount indicator of legislative intent.

However, in situations where the words of a statute "are not explicit," the legislature's intent may be determined by considering any of the factors enumerated in Section 1921(c). *DEP v. Cumberland Coal*, 102 A.3d 962, 975 (Pa. 2014). These factors include the occasion and necessity for the statute; the object to be attained; and the consequences of a particular interpretation. 1 Pa.C.S. § 1921(c). Additionally, the General Assembly has cautioned that, in construing a statute, courts, *inter alia*, should presume that the legislature did not intend a result that is absurd, impossible of execution, or unreasonable. 1 Pa.C.S. § 1922(1).

A trio of MHPA provisions informs our analysis. Thus, we turn to consider the scope of the MHPA, the Act's immunity and cause of action provision, and the prerequisites necessary for the initiation of an involuntary emergency examination.

In determining whether Appellants have stated a cause of action under the MHPA, we begin with Section 103, which sets forth the scope of the Act. 50 P.S. § 7103. Under the plain and unambiguous language of Section 103, the MHPA applies only to inpatients and involuntary outpatients: "This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons." *Id*. Appellants do not allege that Appellees' physicians were negligent in their actual examination or treatment of Shick on an involuntary basis or a voluntary inpatient basis. As there is no suggestion that Appellees' physicians treated Shick on anything but a voluntary outpatient basis, their *treatment* actions clearly fall outside the coverage of the MHPA.

To avoid this result, however, Appellants maintain that the physicians began, but, albeit, did not complete, the statutory process for involuntary commitment. Because Appellees' physicians were allegedly grossly negligent in their failure to follow through and require that Shick be involuntarily examined, according to Appellants, Appellees' actions nonetheless fell within Section 103, and Appellees "participate[d] in a decision that a person be examined or treated" under Section 114. 50 P.S. § 7114. This, Appellants assert, supports their statutory cause of action.

As noted, Section 114 has been characterized as an immunity provision, as well as providing for a statutory cause of action, albeit by implication. It immunizes an individual who, *inter alia*, "participates in a decision that a person be examined or treated

under [the MHPA]," except for instances of willful misconduct or gross negligence. 50 P.S. § 7114(a). Thus, Section 114 protects from civil and criminal liability those parties that examine and provide treatment to mentally ill patients under the MHPA. Furthermore, by implication, Section 114 creates a cause of action upon a showing of willful misconduct or gross negligence against an individual for, *inter alia*, participating in a decision that a person be examined or treated under the MHPA:

> In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any other authorized person *who participates in a decision that a person be examined or treated under this act*, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

50 P.S. § 7114(a) (emphasis added).

Related thereto, the decision to undertake an emergency involuntary examination of an individual for involuntary commitment is governed by Section 302 of the MHPA. 50 P.S. § 7302. Specifically, one who is severely mentally ill[4] may be subjected to an

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[4] Section 301 provides that when a person is severely mentally disabled and in need of immediate treatment, he may be subjected to an involuntary emergency examination. A person is severely mentally disabled when:

> as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

50 P.S. § 7301.

involuntary emergency examination if one of three mandatory prerequisites is met: (1) certification of a physician; (2) warrant issued by the county administrator authorizing such examination; or (3) application by a physician or other authorized person who has personally observed actions indicating a need for an emergency application:

> (a) Application for Examination.--Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.
>
> > (1) Warrant for Emergency Examination.--Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

50 P.S. § 7302.

We hold, based upon the clear and unambiguous language contained in this constellation of statutory provisions, that "participat[ing] in a decision that a person be examined" under the MHPA is achieved for purposes of Section 114 *only* after one of the prerequisites set forth in Section 302 for an involuntary emergency examination is satisfied. The requirements of Section 302 are exclusive, clear, and unequivocal. Physicians who never invoke a necessary requirement for involuntary emergency examination are not, for purposes of Section 114, participating in a decision that a person be examined. It is only when a physician files the required documentation for involuntary emergency examination that he becomes a participant in the decision-making process under the Act.

In addition to the manifest requirements of Section 302, this conclusion is supported by the later phrase in Section 1114 which grants immunity to those "who den[y] an application for voluntary treatment or for involuntary emergency examination and treatment." 50 P.S. § 7114. Clearly, an application cannot be denied until it is first formally made.

Actions by a physician in an outpatient setting that fall short of satisfying these mandatory requirements do not transform voluntary outpatient treatment into involuntary treatment. 50 P.S. § 7103; *see DeJesus*, *supra* (determining that the MHPA does not apply to voluntary outpatient treatment); *Fogg*, 686 A.2d at 1358 (noting that while a patient presented himself for treatment at an emergency room, he was not examined or treated by anyone in the field of mental health, and, thus, the hospital had not been "treating" the patient for his mental illness, the hospital's actions did not fall under Section 114).

Furthermore, our holding is buttressed by the presumption that, in construing a statute, we must presume that the legislature did not intend a result that is absurd, impossible of execution, or unreasonable. 1 Pa.C.S. § 1922(1). In our view, if we interpreted the phrase "participat[ing] in a decision that a person be examined or treated" under Section 114 to include the mere thinking, consideration, or the taking of some preliminary action shy of the formal statutory steps necessary for an involuntary emergency examination, it would lead to an unreasonable result. First, and unlike a common law cause of action, such an interpretation would create a statutory gray area in which physicians would have to speculate as to the point at which their conduct might be subject to liability under the MHPA. Yet, in construing a statute, we strive to resolve, not

create, ambiguity. Second, and related thereto, we are mindful that such a broad interpretation would significantly expand liability, not only for those trained as mental health professionals, but also for those, as here, who are untrained "in rendering treatment in [the] unscientific and inexact [mental health] field." *Farago v. Sacred Heart General Hospital*, 562 A.2d 300, 304 (Pa. 1989). Moreover, Appellants' interpretation of the MHPA would, if taken to its logical conclusion, render health care workers potentially liable for any thought or act, no matter how inconsequential, tangentially related to the consideration of an involuntary examination of a patient.

Additionally, a broad imposition of liability would be inconsistent with Section 114's immunization provision, and its goal of ensuring the availability of mental health treatment, and, indeed, would potentially discourage health care workers from treating patients who exhibit mental ailments. 50 P.S. § 7102; *see also Dean*, 225 A.3d at 869 ("Section 114 protects from civil and criminal liability those individuals and institutions that provide treatment to mentally ill patients, and thus promotes the statutory goal of ensuring such treatment remains available."); *Farago*, 562 A.2d at 304 (one purpose of MHPA "is to provide limited protection from civil and criminal liability to mental health personnel and their employers in rendering treatment"). Furthermore, expanding the duties under the MHPA giving rise to a civil action to include merely informal considerations regarding an involuntary examination would encourage the over commitment of patients to avoid potential liability. This incentive would not only be inconsistent with the goal of treating patients with the least appropriate restrictions, 50 P.S. § 7102, but would result in the unnecessary deprivation of the patient's liberty. Contrary to Appellants' suggestion, our interpretation limits liability to discrete and clear actions on the part of health care workers,

creates a bright line consistent with the plain language of the MHPA, and serves both the physician and the mental health patient.

Additionally, we find Appellants' reliance upon *Goryeb*, *supra*, to be inapt. In *Goryeb*, a police officer escorted an individual to a state hospital after the individual threatened suicide with a hunting knife unless he received treatment, and told the officer that he contemplated shooting himself the prior week over the termination of his relationship with his girlfriend. He was involuntarily admitted for the statutory 120-hour period, but he was subsequently discharged after no certification for extended treatment was filed. One week later, he shot his ex-girlfriend and others, and then killed himself. The victims brought suit against the admitting hospital and treating physicians, arguing that they were grossly negligent in discharging a patient when they knew or should have known that he was a continuing danger to himself and to others. The Department of Public Welfare, the state hospital, and its physician raised sovereign immunity as a defense to the complaint. Our Court, reading the Sovereign Immunity Act, 42 Pa.C.S. § 8521 *et seq*., and the MHPA *in pari materia*, determined that, since the immunity act contained a medical-professional liability exception, it was not inconsistent with the immunity provision contained in Section 114 of the MHPA. As a result, we concluded that an individual participating in a decision to examine, treat, or discharge a mentally ill patient under the MHPA, and who commits willful misconduct or gross negligence in doing so, may be liable for such decision, examination, or discharge; and that such individual owes a duty to third parties for the consequences of their conduct.

Goryeb is plainly distinguishable from the matter *sub judice*. *Goryeb* involved the negligent *discharge* of a mentally ill patient from involuntary commitment in a mental

health facility. The decision to discharge is specifically set forth in Section 114, which refers to the "act" of discharge. 50 P.S. § 7114 (immunizing, in the absence of willful misconduct or gross negligence, a "person who participates in a decision that a person be examined or treated under this act, or *that a person be discharged*" (emphasis added)). As the patient in *Goryeb* was already being treated in a mental health facility, there was no question that his discharge fell within the Section 114. *Goryeb*, 575 A.2d at 549 ("discharging a severely mentally disabled person, especially an involuntary admittee who has been classified, by statutory definition, as a clear and present danger to himself or others, is a potential serious danger not only to the patient himself but to 'others'"). Here, unlike *Goryeb*, the physicians never initiated the formal prerequisites for the involuntary commitment process; never found Shick to be a "clear and present danger;" never involuntarily committed him; and therefore never discharged him into the community. *See also Sherk*, 614 A.2d at 233 (plurality) (addressing sovereign immunity in the context of treating and releasing an already committed psychiatric patient from a mental health facility).

Applying our interpretation of the MHPA's provisions to the instant case, we find that Appellees' physicians never satisfied the prerequisites for the involuntary emergency examination process under Section 302 for Shick. That being the case, the physicians did not take part in a decision that Shick be examined or treated under Section 114, and, therefore, they were not engaged in an involuntary commitment decision. We reiterate that mere thoughts, consideration, or steps short of the mandated Section 302 prerequisites for initiating an involuntary emergency examination lie outside of a Section 114 cause of action. As Appellees and their physicians never participated in a "decision

that a person be examined or treated under the [MHPA]," we are compelled to conclude that Section 114 is inapplicable and Appellants cause of action was rightfully dismissed.

Finally, we recognize that Shick's actions were horrendous, and that the injuring of Kathryn Leight, among others, and the killing of another person was a profound tragedy. However, the issue before our Court is one of statutory liability under the MHPA, and, as explained above, we find its provisions simply do not allow Appellants to pursue a cause of action under the Act in these circumstances.

For the above-stated reasons, the order of the Superior Court is affirmed.

Chief Justice Saylor and Justices Baer, Donohue, Dougherty and Wecht join the opinion.

Justices Dougherty and Wecht file concurring opinions.

Justice Mundy files a dissenting opinion.