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119 MAP 2023

IN THE SUPREME COURT OF PENNSYLVANIA

No. 119 MAP 2023

KATHRYN J. WUNDERLY, Executrix of THE ESTATE OF KENNETH E. WUNDERLY, Deceased,

Appellant,

v.

SAINT LUKE'S HOSPITAL OF BETHLEHEM, PENNSYLVANIA d/b/a ST. LUKE'S HOSPITAL – SACRED HEAT CAMPUS AND ST. LUKE'S HEALTH NETWORK, INC. d/b/a ST. LUKE'S UNIVERSITY HEALTH NETWORK and ABOVE AND BEYOND INCORPORATED d/b/a ABOVE & BEYOND MOUNTAIN VIEW,

Appellees.

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE PENNSYLVANIA MEDICAL SOCIETY AS AMICI CURIAE IN SUPPORT OF APPELLEES

On Allowance of Appeal of the June 14, 2023 Order of the Superior Court in Case No. 2796 EDA 2022, Affirming the October 14, 2020 Order of the Court of Common Pleas of Lehigh County, Civil Division, in Case No. 2021-C-1562.

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Statement of Interest of Amici Curiae[1]

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making 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 medical specialty area and in every state, including Pennsylvania. In support of its mission, the AMA regularly participates as amicus curiae in state and federal courts, including Pennsylvania courts.

The Pennsylvania Medical Society (PAMED) is a Pennsylvania nonprofit corporation that represents physicians of all specialties and is the Commonwealth's largest physician organization. PAMED regularly participates as amicus curiae before the Supreme Court of

[1] No other person or entity other than the AMA or PAMED, their members, or their counsel, paid in whole or in part for preparing this Amici Curiae Brief. *See* Pa.R.A.P. 531(b)(2).

Pennsylvania in cases raising important healthcare issues, including issues that have the potential to adversely affect the quality of medical care.

The AMA and PAMED appear for themselves and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of all states and the District of Columbia. The mission of the Litigation Center is to represent the interests of patients and physicians in the courts of the United States, according to policies of the AMA.

Proper interpretation of the Mental Health Procedures Act (MHPA)[2] is vital to the AMA and PAMED. Amici submitted briefs in all this Court's recent civil cases interpreting the MHPA. *See Leadbiter v. Keystone Anesthesia Consultants, Ltd.*, 256 A.3d 1164 (Pa. 2021); *Leight v. Univ. of Pitts. Physicians*, 243 A.3d 126 (Pa. 2020); *Dean v. Bowling Green-Brandywine*, 225 A.3d 859 (Pa. 2020). The AMA and PAMED submit this Brief in support of Appellees, Saint Luke's Hospital of Bethlehem, Pennsylvania d/b/a St. Luke's Hospital – Sacred Heart

[2] Act of July 9, 1976, P.L. 814, No. 143, *as amended*, 50 P.S. § 7101, *et seq.*

Campus and St. Luke's Health Network, Inc. d/b/a St. Luke's University Health Network (collectively, "Saint Luke's"). Amici have a substantial interest in the outcome of this case. MHPA § 114(a), 50 P.S. § 7114(a), provides immunity to certain persons "who participate[] in a decision that a person be examined or treated[,]" among other things. The immunity is qualified, because it excepts gross negligence and willful misconduct from its scope. That statute prevents Appellant, Kathryn Wunderly, from suing Saint Luke's for ordinary negligence arising from her husband's passing. Accepting Wunderly's atextual argument would gut the MHPA's statutory qualified immunity. Substantially lessening this protection would, in turn, deleteriously affect mental-heath treatment in Pennsylvania.

Summary of the Argument

The Supreme Court should affirm the Superior Court's order. The trial court correctly dismissed Wunderly's ordinary professional negligence claims against Saint Luke's, and the Superior Court correctly affirmed that order.

First, § 114(a) does not distinguish between allegedly negligent treatment and an alleged failure to treat. The statute does not support Wunderly's atextual work-around. She cannot avoid § 114(a) qualified immunity by casting her claims as the "failure" to treat. A failure to treat is an omission and an omission is ordinary negligence, just like affirmative acts that fall below the professional standard of care.

Second, MHPA qualified immunity seeks to safeguard Pennsylvania mental-health providers, who perform a necessary public good. Improperly cabining immunity would detrimentally affect mental-health treatment in Pennsylvania, and could prompt those providing mental healthcare to overtreat. Both effects would be contrary to the MHPA's goals of ensuring adequate care and the least restrictive means of treatment.

Argument

Section 114(a) of the MHPA "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*, 225 A.3d at 869 (citing *Farago v. Sacred Heart Gen. Hosp.*, 562 A.2d 300, 304 (Pa. 1989)). "Unquestionably, the clear intent of the General Assembly in enacting [§ 114] was to provide limited civil and criminal immunity to those individuals and institutions charged with providing treatment to the mentally ill." *Farago*, 562 A.2d at 303.

Wunderly's late husband was involuntarily committed to St. Luke's under MHPA § 302 and remained involuntarily committed under § 303. *See* 50 P.S. §§ 7302-03. He was an inpatient at Saint Luke's for just over two weeks. (R. 31a.) He was then transferred to Above & Beyond for long-term care, where he sadly passed away. (R. 11a.) Wunderly's husband had dementia, suffered from auditory and visual hallucinations, and was physically abusive toward treating staff.

Unlike cases that Wunderly cites, no party disputes that the MHPA applies to the commitment of Wunderly's husband. And because

the MHPA applies, its qualified immunity provision applies. *See* 50 P.S. § 7114(a). This is so, because the MHPA does not limit "treatment" only to things "directly related to a patient's mental illness. Instead, treatment is given a broader meaning in the MHPA to include medical care coincident to mental health care." *Allen* ex rel. *Allen v. Montg. Hosp.*, 696 A.2d 1175, 1179 (Pa. 1997).

Thus, the issue is whether the MHPA's qualified immunity provision bars Wunderly's claims of ordinary negligence against Saint Luke's. It does. In essence, Wunderly relies on an untenable distinction between actual treatment and the failure to treat. Section 114(a) does not support this distinction, which would be unworkable in practice. Both inadequate treatment and the failure to provide treatment can be ordinary negligence, and § 114(a) provides immunity from claims of ordinary negligence. Further, were Wunderly correct, parties could dodge MHPA qualified immunity through artful pleading. Wunderly appears to concede as much by disputing the trial court's characterization of her complaint. (*See* Appellant's Br. 21 n.2.)

Likewise, applying § 114(a) here makes sound sense from a policy perspective. Wunderly's argument, if accepted, could induce healthcare

providers to overtreat for fear of being accused of failing to treat or provide unnecessary treatment. Yet the MHPA encourages the least restrictive means of treatment. Even worse, faced with the threat of increased liability, mental-health providers might refuse to provide treatment for patients with mental illness, if they are able to do so. This result would undermine the MHPA's goal of ensuring "adequate treatment" for persons with mental illness. The Court should reject Wunderly's arguments because they misuse statutory interpretation to subvert the MHPA's goals.

I. The MHPA's text does not support Wunderly's linguistic gymnastics.

In Pennsylvania, the General Assembly has dictated how courts should "discern its statutory intent." *Leight*, 243 A.3d at 139. "The judiciary's task in cases of statutory interpretation differs markedly from its role in cases brought under the common law." *Id.* at 146 (Wecht, J., concurring). The Statutory Construction Act requires courts to "ascertain and effectuate the intention of the General Assembly." 1 Pa.C.S. § 1921(a). It also requires courts to give effect to unambiguous statutory provisions, and not eschew unambiguous language in favor of pursuing a law's supposed spirit. *See id.* § 1921(b).

The Statutory Construction Act instructs courts to begin with the text. 1 Pa.C.S. § 1921(b). Section 114(a) provides qualified immunity to certain persons providing treatment for persons with mental illness:

> 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). Broken down, § 114(a) applies anytime a qualifying person "participates in a decision that":

- A person be examined or treated under the MHPA.
- A person be discharged from commitment, placed under partial hospitalization, outpatient care, or leave of absence.[3]
- A restraint upon a person be reduced.

Id. The qualified immunity provision also applies to a county administrator or other authorized person who denies an application for

[3] The term "leave of absence" comes from § 419 of the Mental Health and Intellectual Disability Act of 1966, Act of Oct. 20, 1966, P.L. 96, 3d Spec. Sess. No. 6, § 419, *found at* 50 P.S. § 4419. Section 419 permits a "director" of a "facility" to allow an inpatient at the facility to leave the facility under certain conditions.

voluntary treatment, or for involuntary emergency examination and treatment. *Id.*

The *Allen* Court appropriately imparted a broad meaning to "treatment" under § 114(a), because the General Assembly gave that word a broad meaning. *Allen*, 696 A.2d at 1179. Wunderly tries to avoid *Allen* by claiming that treatment for her husband's pressure ulcers "in no way arose out of . . ." his mental illness. (Appellant's Br. 18.) But § 114(a) does not require a causal connection between a patient's mental illness and the treatment rendered by healthcare providers. And even so, all treatment rendered by Saint Luke's *did* arise from her husband's mental illness. But for his involuntary commitment, Wunderly's husband would not have been an inpatient at Saint Luke's.

A 2022 amendment to the MHPA provides another reason to broadly interpret "treatment." That year, the General Assembly amended 50 P.S. § 7103.1 and adopted an expansive definition of treatment that incorporates federal regulations, specifically 45 C.F.R. § 164.501.[4] That regulation, in turn, defines "treatment" as:

> . . . [T]he provision, coordination, or management of health care and related services by one or more health care providers,

[4] *See* Act of July 7, 2022, P.L. 428, No. 32, § 1.

> including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

45 C.F.R. § 164.501. This broad definition applies to § 114(a), because that section applies anytime a person is "examined or treated" under the MHPA. The MHPA further defines "adequate treatment," *see* 50 P.S. § 7104, and delineates the need for an "individualized treatment plan," *id.* § 7107.

Based on all these provisions broadly defining "treatment," the MHPA does not distinguish between actual, affirmative care that falls below the professional standard of care and the alleged failure to provide care. Both allegedly inadequate actual care, and alleged failure to provide care both can be ordinary negligence. Ordinary negligence is quintessentially an "act or *omission* upon which liability is asserted." *Feleccia v. Lackawanna Coll.*, 215 A.3d 3, 29 (Pa. 2019) (emphasis added) (quotation omitted). In other words, negligence includes acts that fall below the standard of reasonable care and omissions—or the failure to act reasonably when one is under a duty to do so. *See id.* Indeed, another word for the failure to act is "neglect," which has the

same etymological origin as "negligent." *See* Am. Heritage Dictionary 1179 (5th ed. 2018) (both originating from the Latin *neglegere*).

There is no general distinction in Pennsylvania law between negligent acts and negligent omissions. At one time, the common law distinguished between "active" and "passive" negligence, and it still does in limited circumstances. *See Bernotas v. Super Fresh Fook Mkts., Inc.*, 863 A.2d 478, 486 n.4 (Pa. 2004). But the terms were criticized because of their vagueness, *id.* (citing *Urban Redev. Author. v. Noralco Corp.*, 422 A.2d 563, 570-72 (Pa. Super. 1980) (Spaeth, J., concurring)), and they no longer have a place in defining negligence generally. Simply put, negligence is negligence, whether through a failure to act or an affirmative act that falls below the applicable standard of care.

A distinction between negligent acts and negligent omissions should especially have no place in a statute that does not mention it. Nothing in § 114(a) requires that a person affirmatively act before qualified immunity attaches. Wunderly misreads § 114(a), and would have the Court write a different statute that applies only if a qualifying person actually treats a person with mental illness. That is not what the statute says. Instead, the statute applies anytime a covered person

"participates in a decision that a person be examined or treated . . . ." This can mean affirmative treatment, a course of one treatment to the exclusion of another, or the decision not to treat.

Wunderly's contention should have a familiar ring to this Court. Thirty-five years ago, the Court rejected a similar argument, holding that § 114(a) bars claims of ordinary negligence against caregivers for their failure to provide certain treatment. *Farago*, 562 A.2d at 304. The plaintiff in *Farago* alleged that hospital was negligent for "failing to adequately supervise and protect" her while she was an inpatient in the psychiatric ward, where another patient sexually assaulted her. *Id.* at 301-02. Though *Farago* was ultimately about whether § 114(a) protected the hospital together with its employees, the plaintiffs made essentially the same argument as Wunderly does here: "their theories of liability are predicated on the hospital's complete lack of treatment of Mrs. Farago in addition to its failure to provide a safe and secure environment." *Id.* at 304. This Court rejected the plaintiffs' argument that immunity applies only to decisions to admit, discharge, or reduce patients' restraints, finding that "interpretation to be much too narrow

and restrictive."[5] *Id.*; *see also Albright v. Abington Mem. Hosp.*, 696 A.2d 1159, 1166-67 (Pa. 1997) (hospital's alleged ignorance of patient's deteriorating mental health and its failure to commit her did not rise to level of gross negligence).

In addition, Wunderly glosses over the governing Statutory Construction Act. She examines the MHPA's text only at a superficial level. Rather than engaging with the text, she skips right to distinguishable cases like *Dean*, and she describes those cases inaccurately. *Dean* dealt with whether the MHPA applied in the first instance, not the particular scope of § 114(a). *See Dean*, 225 A.3d at 861. Wunderly omits the passage from *Dean* right after the one she discusses, which recognizes that it is "clear" that the "MHPA applies to treatment decisions that 'supplement' and 'aid' or 'promote' relief and recovery from 'mental illness.'" *Dean*, 225 A.3d at 871 (quoting 50 P.S. § 7104). Moreover, the *Dean* Court relied on regulations which excluded treatment for drug dependency from the definition of "mental illness."

[5] When this Court decided *Farago*, the MHPA lacked a definitional section. *Farago*, 562 A.2d at 303. The General Assembly later added one. *See* Act of Oct. 24, 2018, P.L. 690, No. 106, § 2. Since 2022, 50 P.S. § 7301.1 has included a definition for "treatment."

Id. at 873 (citing 55 Pa. Code § 5100.2).

Wunderly's husband was admitted to Saint Luke's under MHPA § 302, not because of a drug dependency or some other reason. He was admitted because his mental health deteriorated. All treatment for Wunderly's involuntarily committed husband was to aid or promote relief from mental illness. Wunderly's husband was an inpatient psychiatric admission. (R. 34a.) Wunderly has never disputed that fact, so *Dean*'s analysis of the MHPA does not apply.

Wunderly also tries to distinguish *Farago* by claiming that it "could be characterized as decisions made in the exercise of professional judgment." (Appellant's Br. 24.) That is now how this Court characterized its holding. The Court rejected an argument that alleged "complete lack of treatment" could avoid § 114(a). *Farago*, 562 A.2d at 304.

In sum, Wunderly's hair-splitting argument proves unworkable. For patients committed under § 302, the MHPA does not distinguish between alleged negligently provided treatment and alleged unprovided-but-needed treatment. Based on § 114(a)'s plain text, the Court should reject Wunderly's argument.

II. Qualified immunity is integral to the MHPA, and Wunderly's argument threatens the quality of mental-health care in Pennsylvania.

The Court need not rely on extra-textual statutory interpretation aids, because § 114(a)'s plain text resolves the issue on appeal. Even so, the occasion and necessity for the MHPA, the circumstances under which it was enacted, its objects, and public policy, *see* 1 Pa.C.S. § 1921(b), provide further reasons to reject Wunderly's argument. The MHPA comprehensively reformed Pennsylvania's laws governing mental-health treatment. The General Assembly passed the MHPA to "assure the availability of adequate treatment to persons who are mentally ill." 50 P.S. § 7102. The Act embodies a preference for voluntary treatment over involuntary treatment, and "in every case, the least restrictions consistent with adequate treatment shall be employed." *Id.* Rejecting Wunderly's argument will vindicate these public policies embodied in the law.

To understand the MHPA and its immunity provision, it helps to understand the context in which the General Assembly passed the MHPA. Before the MHPA, and for most of Pennsylvania's history, it was easy to involuntarily commit individuals because of mental illness.

Deborah Doyle Belknap, J.D., Ph.D., Maas v. UPMC*: Muddying the Waters of Therapist Liability in Pennsylvania*, 92 Pa. Bar Ass'n Quarterly 163, 165 (Oct. 2021). The law presumed persons committed for mental-health care to be incompetent; and family members, doctors, or the state took over decision-making. *Id.* Persons with severe mental illness were warehoused for community safety, and were given no treatment whatsoever. Megan Testa, M.D., & Sara G. West, M.D., *Civil Commitment in the United States*, Psychiatry Vol. 7, No. 10, at 32 (2010).[6]

A 19th century reform movement prompted Pennsylvania to establish a state system of asylums to care for persons with mental illness in institutional settings. Over time, institutionalization of the mentally ill became disfavored, because of harmful conditions in those asylums and because of the lack of protections for individuals committed to those hospitals. *See* Belknap, 92 Pa. Bar Ass'n Quarterly at 165. A second reform movement beginning in the mid-20th century secured due process rights for such persons. In *O'Connor v. Donaldson*,

[6] *Available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf.

422 U.S. 563, 576 (1975), the U.S. Supreme Court held that a state may not civilly commit individuals who pose no threat to themselves or others. And in *Addington v. Texas*, 441 U.S. 418, 433 (1979), it held that due process requires a state to produce and convincing evidence to involuntarily commit a psychiatric patient. Around the same time, a public push for deinstitutionalization occurred. *See* Testa & West, *supra*, at 32-33. And a plurality of the Pennsylvania Superior Court found a prior civil commitment statute to be unconstitutionally vague. *See Commonwealth* ex rel. *Finken v. Roop*, 339 A.2d 764, 779 (Pa. Super. 1975), *appeal dismissed sub nom. Finken v. Roop*, 424 U.S. 960 (1976).

In this overall context, the General Assembly passed the MHPA, which adopted the *O'Connor* standard by requiring evidence that persons pose a clear and present danger to themselves or others before they may be involuntarily committed. Belknap, 92 Pa. Bar. Ass'n Quarterly at 165 (quoting 50 P.S. § 7301). When individuals are committed for treatment, the MHPA mandates the least restrictive means of treatment. 50 P.S. § 7102. It places limitations on the length of involuntary treatment. 50 P.S. §§ 7302-05. And the MHPA has as its

goal to assure availability of adequate treatment for persons who are mentally ill. 50 P.S. § 7102. The MHPA has provided qualified immunity for caregivers and others since its inception.[7] 50 P.S. § 7114. Early in the Act's history, the Legislature broadened § 114 by including peace officers and the denial of applications for voluntary treatment within the scope of immunity.[8]

Just as they had in 1976, Pennsylvania and the United States now have a pressing need for accessible mental-health treatment. That need is acute in light of the COVID-19 pandemic, which disrupted access to care and led to an increase in reports of mental-health disorders. For instance, for persons ages 18 to 44, insurance claims for psychotic episodes rose 30% from 2019 to 2023. *See* Julie Wernau, *A Lawyer Abandoned Family and Career to Follow the Voices in His Head*, Wall St. Journ., Mar. 23, 2024, 9:00 a.m.[9] One in five U.S. adults experiences mental illness each year, and one in twenty experience serious mental illness. Nat'l Alliance on Mental Illness (NAMI), *Mental Health by the*

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[7] The 1966 Act has a similar immunity provision. *See* 50 P.S. § 4603.

[8] *See* Act of Nov. 26, 1978, P.L. 1362, 1364, No. 324, § 1.

[9] Available at: https://www.wsj.com/us-news/homeless-california-mental-illness-care-court-f63d2027.

Numbers (Nov. 2022), https://nami.org/mhstats. In Pennsylvania, about 5.83% of the population, or 591,000 people, experienced a serious mental illness in 2021-22. *See* Substance Abuse and Mental Health Services Administration, *2021-2022 NSDUH: State Specific Tables*.[10]

Amici stridently support increasing access to mental-health services. Pennsylvanians need more available and accessible mental-health care, not less. So the Court should not interpret the MHPA in a way that would detrimentally affect care or access to care. Increasing liability contrary to statutory dictates could impair treatment. Counterintuitively, increasing the liability of providers of mental healthcare does not necessarily lead to better treatment outcomes. For example, expanding psychiatrists' tort liability for patients' suicides might *increase* suicide rates. *See* J. Shahar Dibary, et al., *Why Exempting Negligent Doctors May Reduce Suicide: An Empirical Analysis*, 93 Ind. L.J. 457, 460 (2018).

One of the way the MHPA assures the availability of treatment is through qualified immunity. Treating patients with mental illness

[10] Available at: https://www.samhsa.gov/data/report/2021-2022-nsduh-state-specific-tables. Each state's table is available for download at this link. Table 87A lists Pennsylvania's raw numbers, and Table 88A gives percentages.

requires special skill—and includes special risks. Healthcare providers perform a necessary public good, often under taxing conditions. Patients with severe mental illness are harder to treat than those without such illness. Unfortunately, sometimes, seriously mentally ill patients must be restrained. Sometimes, such patients become violent and threaten the physical safety of healthcare providers, third parties, or themselves. And such patients may be unwilling, unable, or unreliable historians of their own physical- and mental-health history.

Sadly, all those facts were present here. The medical records for Wunderly's husband note that he had a history of dementia and presented for evaluation of aggressive behavior toward Wunderly, including physical abuse. (R. 35a, 51a.) When he was admitted to Saint Luke's for emergency care, most members of his care team were behavioral health or psychiatry providers. (*Id.*) He was involuntarily committed pursuant to an emergency application. Despite the care team's best efforts, he was orally and physically aggressive with staff, and he did not fully comply with treatment.

By providing qualified immunity, the General Assembly appropriately balanced the safety of patients and others against the

need to ensure liability protections for healthcare providers so that mental-health treatment is available. This qualified immunity does not condemn persons with mental illness to substandard care. To the contrary, by requiring the "least restrictive means" of treatment, the MHPA prevents the discarded practice of warehousing the mentally ill. It also excepts from qualified immunity cases of gross negligence or willful misconduct.

Slicing and dicing § 114(a), as Wunderly requests, would detrimentally affect mental-health care in Pennsylvania. Healthcare providers might have an incentive to recommend overtreatment, or use more restrictive means of treatment. For example, a doctor might prescribe certain mediation to a patient defensively, to prevent the patient or a third party from suing the doctor for ordinary negligence for failing to provide that medication. Or, a plaintiff could artfully dodge qualified immunity by arguing that the doctor "failed" to prescribe a certain regimen of treatment rather than the one prescribed. Administrators might refuse to discharge a patient from commitment to avoid liability from a claim that they "failed" to keep that patient inpatient. Such a liability regime would require persons to violate the

MHPA's least-restrictive means goal.

Worse, providers might decline to treat patients with mental illness or exit the mental healthcare field entirely. The *Allen* Court recognized these exact concerns in rejecting a narrow construction to the term "treatment":

> If [§ 114(a)] were interpreted narrowly such as urged by appellees so that it only applied to treatment specifically directed at a mental illness, it could reduce or eliminate the willingness of doctors or hospitals to provide needed medical care to a mentally ill patient who is referred by a mental hospital for medical treatment. Even if doctors or hospitals still provided treatment for physical ailments in such a situation, it could lead such providers of medical care to minimize their risks by placing the mentally ill patients in a more restrictive environment than is necessary or adopting other precautionary measures which would increase the costs of the medical care provided to the mentally ill.

Allen, 696 A.2d at 1179.

The MHPA represents a comprehensive legislative balancing of many interests. This Court, which necessarily decides individual cases as they come, is less equipped to weigh societal concerns through common law adjudication than the General Assembly is through legislation. Thus, the Statutory Construction Act provides guidance for interpreting legislation. Here, those guardrails protect the MHPA's clear purpose and goals. To effect those goals, the General Assembly

established qualified immunity protections for certain persons. The Court should not interpret the MHPA in a way that would undermine the Act's goals. It should not discard § 114(a)'s plain text and create an unworkable rule that excepts so-called "failure to treat" claims from blanket, qualified immunity. The Court should reject Wunderly's arguments and confirm that the lower courts properly dismissed her case.

Conclusion

The Supreme Court should affirm the Superior Court's order.

Respectfully submitted,

Dated: April 5, 2024

FOWLER, HIRTZEL, MCNULTY & SPAULDING, LLC

By: */s/ Matthew D. Vodzak*

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Combined Certificates of Compliance and Service

This Brief contains 4,274 words (exclusive of supplementary matter). In preparing this certification, I relied on the word count of the word processing system used to prepare the brief.

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

This Brief is being filed by electronically under Pa.R.A.P. 125 and served on all counsel under Pa.R.A.P. 121, and paper copies will be submitted under Pa.R.A.P. 124(c).

Dated: April 5, 2024

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