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## Articles

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Emerging from the Ticket

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Taking a *Chance* on Patient Life: Suicidal Patients,  
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in Maryland

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# HEALTH LAW & POLICY BRIEF 2017-2018

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# LETTER FROM THE EDITORS

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Dear Reader:

On behalf of the Editorial Board and staff, we proudly present Volume 12, Issue 2 of the Health Law & Policy Brief (HLPB). HLPB is an online publication run by law students at American University Washington College of Law (WCL). Since its formation in 2007, HLPB has published articles on a wide array of cutting-edge topics in the areas of health law, disability law, and food and drug law. Such topics include international and domestic issues of health care compliance, fraud and abuse enforcement, health insurance payment and reimbursement issues, intellectual property issues, international human rights issues, FDA initiatives and policies, and a host of other matters. HLPB also maintains a blog on current health law issues which can be found on our website at [www.healthlawpolicy.org](http://www.healthlawpolicy.org). Furthermore, each year, HLPB organizes an original symposium on an emerging health law topic. At this year's symposium in April 2018, distinguished speakers and moderators discussed emerging issues in mHealth, wearables and the Internet of Things.

Our first article participates in the everlasting healthcare reform debate by analyzing the ongoing regulatory implementation of the Medicare and CHIP Reauthorization Act ("MACRA"). Written by David Heller, Corporate Counsel at Greenway Health, the article begins by explaining MACRA's legislative predecessors and history. Heller then goes on to discuss recent developments in MACRA's regulatory implementation. Throughout his analysis, Heller recognizes and examines the regulatory burden of the current legislation and its predecessors. He provides potential solutions to these regulatory burdens, proposing changes to the regulatory scheme that would ease the legislation's regulatory burden while leaving its original intent intact.

Our second author, Lauren Miller, evaluates the state of Maryland's current approach to involuntary admission of suicidal patients. Miller uses statutory and case law to explore jurisdictional differences between physicians' duty to foreseeably suicidal patients. She then applies her findings to *Chance v. Bon Secours Hospital*, advocating against an expansion of statutory immunity for physicians that recklessly release involuntarily admitted patients from treatment before achieving improvements to their mental health.

We would like to thank our authors for their hard work and cooperation in writing, researching, and editing two important articles that are increasingly relevant to today's health law dialogue.

We would also like to thank HLPB's articles editors and staff members who worked diligently on this issue, the blog, and our programming throughout the year. They are greatly appreciated and should be proud of their work.

For questions or information about the Health Law & Policy Brief, or for questions on how to subscribe to our electronic publication, please visit our website at [www.healthlawpolicy.org](http://www.healthlawpolicy.org).

Sincerely,

Justine and Sandeep

Justine Deitz                      Sandeep Purewal  
*Editor-in-Chief*                      *Executive Editor*





# MACRA: EMERGING FROM THE THICKET

by David M. Heller\*

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## I. INTRODUCTION

Since the 1990s, healthcare reform has roiled domestic politics in the United States. Issues of insurance coverage, drug pricing, healthcare delivery, and the role of the state deeply divided the country's political parties and living rooms. However, one area of reform maintains broad bipartisan consensus: physician reimbursement reform.

Healthcare expenditures as a percentage of Gross Domestic Product ("GDP") continue to rise at unsustainable levels,<sup>1</sup> leading to serious questions about the sustainability of the Medicare Trust Fund. The Medicare and Medicaid reimbursement system currently operates predominantly through a Fee-For-Service ("FFS") structure, where the government reimburses providers for each individual procedure. FFS is perceived as a major contributor to the exponential increase in healthcare expenditures over recent decades.<sup>2</sup>

In 2015, Congress sought to reign in FFS expenditures and improve physician reimbursement by passing the Medicare and CHIP Reauthorization Act of 2015 ("MACRA"). MACRA leverages multiple policy initiatives and incentivizes providers through a payment structure that is commonly referred to as "value-based care." Value-based care rewards positive clinical outcomes rather than providing payment based on volume. However, as exhibited by similar programs in the past, uneven regulatory implementation threatens to foil MACRA's efficacy.

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\* David Heller is Corporate Counsel at Greenway Health, a leading provider of health information technology to ambulatory healthcare practices. He is also a member of the Executive Committee of the Electronic Health Records Association (EHRA.). The opinions expressed in this Article are solely those of Mr. Heller, and do not reflect the views of Greenway Health, the EHRA, or any other entity or individual. The author would like to thank Debbie J. Alfstad, the practice administrator of the Retina Institute of Texas, P.A. for her contribution to this article with respect to health information exchange and emergency-based specialists. *See infra* note 69.

<sup>1</sup> The Center for Medicare and Medicaid Services (CMS) estimates that healthcare expenditures will account for nearly 20% of GDP by 2020. Spending growth is set to outpace GDP growth by 1.2% each year. Center For Medicaid and Medicare Services, *2016-2025 Projections of National Health Expenditures Data Released* (Feb. 15, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-02-15-2.html>.

<sup>2</sup> Writing for the *New England Journal of Medicine*, Dr. Steven Schroeder and Dr. William Frist, who served on the National Commission on Physician Payment Reform, noted that "[c]ontrolling rising expenditures for health care will not occur without changing the way that physicians are paid." They further elaborated stating that "fixing current payment inequities under fee-for-service models will be of the utmost importance." Steven Schroeder & William Frist, *Phasing Out Fee-for-Service Payment*, 368 N. ENGL. J. MED. 2029, 2030 (2013), <http://www.nejm.org/doi/pdf/10.1056/NEJMsb1302322>.

This article explores MACRA’s policy roots and history, analyzes how its current regulatory implementation echoes past reform efforts, and sets forth recommendations for easing the program’s regulatory burden on providers while preserving Congress’s intended implementation of the legislation. It reasons that failure of the Sustainable Growth Rate and other programs designed to control healthcare spending led to MACRA’s passage in 2015, and argues that MACRA’s regulatory implementation suffers from many of the same defects as its predecessors (namely inconsistent implementation and unrealistic expectations of the healthcare delivery and health IT markets). Absent a change from CMS, implementation defects threaten the long-term viability of the statute and undermines its policy goals of improving quality and controlling spending.

## II. MACRA’S AND DELIVERY SYSTEM REFORM’S HISTORY

### A. The Sustainable Growth Rate Becomes Unsustainable

MACRA’s history is rooted in a series of budget debates that took place in the 1990s. The Balanced Budget Act of 1997 sought to balance the federal budget by cutting Medicare expenditures. To do so, the Act implemented the Medicare Sustainable Growth Rate (“SGR”). Designed to hold the growth of Medicare Part B expenditures in line with GDP growth, SGR calculations were based on four factors:

1. Estimated percentage changes in fees for physicians’ services;
2. Estimated percentage changes in the number of Medicare beneficiaries;
3. Estimated change in GDP per capita; and,
4. Estimated percentage change in expenditures due to changes in law or regulations.<sup>3</sup>

As the economy grew through the late nineties, doctors experienced moderate increases in their FFS rates. However, when the economy slowed in 2000 and later years, these increases turned into rate cuts under the SGR. Congress intervened by replacing cuts to providers’ FFS rates with small increases to physician payments. Following Congressional intervention, the gap between the statute’s target expenditures and actual expenditures continued to grow.<sup>4</sup> Between 2003 and 2014, Congress passed 16 laws overriding the SGR’s cuts due to annual physician outcry<sup>5</sup> and the sudden

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<sup>3</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4502-4503, 111 Stat. 251, 432-434 (1997).

<sup>4</sup> Conor Ryan, a statistician and data analyst, provides an excellent overview of the history and math that led to the S.G.R.’s unsustainability, and how the cuts became unintendedly deeper than contemplated. Conor Ryan, *Explaining the Medicare Sustainable Growth Rate*, AMERICAN ACTION FORUM (March 25, 2015), <https://www.americanactionforum.org/insight/explaining-the-medicare-sustainable-growth-rate/>.

<sup>5</sup> For example, in a letter directed at Dave Camp and other members of the House of Representatives, the American Medical Association (AMA) sharply criticized members of the House who did not support a bill to replace the SGR because “limiting growth of physician services to GDP would inevitably lead to sharp cuts in physician reimbursement rates[.]” The AMA further stated “[a]s predicted, the SGR did result in a 4.8% cut in 2002. Congress declined and that cut went into effect. In subsequent years, Congress did step in to prevent additional cuts from occurring. The

negative adjustment on physician reimbursement rates.<sup>6</sup> As Congress continued to delay Medicare spending cuts, lawmakers delivered a series of reforms designed to reward doctors for controlling utilization while maintaining or improving the quality of care. This series of reforms measures clinicians from three aspects: (1) quality, (2) the utilization or cost of patient care, and (3) process and technology. Lawmakers incorporated these elements in three main programs: the Physician Quality Reporting System (“PQRS”), the Value-based Modifier (“VBM”), and the Electronic Health Record Incentive Program, commonly called “Meaningful Use.” Each of these programs adjusted physicians’ reimbursement on Medicare claims based on their performance on the programs’ respective measures.

## **B. Quality Reporting Becomes Undermined by Complexity**

In 2006, Congress authorized Medicare incentives for quality reporting through the Tax Relief and Health Care Act of 2006<sup>7</sup> and CMS implemented the statute by creating the PQRS. The program underwent a series of statutory changes over time. The Medicare, Medicaid, & SCHIP Extension Act of 2007 solidified the PQRS with a permanent place in the reimbursement structure.<sup>8</sup> In 2010, the Affordable Care Act (“ACA”) added another layer to PQRS by introducing penalties. Physicians who failed to report quality data to CMS were penalized, and penalties continued to escalate on a yearly basis. In tandem, the ACA ended PQRS incentives, converting the system into a pure penalty program.<sup>9</sup>

From a regulatory perspective, PQRS was complex. At its height, it required reporting on nine separate clinical quality measures.<sup>10</sup> Physicians had to choose a measure that was “cross-cutting,” or broadly applicable to most specialties. There were also guidelines on selecting “high priority measures,” which specifically focused on quality measures that had certain domain designations, such as “population management.”<sup>11</sup> At its start, the program offered 74 total quality measures, a figure that eventually increased to 281 total measures by the program’s end. Further complicating matters,

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Consolidated Appropriations Resolution of 2003, the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007, and the Medicare Improvement for Patients Act of 2008 each provided temporary relief for seniors and their physicians from pending cuts.” Letter from the AMA to Dave Camp, House of Representatives (November 19, 2007).

<sup>6</sup> Jim Hahn lays out these laws tabularly, which includes several continuing resolutions. Jim Hahn, *The Sustainable Growth Rate (S.G.R.) and Medicare Physician Payments: Frequently Asked Questions*, CONGRESSIONAL RESEARCH SERVICE (Mar. 21, 2014), <http://www.ncsl.org/documents/statefed/health/S.G.R.faqs3212014.pdf>.

<sup>7</sup> Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 101, 120 Stat. 2922, 2975-2981 (1997).

<sup>8</sup> Medicare, Medicaid, & SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 101, 121 Stat. 2492, 2494 (2007).

<sup>9</sup> Affordable Care Act, Pub. L. No. 111-148, § 3002, 124 Stat. 119, 363 (2010).

<sup>10</sup> Center for Medicare and Medicaid Services, *2017 Physician Quality Reporting System (PQRS): Payment Adjustment Fact Sheet*, 2 (2016).

<sup>11</sup> *Id.*

physicians could report on quality measures using different submission mechanisms.<sup>12</sup> Initially, clinicians could report only on their Medicare claims using codes such as Quality Data Codes (“QDCs”) or G-Codes, and the claim code would have to tie back to the appropriate diagnosis code or procedure code. Depending on the patient’s treatment plan, some measures involved a host of applicable CPT codes, G-codes, or QDCs at the same time.<sup>13</sup>

Later, CMS drastically expanded the available reporting mechanisms in response to the industry’s health information technology (“health IT”) implementation. Eventually, clinicians could opt to report measures via electronic health record (“EHR”) or clinical data registries. However, providers were unable to report each measure via all of the available submission mechanisms. For example, one measure might be reportable only through a registry, and another measure might only be reportable through an EHR.<sup>14</sup> The number of measures available for each mechanism also varied. When CMS introduced EHR-based reporting, there were only ten measures available for that mechanism. The number of measures available for EHR-based reporting eventually expanded to 64 out of 281 total measures.<sup>15</sup> If a provider desired to report on a different measure excluded from the EHR-based reporting mechanism, they were required to select a claims-based measure or purchase a registry connection in addition to the EHR. This could quickly become a rather expensive and complex proposition depending on how a provider wanted to participate.

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<sup>12</sup> Each year CMS published, and still does pursuant to MACRA, a list of quality measures available for physicians to select. For example, for the 2016 performance period, the Physician Fee Schedule listed measures available for Claims, registry, or EHR reporting. Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70,886, 71,216 (Nov. 16, 2015).

<sup>13</sup> CMS maintains a comprehensive list of Quality Measure Specifications and their supporting documents. For a full listing of measure specifications used today, visit <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html>.

<sup>14</sup> Physicians “choose” their quality measures through the Quality Payment Program’s website at <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures>. There, a physician or practice manager generally filters by specialty to see what quality measures are supported for their specific practice that year. Many fail to take the second step and filter by submission mechanism. A mental health practitioner may filter by specialty and find that his or her practice can choose both the Adult Major Depressive Disorder (MDD): Suicide Risk Assessment measure or Adherence to Antipsychotic Medications for Individuals with Schizophrenia. However, the former can only be reported through an EHR, and the latter can only be reported through a registry. Whether a physician can use both measures depends on what technologies they have purchased or licensed. This can be counterintuitive because the technology used to send measure data to CMS is not clinically relevant, nor is it readily apparent why a clinical quality measure could only be reported in one way.

<sup>15</sup> Center for Medicare and Medicaid Services, *2015 Reporting Experience Including Trends (2007-2015)*, 3 (2017).

The effect of this complexity is evident in the number of clinicians who successfully submitted data. Initially, only 15% of physicians participated voluntarily.<sup>16</sup> 2015 marked the height of the PQRS program; participation was mandatory at that time.<sup>17</sup> Even then, over 30% of physicians took a penalty to their Medicare revenue instead of participating in the *reporting* program.<sup>18</sup> For providers who chose to participate, success varied based on the method of reporting. Physicians who reported using the EHR successfully submitted nine measures more frequently than those reporting via another mechanism.<sup>19</sup> Varying success rates between mechanisms was potentially attributed to a provider's use of a single set of technology or employ of only one system's workflows.<sup>20</sup> For example, most providers chose to have an EHR installed. Those providers then used the EHR to capture data and used a registry to report the captured data. This process required, at a minimum, multiple logins and portals. In the most extreme circumstances, providers were required to conduct a manual chart review to ensure that the data passing between the EHR and the registry was accurate. Even those using EHR-based reporting experienced setbacks because the number of EHR-based quality measures was severely limited compared to registry measures. In 2017, Medicare's quality reporting only supported 53 EHR-based measures even though there were 216 registry measures available. Overall, low participation rates over the course of the program's lifespan were likely a result of the difficulties that clinicians faced when completing the reporting process.

### **C. Health Information Technology and EHRs Suffer from Complex Measurement**

Congress's incentive program eventually morphed into a penalty program, producing EHRs. In 2009, as part of the American Recovery and Investment Act, Congress enacted the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"). When the law was passed, most patient records were recorded and stored on paper.<sup>21</sup> Physicians appeared particularly resistant to adopting new technology,

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<sup>16</sup> *Id.* at xiv.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at xiii.

<sup>19</sup> 96% of physicians reporting through their EHR satisfactorily reported on 9 or more measures, fulfilling the program's requirement. Qualified Clinical Data Registries come in at a close second, with 86% of their users reporting on 9 or more measures. From there, it's a steep drop to 39% via registry reporting. *Id.* at xvi.

<sup>20</sup> Generally speaking, the manual effort involved in reconciling data increases with the number of platforms used to communicate the same basic set of data. The technology platforms may read the data in different ways, or record it using different vocabularies. To illustrate the problem properly, imagine trying to transfer contact lists from one Apple phone to another. It is simple because both phones use the same architecture. However, when migrating the same contact list from an Apple phone to a Google phone, the transfer may result in duplicates, or contacts splitting into discrete entries. Now imagine leaping from Apple, to Google, to Microsoft. Then the list is exported from Microsoft to an Excel file. The fields are bound to be messy without manual manipulation of the data at each transfer. Doctors face the same challenge. However, health information, namely treatment, diagnosis, and payment data, is far more complex than the name, email, and phone number format of a basic contacts list.

<sup>21</sup> In 2009, only 48.3% of office-based physicians had *any* EHR installed. A basic EHR, which computerized patient demographics, patient problem lists, medication lists, clinician notes, orders

particularly because no standardized electronic health record existed. In contrast, Congress aimed to create a modern health IT infrastructure capable of delivering more efficient, transparent, and timely care.

The HITECH Act created the “Meaningful Use” program as an incentive for providers to acquire EHRs.<sup>22</sup> These incentives were calculated as a percentage increase in a provider’s Medicare or Medicaid revenue.<sup>23</sup> As applied to Medicaid, the program was a pure incentive program.<sup>24</sup> CMS was responsible for overseeing the program and defining the guidelines for how to measure Meaningful Use. Over the following years, the Medicare Part B side of Meaningful Use morphed into a penalty program. Physicians who did not “meaningfully use” technology lost a percentage of their Medicare Part B revenue.<sup>25</sup> In application, the Meaningful Use program became mandatory.

Meaningful Use was originally intended to take effect in incremental stages.<sup>26</sup> CMS implemented the system as a pass/fail program with measure thresholds. A provider’s failure on one measure (out of roughly 8-10 total measures) caused the provider to fail entirely. However, the regulatory implementation of Meaningful Use was inadequate, and continued to decline when the program’s penalties took effect. Manifold problems added to the program’s demise. For example, the patient engagement requirements lacked reasonable thresholds.<sup>27</sup> Further, CMS frequently delayed changing requirements, failing to recognize that the original deadlines for participation or thresholds were patently too aggressive in the first place.<sup>28</sup> This scenario continued

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for medications, and viewing lab results, was only present in 21.8% of physician offices. *Office-based Physician Electronic Health Record Adoption*, HEALTH IT DASHBOARD, <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php> (last visited Feb. 11, 2018).

<sup>22</sup> HITECH Act, Pub. L. No. 111-5, § 4101, 123 Stat. 115, 467-468 (2009).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.* at § 472.

<sup>26</sup> Specifically, the HITECH act states that “[t]he Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use[.]” *Id.* at § 470.

<sup>27</sup> Meaningful Use Stage 2 originally required that 5% of all unique patients seen by an EP view, download, or transmit their health record (VDT). Many providers expressed frustration with this measure because it penalized providers for actions not always reasonably within their control. The measure was later reduced to just one patient in response to the outcry. Medicare and Medicaid Programs: Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 Fed. Reg. 62762, 62789 (Oct. 16, 2015).

<sup>28</sup> In another example, CMS later released “Modified Stage 2,” which required providers to connect to a public health agency, clinical data registry, or specialty registry. This caused industry-wide panic, as many providers did not plan to attest this way because it was not initially required. CMS later pulled back this requirement, stating that if a provider had not planned to attest to this requirement, they were excluded from the measure. This was done through a fact sheet rather than formal rulemaking. *EHR Incentive Programs in 2015: Alternate Exclusions & Specifications*, CENTER FOR MEDICARE AND MEDICAID SERVICES (2015), [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015\\_AlternateExclusionsandSpecifications.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015_AlternateExclusionsandSpecifications.pdf).

to play out through “Modified Stage 2.” Stage 2 contained aggressive timelines that were poorly received by physicians. To accommodate providers, CMS dramatically changed the measure specifications and exclusions for years 2015-2017 through the Modified Stage 2 regulation. However, these accommodations were undermined by their delayed adoption because CMS took action in October of 2015, about 10 months into the 2015 performance period.<sup>29</sup> Finally, CMS consistently introduced incremental flexibility through a series of exclusions from measures or objectives.<sup>30</sup> This flexibility supplemented the complex nature of the program by adding exclusions and different paths for disqualification from certain measures into an already complicated measurement scheme.

In aggregate, these shortcomings had notable effects on the market. Physicians across the country developed a distaste for EHRs.<sup>31</sup> Providers expressed frustration and confusion with Meaningful Use’s seemingly ever-changing requirements. Many did not see a practical purpose in their EHR and wished to return to the era of paper charts.<sup>32</sup> Retirements spiked.<sup>33</sup> In the eyes of many clinicians, the program rendered the word “meaningful” meaningless.

#### **D. The Value-Based Modifier and the Cost of Patient Care**

Congress established the Value-based Modifier (“VBM”) through the Affordable Care Act in 2010, one year after the passage of the HITECH Act. VBM represents Congress’s attempt to reward clinicians for controlling the cost of patient care while maintaining quality. Similar to PQRS and Meaningful Use, the VBM plan furnished provider payments two years after the applicable performance period.<sup>34</sup> CMS introduced VBM

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<sup>29</sup> 80 Fed. Reg. 62762, 62787 (Oct. 16, 2015).

<sup>30</sup> The exclusions governing public health reporting are a good example of the complexity involved in a single measure. The “general exclusions” of that measure provided that the measure did not apply if 1) there was no registry in their jurisdiction ready to accept data, 2) if there was no registry at all. Then there was a set of three specific exclusions that applied to the three sub-types of registries, immunization registries, syndromic surveillance registries, and specialty registries. On top of the complexity within this one measure, each other measure out of the 10 objectives in 2016 all had 2-3 specific exclusions. 80 Fed. Reg. 62762, 62820 (Oct. 16, 2015).

<sup>31</sup> According to a 2017 survey by Medical Economics, 63% of users had a negative opinion of their EHR. *2017 EHR Report Card*, MEDICAL ECONOMICS (Oct. 25, 2017), <http://medicaleconomics.modernmedicine.com/medical-economics/news/2017-ehr-report-card>.

<sup>32</sup> The former president of the AMA noted that “[t]he message from physicians is loud and clear: Electronic Health Record (EHR) systems have so much potential, but frustrating government regulations have made them almost unusable.” Steven J. Stack, *Physicians, we hear you: EHR meaningful use isn’t meaningful*, AMA WIRE (July 21, 2015), <https://wire.ama-assn.org/ama-news/physicians-we-hear-you-ehr-meaningful-use-isnt-meaningful>.

<sup>33</sup> While there is a question of causality, the ONC noted that 41% of providers who did not adopt or plan to adopt an EHR cited retirement as their main reason. Office of the National Coordinator for Health IT, *Physician Motivations for Adoption of Electronic Health Records* (Dec. 2014) <https://www.healthit.gov/sites/default/files/oncdataabrief-physician-ehr-adoption-motivators-2014.pdf>.

<sup>34</sup> Affordable Care Act, Pub. L. No. 111-148, § 3007, 124 Stat. 119, 373 (2010).



by phasing the program in over the course of three years and applying it to physician organizations of varying sizes depending on the performance period.<sup>35</sup>

The program included a complex measurement process that leveraged an array of data, including quality data received from the PQRS program, composite measures of hospital admissions for acute and chronic conditions sensitive to ambulatory care, and a measure of 30-day all-cause hospital readmissions.<sup>36</sup> Finally, to calculate cost, the program implemented CMS claims data to calculate six separate measures, including: (1) total per capita costs for all beneficiaries measure and total per capita costs for beneficiaries with specific conditions, (2) diabetes, (3) coronary artery disease, (4) chronic obstructive pulmonary disease, (5) heart failure; and (6) Medicare spending per beneficiary measure.<sup>37</sup>

Because CMS calculated the VBM score through claims data aggregated after the close of the performance period, physicians were largely unable to predict how their cashflow would be impacted in later years because they could not fully assess their performance in the present. Between 2011 and 2015, the administrative and reporting burden ballooned. With the VBM, PQRS, and Meaningful Use combined, ambulatory physicians were subject to no fewer than 25 measures that had different reporting requirements, workflows, reporting deadlines, and portals.

### III. 2015: MACRA USHERS IN A NEW ERA

2015 saw the dawn of a new era in healthcare reform through a rare act of bipartisanship. SGR once again came into play as the politically toxic nature of the program motivated Congress to change or repeal the law. At the same time, representatives received numerous complaints from physician associations and technology vendors stating that the various reporting programs were too complex and burdensome.<sup>38</sup> While Congress desired to replace the SGR, it also wanted to leave in place a simplified regime that could control costs to stabilize healthcare expenditures. Congress addressed these concerns in the Medicare and CHIP Reauthorization Act of 2015.<sup>39</sup> The measure passed overwhelmingly. 92 Senators and 392 Representatives from the House voted in favor of the Act.<sup>40</sup>

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<sup>35</sup> Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70,886, 71,384 (Nov. 16, 2015).

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* at 71,279.

<sup>38</sup> The AMA submitted a detailed letter to CMS in October 2014 that provided a fairly comprehensive view of physician concerns prior to MACRA's passage. While focused on Meaningful Use, it calls out other programs such as PQRS. As a whole, the letter attacks Meaningful Use's measure thresholds, lack of alignment with other reporting programs, lack of flexibility, and complexity. *See* Letter from the AMA to Marilyn B. Tavenner, et al., Administrator For the Centers for Medicare & Medicaid Services (Oct. 14, 2014).

<sup>39</sup> MACRA, Pub. L. No. 114-10, 129 Stat. 87 (2015).

<sup>40</sup> All Actions HR. 2 – 114<sup>th</sup> Congress (2015-2016) (last accessed Feb. 12, 2018) <https://www.congress.gov/bill/114th-congress/house-bill/2/>.



In addition to repealing the SGR, MACRA created the Merit-based Incentive Payment System (“MIPS”).<sup>41</sup> MIPS rolled PQRS, Meaningful Use, and the Value-based Modifier into a single reporting program. Under MACRA, each category was respectively labelled quality, meaningful use of certified EHR technology, and resource use.<sup>42</sup> Congress also added a new element called Clinical Practice Improvement Activities, which gave physicians credit for making clinical process changes.<sup>43</sup> Under MACRA, Medicare reporting would have one deadline and a single reporting portal. It would also be regulated through a single regulatory stream. All in all, MACRA aimed to simplify the process of reporting quality data to Medicare. In addition to easing the reporting process, the program authorized CMS to give providers significant flexibility in the first two years of the program.<sup>44</sup> Most notably, Congress gave CMS flexibility to set the composite score lower than the mean or median of prior performance scores.<sup>45</sup>

However, consolidation of the various programs came with serious financial consequences. Over time, MIPS is set to become more financially aggressive. In 2017, physicians faced incentives or penalties of 4% of their Medicare revenue.<sup>46</sup> After full implementation occurs, physicians will face incentives or penalties of up to 9% of their Medicare revenue.<sup>47</sup> For organizations whose payer mix consists of predominantly Medicare beneficiaries, the incentives or penalties could represent the organization’s entire profit margin. 9% also presents a three percent increase in the net total financial downside presented by PQRS, Meaningful Use, and the Value-Based Modifier. The program is budget neutral<sup>48</sup> (*i.e.* for every incentive dollar earned, another physician receives a one-dollar penalty). Additionally, providers will be measured against the mean or median of the market’s overall performance.<sup>49</sup>

Congress designed MIPS as a budget neutral program to create a business case for participation in an Advanced Alternative Payment Model (“APM”). Under an Advanced APM, a provider shares the financial risk of the cost of patient care with CMS. If the provider is capable of lowering the cost of care while maintaining quality, CMS rewards the provider with a financial incentive. Alternatively, if the provider fails to lower the cost, or does so by decreasing the quality of care, CMS punishes the provider by imposing a financial penalty. The statute defines an Advanced APM as a payment model based on the organization’s undertaking of “more than nominal risk.”<sup>50</sup> This heightened financial risk usually occurs in the form of shared savings or shared losses. In other words, CMS will share the government’s savings with

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<sup>41</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 92 (2015).

<sup>42</sup> *Id.* at 96.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.* at 107.

<sup>45</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 106 (2015).

<sup>46</sup> *Id.* at 106.

<sup>47</sup> *Id.*

<sup>48</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 108 (2015).

<sup>49</sup> *Id.* at 107.

<sup>50</sup> *Id.* at 119.

healthcare providers who decrease CMS's overall cost of patient care by reducing hospitalizations, preventing health catastrophes, and providing proactive care. Instead, if a provider costs CMS additional funds, the provider will pay a fraction of that cost out to CMS and the broader healthcare system.<sup>51</sup> Designed to be a direct replacement for the SGR, Congress hoped Advanced APMs and the MIPS penalty structure would streamline and improve the reporting process.

Despite Congress's intention to simplify MACRA and remove political uncertainty from physician payments, providers have expressed hostility towards the program. Lamenting about the financial components and the infancy of the program, many physician organizations have resisted the program's implementation at each stage of adoption. Notwithstanding MACRA's simplification in comparison to prior programs, even the Medicare Payment Advisory Commission has now recommended that Congress replace MIPS with a simpler or voluntary alternative.<sup>52</sup> In response, the authors of MACRA indicated their expectation that CMS fully and faithfully implement the statute.<sup>53</sup> Despite widespread pushback, MACRA is bolstered by bipartisan buy-in and general dislike of the fee-for-service system. Relying on this supportive base, it appears that MACRA is here to stay. As CMS proceeds with MACRA, it is increasingly clear that the program's success depends on the details of implementation and physician buy-in. However, inconsistent implementation, initial aggressive and unrealistic programmatic requirements, and late adjustments to those requirements threaten the program's future.

#### **IV. MACRA IN 2017 & 2018: WALKING IT BACK**

##### **A. 2017's Proposed Regulation: Panic in the Market**

On May 9, 2016, CMS released the first in a series of proposed rules implementing MIPS and the other provisions of MACRA. Similar to the implementation of its legacy programs, the rule set out aggressive requirements with significant financial impacts for the first year. To begin, CMS required one full year of reporting.<sup>54</sup> If a physician accepted more than \$10,000 in Medicare revenue and cared for fewer than 100 Part B

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<sup>51</sup> *See id.*

<sup>52</sup> Kate Bloniarz et al., *Assessing Payment Adequacy and Update Payments: Physician and Other Health Professional Services; and Moving Beyond the Merit-based Incentive Payment System*, MedPac (Jan. 11, 2018) <http://www.medpac.gov/docs/default-source/default-document-library/jan-2018-phys-mips-public.pdf?sfvrsn=0>.

<sup>53</sup> A bipartisan group with members from multiple committees wrote that "Congress overwhelmingly passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). We write to express the importance of successful implementation, as intended by Congress, of the reforms included in MACRA and the establishment of the Merit-Based Incentive Payment System (MIPS) and Alternate Payment Model (APM) tracks for physician payment." Letter from Congress to Sylvia Burwell, Secretary of the U.S. Department of Health and Human Services (Sept. 6, 2016), <https://waysandmeans.house.gov/wp-content/uploads/2016/09/09.06.16-EC.WM-MACRA-Letter.pdf>.

<sup>54</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, 81 Fed. Reg. 28,162, 28,218 (May 9, 2016).

beneficiaries, they were subject to MIPS payment adjustments.<sup>55</sup> CMS summarized the program's costs and benefits, estimating \$833 million in negative adjustments and \$833 million in positive adjustments over the first year; the adjustments would be spread out over a range of 687,000 to 746,000 total "eligible clinicians."<sup>56</sup>

Generally, the statute commands CMS to set the performance threshold each year based on the mean or median of the prior year's score.<sup>57</sup> For the first performance period, CMS proposed an alternative threshold determination based on an analysis of Part B allowed charges, 2014 and 2015 PQRS data submissions, feedback data on cost and quality, and Meaningful Use program data.<sup>58</sup> Though the program took effect on January 1, 2017, providers did not receive their first year target for the 2017 performance period until October-December 2017.

In addition to obvious obstacles such as time compression, physicians also faced the daunting task of understanding and adopting a new and complex MIPS scoring system. CMS proposed a calculation of 50% for Quality, 25% for Advancing Care Information (ACI) (the new regulatory designation for Meaningful Use), 15% for Clinical Practice Improvement Activities, and 10% for Cost. However, each specific category required a different number of total points in order for providers to earn full credit.

Quality scoring required reporting on six measures, including at least one outcomes measure.<sup>59</sup> Providers had to earn a quality score of 60 points to receive a 100% in that category.<sup>60</sup> Thus, earning 30 Quality points would supply a provider with 25% of their MIPS composite score. CMS measured cost using the familiar Medicare Spending Per Beneficiary measure, in conjunction with 14 new episode-based measures.<sup>61</sup>

A new scoring category, Clinical Practice Improvement Activities, measured the implementation of clinical process improvements called "improvement activities." In the proposed rule, each activity was worth a certain number of points. Most practices had to achieve 60 points to receive full credit in the Clinical Practice Improvement Activities category. Small practices, or those with 15 eligible clinicians or fewer, were only required to earn 30 points.<sup>62</sup> Under this category, there were "high priority" activities worth 20 points (e.g. providing 24/7 access to the care team), and "medium priority" activities worth 10 points (e.g. screening patients with certain mental health conditions for depression).<sup>63</sup>

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<sup>55</sup> *Id.* at 28,230.

<sup>56</sup> *Id.* at 28,165.

<sup>57</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 107 (2015).

<sup>58</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, 81 Fed. Reg. 28,162, 28,274 (May 9, 2016).

<sup>59</sup> *Id.* at 28,164.

<sup>60</sup> *Id.* at 28,256.

<sup>61</sup> *Id.* at 28,196.

<sup>62</sup> *Id.* at 28,266.

<sup>63</sup> *Id.* at 28,267.

Next, the scoring scheme for Advancing Care Information (ACI) (previously referred to as Meaningful Use) was, and remains, a tangled web of requirements. It was composed of several elements, including a base score, performance score, and bonus score.<sup>64</sup> Although CMS announced that MIPS eliminated the arbitrary pass/fail elements of the legacy programs, the elimination was not fully executed. The base score included a set of 4-5 “required” measures, which consisted of a numerator and denominator.<sup>65</sup> The numerator is the number of times a provider takes a particular action using technology, and the denominator represents the number of encounters where that action is presumably relevant. Under ACI, the provider had to earn a 1 in the numerator for these “base” measures.<sup>66</sup> Providers who did not meet the base measures threshold failed the entire category, echoing the pass/fail structure of Meaningful Use.<sup>67</sup> Because of the low thresholds, CMS elected not to provide for exclusions in 2017.<sup>68</sup> Thus, providers who did not write prescriptions, take referrals or receive transitions of care would fail the entire category.<sup>69</sup> Providers who passed the base score would receive 50% of the ACI score. To reach 100% under ACI (25% of the MIPS composite), providers had to rely on performance score or “bonus score.”<sup>70</sup> The performance measures, which sometimes overlapped with the base measures, were best explained as “the more you do, the more you earn.”<sup>71</sup> Finally, the bonus score rewarded physicians for connecting

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<sup>64</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, 81 Fed. Reg. 28,162, 28,220 (May 9, 2016).

<sup>65</sup> *Id.* at 28,221.

<sup>66</sup> *Id.* at 28,268.

<sup>67</sup> *Id.*

<sup>68</sup> In Meaningful Use and ACI, exclusions state that a provider does not need to report on the measure because there are not enough relevant encounters for the measure to be relevant. For example, under 2018’s rule, providers who write fewer than 100 prescriptions are excluded from the e-prescribing measure and do not have to report on it. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,680 (Nov. 16, 2017).

<sup>69</sup> Even if a practice does take referrals or transitions of care, the health information exchange measurement can be problematic. Imagine a retinal practice. Retinal medical issues are immediate emergencies; if action is not taken within hours, the patient may become permanently blind. If most patients are having a problem, they generally go to their optometrist or general ophthalmologist before seeking alternative care. If the optometrist or ophthalmologist sees a retinal problem, they will frequently arrange for an immediate evaluation with a retinal specialist, even walking the patient across the street to the retinal specialist for immediate surgery. At no point is the referring physician slowing down to send an electronic summary of care. The retinal specialist is not going to “query” or ask the referring physician’s system for a summary of care. Instead, the retinal specialist will likely ask the physician and patient about the patient’s current medications and potential allergies before whisking the patient away to surgery. Even in the event of a specialist’s request for a summary of care, it may take days for the summary to be completed and delivered. The referring physician’s direct address may also be wrong in the directory, which is generally maintained by a private technology vendor like Surescripts. It is not maintained in NPPES, where all other provider contact information and the NPIs are kept, so there is no universal source of truth.

<sup>70</sup> *Id.*

<sup>71</sup> For example, if a provider gives 3/10 patients access to their electronic health record, that provider receives 3 points under ACI.

to public health registries or reporting improvement activities through an EHR.<sup>72</sup> In aggregate, this amounted to a great deal of complexity to achieve only 25% of a provider's score.

The program's complexity, rapid implementation, and perceived threat to small practices provoked industry outcry. In response to the turmoil, the American Medical Association (AMA) released a 70-page comment letter about the proposed regulation. The letter specifically advocated for a transitional period of reduced thresholds, seeking "a much more progressive and welcoming environment."<sup>73</sup> The American Academy of Family Physicians (AAFP) used stronger language, stating that "we see a strong and definite need and opportunity for CMS to step back and reconsider the approach to this proposed rule which we view as overly complex and burdensome[.]"<sup>74</sup> Both organizations called for an interim rule to scale back many of the proposed rule's provisions. The American Hospital Association (AHA) also weighed in, "urg[ing] CMS to monitor ongoing feedback of the field to implement MACRA, and to be willing to consider additional flexibility in its timeline and other requirements such as quality measure data completeness."<sup>75</sup> Specialist societies lent their voices as well. The American College of Cardiology (ACC) called for CMS to "streamline and simplify" the program,<sup>76</sup> while the American Academy of Orthopaedic Surgeons (AAOS) noted that "it will be burdensome, if not impossible for physicians to get ready for the first performance year of 2017."<sup>77</sup>

Physician organizations were not alone in their criticism of the proposed rule. Technology vendors who supported MACRA's reporting and data collection requirements were equally concerned. The EHRA requested that "CMS take every possible step to dramatically simplify provisions and requirements, and to revise and develop provider-focused communications to reduce remaining perceived complexity."<sup>78</sup> The EHRA further requested 18 months of additional development time to support quality measures.<sup>79</sup> The Healthcare Information and Management Systems Society (HIMSS), representing a broader swathe of the health IT market, noted that the timeline was problematic because vendors supporting the program would need to change measure/

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<sup>72</sup> *Id.*

<sup>73</sup> Letter from the AMA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>74</sup> Letter from the AAFP to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 24, 2016).

<sup>75</sup> Letter from the AHA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>76</sup> Letter from the ACC to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>77</sup> Letter from the AAOS to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 24, 2016).

<sup>78</sup> Letter from the EHRA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>79</sup> *Id.*

dashboard logic and user interfaces.<sup>80</sup> tenuous response as it became apparent that the market was not prepared for the ambitious proposed rule.

### **B. Walking Back from Full Implementation to the Transition Years**

In response to overwhelming criticism, CMS drastically walked back its implementation of MIPS, echoing the Meaningful Use and EHR Incentive Programs. Most notably, CMS removed most of the program's financial consequences for the 2017 performance period. CMS changed the performance threshold by setting it at 3 points out of 100 instead of basing the threshold on the legacy programs' prior scores. This change had several financial impacts. First, in order to avoid a penalty, providers had to report on fewer measures than in prior years. CMS provided four "Pick Your Pace," reporting options:

1. Do nothing, and receive a 4% penalty;
2. Report on at least one quality measure, the required Advancing Care Information measures, or one improvement activity for at least 90 days to avoid any penalty;
3. Report on more than one quality measure, the required Advancing Care Information measures, or one improvement activity for at least 90 days and earn a small incentive; or
4. Fully report for a full calendar year and earn an incentive.<sup>81</sup>

In addition, CMS significantly expanded the list of providers who would receive an exclusion from the program. Under the new structure, a physician would be excluded from MIPS if they collected less than \$30,000 in Medicare revenue or saw fewer than 100 Medicare patients.<sup>82</sup> Because CMS lowered the performance threshold and expanded exclusions, the total estimate of incentives and penalties for the 2017 performance period was \$199 million spread across at least 592,000 clinicians.<sup>83</sup> The new structure reduced MIPS incentives and penalties to an average of only \$336.15 per clinician program.

The new and improved 2018 MACRA rule continues the trend of expanding exclusions. The rule extends the transition period by another year while adding complexity and untested features to MIPS through the introduction of improvement scoring, virtual group reporting and new exclusions. The rule also raises the performance threshold to 15 points out of 100.<sup>84</sup> To avoid a penalty, providers can take several pathways, including but not limited to:

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<sup>80</sup> Letter from HIMSS to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>81</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, 81 Fed. Reg. 77,008, 77,011 (Nov. 4, 2016).

<sup>82</sup> *Id.* at 77,012.

<sup>83</sup> *Id.* at 77,016.

<sup>84</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg.

1. Report on six clinical quality measures;
2. Report on the required ACI measures and one quality measure; or,
3. Fully participate in Clinical Practice Improvement Activities, which entails one to two process changes to receive full credit.

Despite increasing the performance threshold, CMS further expanded the list of available exclusions to include providers seeing fewer than 200 patients or taking less than \$90,000 in revenue.<sup>85</sup> Under the expanded exclusions, fewer clinicians will be penalized. With fewer providers paying penalties into the program, the total amount of incentive money available to participating providers will decrease to \$118 million.<sup>86</sup> As a result, clinicians who were subject to the program in 2017 may be excluded in 2018.

Moreover, when CMS proposed the 2018 rule, it introduced another element of complexity to the program by permitting virtual group reporting. This technically complex new reporting scheme allows organizations with 10 or fewer eligible clinicians to report as a single entity.<sup>87</sup> While it presumably enables smaller organizations to scale in the same manner as enterprise healthcare systems, different practices in a virtual group will likely use different EHRs. CMS did not release any guidance on how data would be submitted for virtual groups that use different EHRs.

The rule also introduced “improvement scoring,” where an organization could receive extra credit for improving Quality and Cost. However, CMS measures quality improvement at the category level.<sup>88</sup> This means that CMS would measure the improvement a provider made on the average of all measures selected, rather than the individual measures themselves. Given the high level of variance between quality measures, CMS even noted that this could leave improvement scoring open to gamesmanship.<sup>89</sup>

Finally, CMS also reintroduced exclusions for Advancing Care Information, and retroactively applied the exclusions to the 2017 performance period (just 2 months before the closure of that performance period).<sup>90</sup> Introducing new exclusions at this time-sensitive juncture left many developers with insufficient time to support providers, leaving the dashboards of some providers technically unsupported. This regulatory inconsistency and complexity between 2017 and 2018 has set an uncertain stage for the future of MACRA.

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53,568, 53,576 (Nov. 16, 2017).

<sup>85</sup> *Id.* at 53,589.

<sup>86</sup> *Id.* at 53,926.

<sup>87</sup> *Id.* at 53,953.

<sup>88</sup> *Id.* at 53,740.

<sup>89</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,740 (Nov. 16, 2017).

<sup>90</sup> *Id.* at 53,680.



## V. WHAT'S NEXT AND MAXIMIZING PROGRAMMATIC EFFICACY AND EFFICIENCY

Despite MACRA's challenging regulatory implementation, stabilizing programmatic implementation in the coming years will allow CMS to maximize the program's efficacy and gain buy-in from physicians. MIPS has already made several important improvements over its legacy programs, including a single reporting deadline and a reporting portal that displays a provider's live score before the submission period closes.<sup>91</sup> CMS also recently announced two initiatives aimed at gaining provider support. First, the Meaningful Measures project seeks to reorient quality measures to provide less emphasis on process and have a greater focus on clinical outcomes.<sup>92</sup> CMS has also launched Patients Over Paperwork, a program meant to implement President Trump's executive order to "cut the red tape." One of its primary and most laudable goals is to reduce the administrative time physicians spend on compliance with CMS programs, such as MIPS. In a recent newsletter, CMS stated that the new reporting portal and the removal of several quality measures are by-products of that initiative.<sup>93</sup>

Plus, MIPS' scoring is already an improved version of the scoring systems implemented in the legacy programs. One example of this improvement is the fundamental removal of thresholds from Meaningful Use under ACI. Before, Meaningful Use was a pass/fail program with different thresholds for different measures.<sup>94</sup> Today's program is more comparable to a performance category. Additionally, the removal of a cross-cutting quality measure will help specialists more effectively participate, specifically in the Quality category of MIPS.<sup>95</sup>

However, more work remains if CMS wants to regain physicians' confidence that MACRA will be more than just a reporting program where they must memorize a myriad of requirements. Two changes are integral to the program's future: reducing complexity and lengthening the regulatory cycle to the extent permitted by law. Acting with input from the AMA and other provider organizations, Congress has already provided CMS with the vehicle to accomplish these changes<sup>96</sup> by pushing mean and median scoring

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<sup>91</sup> *Id.* at 53,626.

<sup>92</sup> Center for Medicare & Medicaid Services, *CMS Administrator Verma Announces New Meaningful Measures Initiative and Addresses Regulatory Reform; Promotes Innovation at LAN Summit* (Oct. 30, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-10-30.html>.

<sup>93</sup> Center for Medicare and Medicaid Services, *Patients Over Paperwork* (Jan. 2018), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/JanuaryPoPNewsletter011818.pdf>.

<sup>94</sup> *See id.* at 5.

<sup>95</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,628 (Nov. 16, 2017).

<sup>96</sup> The A.M.A. and other provider organizations requested "to continue the existing flexibility in the MACRA statute that CMS is currently using for an additional three years so that the agency may move forward as the necessary program elements are put in place." Letter from the AMA, *et al.*, to Greg Walden, Chairman of the Committee of Energy and Commerce, (October 2, 2017).



from 2019 to 2022.<sup>97</sup> To accommodate this scoring change and provide a more natural onramp, CMS must gradually increase the performance threshold for the next three years. CMS must release new cost measures by December 31, 2018, with the option to weigh Cost between 10% and 30% (before, it was set to scale to 30% in 2019).<sup>98</sup> In another effort to introduce more simplicity, Congress removed improvement scoring from the program until 2022.<sup>99</sup>

CMS should also take further action to simplify scoring. Under ACI today, providers can earn up to 100%, which then represents 25% of their MIPS composite score. CMS defines full participation in the Quality category as reporting on six quality measures with at least one outcomes measure, a data submission threshold of 60%.<sup>100</sup> The top Quality score is 60 points, and represents 50% of a provider's score.<sup>101</sup> Clinical Practice Improvement Activities contain high priority measures worth 20 points, medium priority measures worth 10 points, and a 40 point or 20 point maximum that, depending on practice size, represents 15% of the provider's total MIPS composite score.<sup>102</sup> This is a tremendously complex scoring scheme that all practices must contend with, regardless of their size or sophistication. Varying the maximum scores in each category and eliminating nuances such as performance scores and base scores would further simplify the program.

CMS should also provide greater consistency and simplicity in terms to aid provider understanding. As noted earlier, ACI contains a reference to a base score, performance score, and a bonus score.<sup>103</sup> For a physician or practice administrator who will not read the entirety of the regulation, the difference between a bonus score and performance score is difficult to understand. CMS's decision to change or replace commonly used terms also presents difficulties to participating providers. CMS adopted the term "eligible clinician," a change from MACRA's statutory use of "eligible provider." Morphing the term Meaningful Use into ACI, while applying identical measure specifications, also caused needless confusion. CMS should avoid unnecessary changes in terminology and consider changing ACI to "MIPS Meaningful Use." This term more accurately describes the category, aligns the category with the terminology in the MACRA statute and allows providers to better understand of the term due to their previous experience with Meaningful Use.

Finally, the broader market would benefit tremendously from extending the regulatory cycle and stabilizing implementation. Allowing some providers to claim an exclusion after participating in 2017 will cause providers to overlook the program based on a belief that it lacks tenacity. Then, if exempt providers become subject to MACRA once

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<sup>97</sup> Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. § 51003 (2018) (enacted).

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,717 (Nov. 16, 2017).

<sup>101</sup> *Id.* at 53,717.

<sup>102</sup> *Id.* at 53,767.

<sup>103</sup> *Id.* at 53,663.

again, they will be disillusioned and ultimately disinclined to participate. CMS should not implement further raises to the exclusionary thresholds. If CMS chooses to lower the thresholds, the agency should engage in significant education efforts so providers are not “blindsided” by the new exclusion guidelines. Moreover, CMS should start proposing new measures and exclusions eighteen months before implementation (rather than six). This extended implementation period would give providers enough time to familiarize themselves with new concepts. It would also provide technology vendors with additional time to support provider participation in MACRA through development of functionality tools such as updated dashboards and optimized EHR workflows.

## **VI. CONCLUSION**

MACRA is a rare bipartisan achievement that streamlines prior programs while attempting to create a business case for changing the way the federal government pays providers. However, the program’s success ultimately depends on its implementation. If CMS can administer the program in a way that allows physicians to buy in, it stands a much greater chance of success. Prior programs suffered because of inconsistent, uneven, and complex measurement. MACRA’s first two years have echoed those prior reform efforts. Avoiding the historical pitfalls of MACRA’s predecessors will allow the program to succeed. Important improvements that should be integrated into MACRA over the coming year include lengthening the regulatory cycle, simplifying the requirements, and consistent implementation. These improvements will ensure achievement of the legislation’s original intent while also providing for the program’s overall success.





# TAKING A CHANCE ON PATIENT LIFE: SUICIDAL PATIENTS, INVOLUNTARY ADMISSIONS, AND PHYSICIAN IMMUNITY IN MARYLAND

Lauren Miller\*

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According to the most recent government data, suicide is the tenth leading cause of death in the United States and the fourth leading cause of death for people ages ten to thirty-four.<sup>1</sup> In 2015 alone, almost ten million adults contemplated suicide.<sup>2</sup> Attempting to address this tragedy, a majority of states authorize involuntary civil commitment<sup>3</sup> for mentally ill persons and “more than one million patients per year” are involuntarily committed.<sup>4</sup> *Parens patriae* and state police powers authorize involuntary commitments,<sup>5</sup> but the Supreme Court of the United States qualifies this treatment as a “massive curtailment of liberty.”<sup>6</sup> States implement procedural and substantive safeguards to counterbalance the Fourteenth Amendment liberty interest that protects patients from being forcibly admitted for mental health treatment.<sup>7</sup>

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<sup>1</sup> U.S. DEP’T OF HEALTH & HUM. SERVS., Results from the 2015 National Survey on Drug Use and Health: Mental Health Findings, 1, 2 (Sept. 2016), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR3-2015/NSDUH-DR-FFR3-2015.htm>.

<sup>2</sup> *Id.* at 3.

<sup>3</sup> The Department of the Treasury’s Bureau of Alcohol, Tobacco, and Firearms defines hospital commitments as “[a] formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. . . . The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.” 27 C.F.R. § 478.11 (2017). This article uses “commitment” and “admission” interchangeably. For a description on the parallel uses of commitment and admission, see *Furda v. State*, 193 Md. App. 371, 410, 997 A.2d 856, 879 (Md. Ct. Spec. App. 2010) (stating that “‘commit[ment]’ [applies] to situations in which, at the very least, the patient has been afforded an evidentiary hearing, held either by a court or a hearing officer; the patient or the defendant has a right to appear and has the right to counsel; and findings are made by the factfinder, based on competent medical evidence.”).

<sup>4</sup> See SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 101–05 (3d ed. 1985) (describing the medical certification for involuntary hospitalizations in the majority of states); William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 261 (2010).

<sup>5</sup> John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL’Y & L. 377, 377 (1998).

<sup>6</sup> *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

<sup>7</sup> See *infra*, Part I.A.

Before applying to commit a mentally ill individual, a physician must perform an evaluation that allows the physician to determine if the patient meets all required admission criteria. The evaluation questions whether the patient is mentally ill, requires treatment, poses a danger to self or others, refuses voluntary commitment, and is unable to be treated in a less restrictive environment.<sup>8</sup> If the individual meets the required criteria, the individual is then committed until the physician releases the patient due to improvement of their condition or, in the absence of improvement, continued treatment to the extent permitted by state statute.<sup>9</sup> If a patient suffering from suicidal ideation is turned away from initial hospitalization or released early without receiving sufficient treatment, it is possible that the patient may make additional suicide attempts, as was the case with Charlie Williams in *Williams v. Peninsula Regional Medical Center*<sup>10</sup> and Brandon Mackey in *Chance v. Bon Secours Hospital*.<sup>11</sup>

Jurisdictions differ on whether a physician may be held liable for failing to prevent a mentally ill individual from committing suicide.<sup>12</sup> Some states predicate liability on the foreseeability of self-harm and incorporate that into the proximate cause analysis for medical malpractice claims.<sup>13</sup> Other states refuse to find liability if the physician did not have custody of the patient, or because suicide is considered an intervening act that breaks the causal link between the physician's negligent conduct and death.<sup>14</sup> Maryland provides immunity from civil and criminal liability to individuals who in good faith apply to involuntarily admit a potentially suicidal individual and to physicians who eschew involuntary admission.<sup>15</sup> This article posits that physicians should have an affirmative duty to involuntarily commit and treat foreseeably suicidal patients. Additionally, physicians failing to comply with the duty should not be insulated from liability; instead, the physicians' potential liability should be evaluated under a reckless failure to act standard.<sup>16</sup>

## I. BACKGROUND

When an individual exhibits signs of mental illness (*e.g.* suicidal thoughts or tendencies), and the severity of the illness appears to warrant inpatient treatment, physicians may

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<sup>8</sup> See *e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016). See generally, Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. 657 (2016) (asserting that the dangerousness requirement for civil commitment insufficiently helps to serve mentally ill patients).

<sup>9</sup> See *e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-632(b) (West 2016) (mandating that a hearing is held "within 10 days of the date of the initial confinement").

<sup>10</sup> 440 Md. 573, 103 A.3d 658 (Md. 2014).

<sup>11</sup> No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017).

<sup>12</sup> See *infra*, Part II.A.

<sup>13</sup> See *infra*, Part II.A.2.

<sup>14</sup> See *infra*, Part II.A.1 & II.A.2.

<sup>15</sup> See *infra*, Part I.C.

<sup>16</sup> A patient may voluntarily admit herself into treatment but this Comment explores only the involuntary admission of patients already brought to a hospital.

elect to apply for involuntary civil commitment (“involuntary commitment”).<sup>17</sup> Part A of this Section traces the history of involuntary commitments and examines how potential infringements of the Fourteenth Amendment liberty interest are forestalled by dangerousness and due process requirements.<sup>18</sup> Part B explores jurisdictional differences, contemplating whether physicians owe (1) a general duty to prevent suicide deaths of their patients and, if so, (2) if that duty can be discharged by involuntarily committing these patients.<sup>19</sup> Finally, Part C details physician immunity in Maryland for the choice to apply for or eschew involuntary commitments of foreseeably suicidal patients.<sup>20</sup>

### A. Deinstitutionalization, Dangerousness, and Due Process

Between the 1960s and 1970s, the general physician approach to involuntary commitments shifted from forcibly treating individuals as a societal prophylactic to prioritizing the individual’s liberty interest.<sup>21</sup> The landmark involuntary commitment cases, *Wyatt v. Stickney*<sup>22</sup> and *Lessard v. Schmidt*,<sup>23</sup> brought forth the federal courts’ deinstitutionalization of mentally ill patients. Shortly thereafter, the United States Supreme Court followed suit in *Specht v. Patterson*<sup>24</sup> and *Jackson v. Indiana*.<sup>25</sup> Since the early 1970s, however, the Supreme Court has held that involuntarily committing mentally ill patients to hospitals for psychiatric treatment is constitutional, provided that

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<sup>17</sup> MD. CODE ANN., HEALTH-GEN. § 10-614(a) (West 2016) (authorizing applications for involuntary admissions by any interested party); MD. CODE ANN., HEALTH-GEN. § 10-616(a) (West 2016) (requiring application materials to include a physician evaluation and mental illness diagnosis of the patient); MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016) (enumerating the qualifications for involuntary admission).

<sup>18</sup> See *infra*, Part I.A.

<sup>19</sup> See *infra*, Part I.B.

<sup>20</sup> See *infra*, Part I.C.

<sup>21</sup> *J.H. v. Prince George’s Hosp. Ctr.*, 233 Md. App. 549, 570, 165 A.3d 664, 677 (Md. Ct. Spec. App. 2017) (quoting Donald H. J. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 83, 85 (1986)).

<sup>22</sup> 325 F. Supp. 781, 784, 785 (M.D. Ala. 1971) (holding that the treatment given to involuntarily committed patients at Bryce Hospital in Alabama was “scientifically and medically inadequate” and remarking that “depriv[ing] any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail[ing] to provide adequate treatment violates the very fundamentals of due process.”).

<sup>23</sup> 349 F. Supp. 1078, 1084 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *reinstated and enforced*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976) (holding Wisconsin involuntary commitment procedures deficient given that the “[s]tate commitment procedures have not . . . traditionally assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of crime.”).

<sup>24</sup> 386 U.S. 605 (1967).

<sup>25</sup> 406 U.S. 715, 737, n.22 (1972). Justice Blackmun commented that “[c]onsidering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.” *Id.* (citing a Congressional report “estimate[ing] that 90% of the approximately 800,000 patients in mental hospitals in this country had been involuntarily committed.”).

certain procedural requirements are met.<sup>26</sup> When a state places a patient in involuntary civil commitment without meeting procedural or substantive due process requirements, the patient's Fourteenth Amendment liberty interest is unjustly infringed.<sup>27</sup>

Nonetheless, the state's *parens patriae*<sup>28</sup> role and inherent police power permit the state to act despite the patient's liberty interests. In *Addington v. Texas*,<sup>29</sup> Justice Burger explained that:

The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.<sup>30</sup>

In the *parens patriae* context, the state steps in as guardian and seeks to protect mentally ill individuals that cannot care for themselves.<sup>31</sup> State police powers, on the other hand, authorize state action to protect the health, safety, and morals of its residents.<sup>32</sup> By permitting involuntary commitment, the state quarantines mentally ill patients that may inflict harm on other people or themselves and places them in a treatment-oriented facility.<sup>33</sup>

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<sup>26</sup> *Kansas v. Hendricks*, 521 U.S. 346, 356 (1997) (remarking that “[the Supreme] Court has consistently upheld involuntary commitment statutes that detain people who are unable to control their behavior and thereby pose a danger to the public health and safety, provided the confinement takes place pursuant to proper procedures and evidentiary standards.” (citing *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992))).

<sup>27</sup> U.S. CONST. amend. XIV, § 1. *See O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (remarking “[t]here can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law.”); *Anderson v. Dep't of Health and Mental Hygiene*, 310 Md. 217, 228, 528 A.2d 904, 910 (Md. 1987) (holding that “civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”).

<sup>28</sup> *Parens patriae* is “used to describe the power of the state to act in loco parentis for the purpose of protecting the property interests and the person of [residents] . . .” *In re Gault*, 387 U.S. 1, 16 (1967).

<sup>29</sup> 441 U.S. 418 (1979).

<sup>30</sup> *Id.* at 426.

<sup>31</sup> *In re Gault*, 387 U.S. 1, 16–18 (describing the historical developments of the *parens patriae* doctrine).

<sup>32</sup> *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (“According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.”) (citations omitted). *See also Crowley v. Christensen*, 137 U.S. 86, 89–90 (1890) (averring that “the possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to be equal enjoyment of the same right by others.”).

<sup>33</sup> *See, e.g., MD. CODE ANN., HEALTH-GEN. § 10-614(a)* (West 2016) (permitting “application for involuntary admission of an individual to a facility or Veterans' Administration hospital . . . under this part by any person who has a legitimate interest in the welfare of the individual.”).



Prior to admission, an evaluating physician must conduct an evaluation and deem the patient dangerous.<sup>34</sup> The Massachusetts Supreme Court explained: “The right to restrain an insane person of his liberty, is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others.”<sup>35</sup> In 1975, the Supreme Court held that “a State cannot constitutionally confine without more a nondangerous individual.”<sup>36</sup> The Supreme Court’s holding signifies that, absent a showing of dangerousness, an involuntary commitment is an unconstitutional deprivation of liberty.<sup>37</sup>

Kenneth Donaldson was involuntarily committed to a Florida hospital for fifteen years despite Donaldson’s repeated assertions that he was not dangerous and did not require treatment.<sup>38</sup> Though it was plausible that Donaldson suffered from a mental illness, the Court stated that this alone was insufficient to deprive an individual of liberty and “there is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.”<sup>39</sup> Only where an individual presents a danger to self or others may they be committed because, although “the State has a proper interest in providing [treatment]” to its mentally ill residents, “the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution.”<sup>40</sup> Jurisdictions differ on the threshold of dangerousness required to meet the involuntary admission criteria.<sup>41</sup> The higher the threshold, the less likely a

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<sup>34</sup> See *infra*, notes 36–37, and accompanying text.

<sup>35</sup> In re Josiah Oakes, 8 Law Rep. 123, 4–5 (Mass. 1845). The court further explained that “[t]he question must then arise in each particular case, whether a person’s own safety or that of others requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restraint can continue as long as the necessity continues.” *Id.* at 6–7.

<sup>36</sup> *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

<sup>37</sup> See also *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (noting that states, when statutorily permitting involuntary commitment, base this choice “not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.”) (dictum). See also *People v. Stevens*, 761 P.2d 768, 772–73 nn. 4–9 (Colo. 1988) (listing the degree of dangerousness required by statute across a majority of jurisdictions).

<sup>38</sup> *O’Connor*, 422 U.S. at 564–63. The hospital provided Donaldson with custodial care rather than mental health treatment and refused to release him despite offers from a half-way house and from a friend to provide Donaldson with the care required upon discharge. *Id.* at 569.

<sup>39</sup> *Id.* at 574.

<sup>40</sup> *Id.*

<sup>41</sup> See e.g., MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016) (requiring that an individual “presents a danger” to self or others); ALA. CODE § 22-52-37 (1975) (requiring an overt act); CAL. WELF. & INST. CODE § 5300(a) (West 1983) (requiring threats, attempts, or infliction of “substantial physical harm”); DEL. CODE ANN. tit. 16, § 5013 (West 2014) (requiring that the individual is “reasonably expected to become dangerous to self” or others, and either (1) a documented history of nonadherence to treatment, or (2) an “extreme threat of danger to self” or others, evidenced by an observation of danger or imminent danger).

patient will be involuntarily committed, and most states require that there be no less restrictive alternative treatment available prior to involuntarily committing a patient.<sup>42</sup>

Following admission, the patient is afforded procedural protections. Federal courts have contemplated the constitutionality of these protections on several occasions.<sup>43</sup> *Vitek v. Jones*<sup>44</sup> identified these safeguards as: (1) notice of transfer to a mental health facility; (2) a hearing with an opportunity to contest evidence; (3) presentation and cross-examination of witnesses; (4) an independent decision-maker; (5) disclosure of the evidence relied on by the decision-maker; and (6) “effective and timely notice of all foregoing rights.”<sup>45</sup> When a patient challenges their involuntary commitment, courts do not apply a specific test to decide if the patient was denied procedural due process. Instead, the courts apply the balancing standard<sup>46</sup> set forth in *Mathews v. Eldridge*,<sup>47</sup> wherein the Supreme Court outlined the interest considerations as follows:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the

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<sup>42</sup> See e.g., DEL. CODE ANN. tit. 16, § 5002 (West 2014); D.C. CODE ANN. § 21-545(b)(2) (West 2004); MISS. CODE ANN. § 41-21-73(4) (West 2010); N.J. STAT. ANN. § 30:4-24.2(d)(3) (West 2013); OKLA. STAT. ANN. tit. 43A, § 4-102(5) (West 2005); and WASH. REV. CODE ANN. § 71.05.230 (West 2016).

<sup>43</sup> See e.g., *Vitek v. Jones*, 445 U.S. 480 (1980); *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (holding “due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed”); *In re Joseph P.*, 943 N.E. 2d 715 (Ill. 2010) (finding potential prejudice to individual where police officer did not identify himself on emergency petition); *Rueda v. Charmaine*, 906 N.Y.S. 2d 246 (N.Y. 2010) (allowing emergency room psychiatrists to petition for non-emergency involuntary commitment); *Kootenai Med. Ctr. v. Bonner Cty. Comm’rs*, 105 P.3d 667 (Idaho 2004) (precluding hospital from petitioning for involuntary commitment where patient has not requested to leave facility); *In re Miller*, 585 N.E.2d 396 (Ohio 1992) (precluding social worker from filing affidavit initiating commitment in lieu of hospital’s chief clinical officer).

<sup>44</sup> 445 U.S. 480 (1980).

<sup>45</sup> *Id.* at 494–95 (citing *Miller v. Vitek*, 437 F. Supp. 569, 575 (D. Neb. 1977), *vacated sub nom.* *Vitek v. Jones*, 436 U.S. 407 (1978)). The plurality, led by Justice White, also found that state-funded legal counsel should be provided to “prisoners who are illiterate and uneducated” or suffering from “mental disease or defect” because they are unlikely to comprehend their rights. *Id.* at 496–97 (Powell, J., concurring).

<sup>46</sup> *Wilkinson v. Austin*, 545 U.S. 209, 224 (2005) (stating that “[b]ecause the requirements of due process are ‘flexible and cal[li] for such procedural protections as the particular situation demands,’ we generally have declined to establish rigid rules and instead have embraced a framework to evaluate the sufficiency of particular procedures.” (quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972))). See also *Addington v. Texas*, 441 U.S. 418, 425 (1979) (holding that “[i]n considering what standard should govern in a civil commitment proceeding, we must assess both the extent of the individual’s interest in not being involuntarily confined indefinitely and the state’s interest in committing the emotionally disturbed under a particular standard of proof.”).

<sup>47</sup> 424 U.S. 319 (1976).

fiscal and administrative burdens that the additional or substitute procedural requirement would entail.<sup>48</sup>

The Supreme Court of Alaska recently applied this test in *Matter of Jacob S.*<sup>49</sup> where an involuntarily committed patient challenged the use of telephonic testimony at his commitment hearing.<sup>50</sup> The patient's domestic partner filed for an emergency evaluation after the patient ceased taking his medication, exhibited violent behavior, and appeared to suffer from paranoid delusions.<sup>51</sup> The evaluating physician applied for an involuntary admission and "approval to administer psychotropic medication because [the patient] lacked capacity to give informed consent."<sup>52</sup> The court held a hearing on both petitions wherein the patient's domestic partner and neighbor testified via telephone. The patient argued that this testimony violated his due process rights.<sup>53</sup> In balancing the interests of the parties, the court recognized that the patient's commitment severely limited his liberty interest.<sup>54</sup> Despite this recognition, the court found that the risk of erroneous commitment in light of the telephonic testimony was minimal because the patient had an opportunity to cross-examine the witnesses at his hearing and did not attack their credibility.<sup>55</sup> The court also recognized the state's interest in quickly gathering evidence; the involuntary commitment hearing was held less than seventy-two hours after the initial detention since a potentially dangerous individual may be discharged and harm the community if fact-finding is not done expeditiously.<sup>56</sup> In weighing these interests, "the low erroneous deprivation risk and the State's great health and public safety interest tip[ped] the scale in the State's favor—even when balanced against [the patient's] significant liberty interest."<sup>57</sup>

## **B. Physician Liability for Failure to Protect Foreseeably Suicidal Patients**

Furthermore, if a physician declines to commit, or prematurely releases, a patient in need of additional treatment, the physician exposes themselves and others to liability for future harm caused by the patient.<sup>58</sup> While a person ordinarily owes no duty to protect

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<sup>48</sup> *Id.* at 335.

<sup>49</sup> 384 P.3d 758 (Alaska 2016).

<sup>50</sup> *Id.* at 764.

<sup>51</sup> *Id.* at 762.

<sup>52</sup> *Id.* at 764.

<sup>53</sup> *Id.* at 762.

<sup>54</sup> *Id.* at 764.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.* at 765.

<sup>57</sup> *Id.*

<sup>58</sup> See e.g., *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App. 2012) (holding that where physician failed to involuntarily commit his foreseeably suicidal patient, he may be liable for her subsequent suicide attempt because "while [physician] had no duty to guarantee that [patient] did not attempt suicide, he had a long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of ... his patient."); and *Foster v. Charter Med. Corp.*, 601 So. 2d 435, 440 (Ala. 1992) (reversing grant of summary judgment in favor of defendant doctor where patient was released from treatment and foreseeably committed suicide afterwards).

someone else from harm, certain special relationships impose such an affirmative duty. For example, psychiatrists have an affirmative duty to protect patients suffering from suicidal ideations.<sup>59</sup> In *Tabor v. Doctors Memorial Hospital*,<sup>60</sup> decedent Andy Tabor was quickly transported to the emergency room<sup>61</sup> after attempting to commit suicide by consuming thirteen Quaaludes.<sup>62</sup> The treating physician diagnosed Andy with depression and recommended that he be placed in the psychiatric ward for seventy-two hours.<sup>63</sup> The physician later learned that Andy's insurance would not cover the psychiatric treatment and released him—despite his ability to waive the payment requirement—because he did not believe Andy's condition was an emergency.<sup>64</sup> Andy shot himself in the heart the next day.<sup>65</sup> The Supreme Court of Louisiana ultimately held the physician liable because his failure to commit Andy into psychiatric treatment, while not guaranteed to prevent Andy's suicide, “was a substantial factor in the cause of Andy's death.”<sup>66</sup>

In addition to the psychiatrist-patient relationship, foreseeability of suicide further establishes the duty to protect another from self-harm. For example, in *Wyke v. Polk Country School Board*,<sup>67</sup> a middle-school aged boy twice attempted to commit suicide at school and neither attempt was reported to his mother.<sup>68</sup> The adolescent took his life shortly after the second suicide attempt, for which the Eleventh Circuit held the school liable because the special relationship between schools and children, coupled with the foreseeability of death in this case, imposed an obligation to inform the decedent's mother about his condition.<sup>69</sup>

Alternatively, many jurisdictions do not recognize physician liability for the failure to commit and treat foreseeably suicidal patients. These jurisdictions utilize various lines of reasoning to excuse physician liability, including: no special relationship exists;<sup>70</sup>

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<sup>59</sup> See *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334, 340 (Cal. 1976) (holding that mental health physicians have a duty to protect intended victims of violent patients). In situations involving patients with suicidal ideation, the intended victim would be the patient herself. Suicidal ideation is either passive or active, wherein “passive suicidal ideation entails thoughts such as wishing that you were dead, while active suicidal ideation entails thoughts of self-directed violence and death.” *Bankhead v. Shulkin*, 29 Vet. App. 10, 20 (Vet. App. 2017).

<sup>60</sup> 563 So.2d 233 (La. 1990).

<sup>61</sup> *Id.* at 235.

<sup>62</sup> *Mendoza v. Sec'y, Florida Dep't of Corr.*, 761 F.3d 1213, 1217 n.3 (11th Cir. 2014) (explaining that “‘Quaalude’ is the brand name for the drug Methaqualone, ‘a non-barbiturate sedative-hypnotic that is a general depressant of the central nervous system.’” (citing *Hardwick v. Crosby*, 320 F.3d 1127, 1168 n. 159 (11th Cir.2003))).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.* Three members of the nursing staff attending to Andy also approached the physician and voiced their opinion “that Andy's condition presented an emergency.” *Id.*

<sup>65</sup> *Id.* at 236.

<sup>66</sup> *Id.* at 238.

<sup>67</sup> 129 F.3d 560 (11th Cir. 1997), *certified question withdrawn*, 137 F.3d 1292 (11th Cir. 1998).

<sup>68</sup> *Id.* at 563–65.

<sup>69</sup> *Id.* at 574.

<sup>70</sup> See, e.g., *Weiss v. Rush North Shore Medical Center*, 865 N.E.2d 555 (Ill. App. Ct. 1st Dist. 2007).

suicide is construed as an intervening act;<sup>71</sup> death by suicide constitutes contributory fault;<sup>72</sup> the exercise of professional medical judgment precludes liability;<sup>73</sup> or the state offers statutory immunity.<sup>74</sup>

### C. Maryland: Physician Immunity for Involuntary Admission Applications

In Maryland, a physician is immune from civil and criminal liability when they “in good faith and with reasonable grounds apply for involuntary admission.”<sup>75</sup> In *Williams v. Peninsula Regional Medical Center*, the Court of Appeals construed Courts and Judicial Proceedings Article § 5-623 (“CJP § 5-623”) and Health–General Article § 10-618 as granting immunity to physicians that elect to commit a mentally ill individual as well as those physicians that elect *not* to commit and treat the individual.<sup>76</sup> In 2009, decedent Charlie Williams (“Charlie”) arrived in an emergency room exhibiting signs of suicidal ideation and auditory and visual hallucinations.<sup>77</sup> Health care providers elected not to admit Charlie, released him into the custody of his mother and “advis[ed] her to remove any firearms from the home.”<sup>78</sup> Charlie immediately escaped his mother’s custody and broke into a Salisbury, MD residence later that evening.<sup>79</sup> When police arrived, he brandished a knife and exclaimed that he wanted to be shot. Charlie then rushed the officers, who opened fire on Charlie and killed him.<sup>80</sup> The Court of Appeals of Maryland exempted the physician from liability after comparing CJP § 5-623 to the entirety of the involuntary admissions part of the Maryland mental health laws.<sup>81</sup> Based

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<sup>71</sup> See, e.g., *Johnson v. Wal-Mart Stores, Inc.*, 588 F.3d 439 (7th Cir. 2009) (affirming Illinois law “describing suicides as intervening acts that break the causal chain because of their presumptively unforeseeable nature”); but see also *Edwards v. Tardif*, 692 A.2d 1266 (Conn. 1997) (recognizing that suicide is ordinarily considered an intervening act but finding an exception where the physician’s conduct fell below the standard of care when treating a foreseeably suicidal patient).

<sup>72</sup> See, e.g., *Skar v. City of Lincoln, Neb.*, 599 F.2d 253 (8th Cir. 1979) (permitting defense of contributory fault under Nebraska law); but see also *McNamara v. Honeyman*, 46 N.E.2d 139, 146 (Mass. 1989) (stating that “there can be no comparative negligence where the defendant’s duty of care includes preventing the self-abusive or self-destructive acts that caused the plaintiff’s injury.”).

<sup>73</sup> See, e.g., *Topel v. Long Island Jewish Medical Center*, 431 N.E.2d 293, 294–95 (N.Y. 1981) (refusing to hold physician liable for patient’s suicide because physician’s choice to forgo continuous observation was an exercise of his professional medical judgment).

<sup>74</sup> See, e.g., GA. CODE ANN. § 37–3–4 (West 2011).

<sup>75</sup> MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 1997); MD. CODE ANN., HEALTH-GEN. § 10-618 (West 2016) (granting immunity to anyone that “applies for involuntary admission of an individual ... under § 5-623(b) of the Courts and Judicial Proceedings Article”).

<sup>76</sup> 440 Md. 573, 587, 103 A.3d 658, 666–67 (Md. 2014) (holding that “[t]he immunity conferred by HG § 10–618 and CJP § 5–623 protects the discretion of health care providers, which in turn safeguards the liberties of those subject to evaluation and possible involuntary admission.”).

<sup>77</sup> *Id.* at 576, 660.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 576–77, 660. Charlie’s actions constitute what is known as “suicide by cop.” United States v. List, 200 F. App’x 535, 544 n.2 (6th Cir. 2006) (defining suicide by cop as “act[ing] in a way that would require law enforcement officers to respond with lethal force.”).

<sup>81</sup> *Williams*, 440 Md. at 583, 664 (Md. 2014). The involuntary admissions part of the Maryland mental health laws is referred to as “Part III” by the Court of Appeals and this Comment.

on this comparison, the court construed the Maryland General Assembly's purpose as conferring immunity on the physician since the physician complied with the other health articles by electing not to admit.<sup>82</sup>

The Court of Appeals will have an opportunity to revisit this issue in an appeal from *Chance v. Bon Secours Hospital*.<sup>83</sup> On March 13, 2011, Dr. Leroy M. Bell ("Dr. Bell") at Bon Secours Hospital gained care of twenty-three-year-old Brandon Mackey ("Brandon") after a suicide attempt in which Brandon slit his wrists.<sup>84</sup> Dr. Bell diagnosed Brandon with major depressive disorder and released him from voluntary commitment eight days later (March 21).<sup>85</sup> Brandon made a second suicide attempt ten days after his release (April 1), and Dr. Bell again gained care of Brandon via involuntary commitment to Bon Secours Hospital.<sup>86</sup> Dr. Bell diagnosed Brandon with "schizoaffective disorder, bipolar type," and administered the drug Risperdal (April 6).<sup>87</sup> Brandon was released three days later (April 9), and tragically died after jumping in front of a metro train the next day.<sup>88</sup> Patricia Chance, Brandon's mother, filed suit against Dr. Bell and Bon Secours Hospital Baltimore, Inc., alleging that Brandon's negligent release from involuntary commitment led to his suicide.<sup>89</sup> At trial, Dr. Nicola G. Cascella ("Dr. Cascella"), certified as an expert in schizophrenic psychiatry, testified that "Bell breached the applicable standard of care by discharging Mackey before confirming that the prescribed medication was showing adequate impact, and that the premature release proximately caused Mackey's suicide the day after his release."<sup>90</sup> The jury awarded Patricia Chance \$6,112 in economic damages and \$2,300,000 in non-economic damages, but the court granted the defendants' motion

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<sup>82</sup> *Id.*

<sup>83</sup> No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017); *Bell & Bon Secours Hosp. v. Chance*, 170 A.3d 289 (Table) (Md. 2017).

<sup>84</sup> *Id.* at \*1.

<sup>85</sup> *Chance*, slip op. at \*1. The Mayo Clinic defines major depressive disorder (depression) as "a mood disorder that causes a persistent feeling of sadness and loss of interest. ... [I]t affects how you feel, think and behave and can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and sometimes you may feel as if life isn't worth living." *Depression (major depressive disorder)*, MAYO CLINIC (last visited October 2, 2017), <http://www.mayoclinic.org/diseases-conditions/depression/home/ovc-20321449>.

<sup>86</sup> *Chance*, slip op. at \*1.

<sup>87</sup> *Id.* at \*1–2. Schizoaffective disorder is defined as "a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression." *Schizoaffective Disorder*, NATIONAL ALLIANCE ON MENTAL ILLNESS (last visited Oct. 24, 2017), <https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizoaffective-Disorder>. Risperdal is a second-generation antipsychotic medication used to treat conditions such as schizophrenia and, if administered via injection, can take up to three weeks before it begins treating symptoms and two to three months before full benefits are realized. College of Psychiatric and Neurologic Pharmacists, *Risperidone (Risperdal)*, NATIONAL ALLIANCE ON MENTAL ILLNESS (June 2016), [https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Risperidone-\(Risperdal\)](https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Risperidone-(Risperdal)).

<sup>88</sup> *Chance*, 2017 WL 1716258 at \*1.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* at \*2 (citing *Chance v. Bell, Jr., M.D.*, 2014 WL 4401077 (Md. Cir. Ct.) (Trial Order)).

for judgment notwithstanding the verdict.<sup>91</sup> On appeal, the Maryland Court of Special Appeals questioned whether the release was a proximate cause of his Mackey's suicide and whether there was sufficient evidence for the jury to conclude that Dr. Bell breached the standard of care by releasing Brandon on April 9.<sup>92</sup> The court stated:

[W]e conclude that sufficient evidence was presented at trial for the jury to find, based upon the testimony of Dr. Cascella: (1) that the standard of care required Dr. Bell not to discharge Mackey until his symptoms of psychosis were significantly reduced by Risperdal, (2) that, at the time Dr. Bell discharged Mackey, the patient continued to present symptoms of responding to internal stimuli, as well as poor insight and poor judgment, indicating that Mackey's symptoms had not yet been significantly reduced by the Risperdal, and (3) that Mackey's premature discharge from Bon Secours was a proximate cause of his death. There was sufficient evidence to support the jury's finding of liability. Therefore, the motion for judgment notwithstanding verdict should not have been granted.<sup>93</sup>

In addition to reversing the verdict, the court ordered a remand because the circuit court did not rule on the appellee's alternative motion for a new trial.<sup>94</sup> Interestingly, the only mention of Health-General Article § 10-618 appeared in Judge Dan Friedman's dissent.<sup>95</sup> He concluded the only way for Dr. Bell to meet the standard of care opined by Dr. Cascella would be to involuntarily commit Brandon, and therefore Dr. Bell would enjoy immunity conferred under *Williams*.<sup>96</sup> The Court of Appeals' upcoming review of the case will provide the court with the ability to reevaluate *Williams* and further shape how physicians treat foreseeably suicidal patients.<sup>97</sup>

## II. ANALYSIS

Maryland should recognize that physicians have an affirmative duty to prevent the foreseeable suicide of their patients (potentially through the use of involuntary admissions) and eliminate the current provision of statutory immunity that is provided when this duty is breached. Part II.A of this Comment explores jurisdictional differences in liability for the failure to prevent an individual's suicide from a judicial perspective and posits that the Maryland judiciary should recognize a physician duty to prevent self-harm which, under some circumstances, must be discharged by involuntarily admitting and treating a patient.<sup>98</sup> The Maryland legislature could reduce medical malpractice litigation, protect patients' right to liberty, and combat unsound involuntary admissions through the adoption of several procedural and substantive safeguards, such as

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<sup>91</sup> *Id.* at \*3–4. The non-economic damages were reduced to \$695,000 in accordance with the statutory limit. *Id.* The appellees also alternatively motioned for a new trial. *Id.* at \*4.

<sup>92</sup> *Id.* at \*5.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* at \*6.

<sup>95</sup> *Id.* at \*6–7.

<sup>96</sup> *Id.* See supra, notes 48–53, and accompanying text.

<sup>97</sup> 456 Md. 52, 170 A.3d 289 (Table) (Md. 2017).

<sup>98</sup> See *infra*, Part II.A.



buttressing the dangerousness requirement with a showing of an overt act and narrowing the establishment of proximate cause with a definitive temporal element.<sup>99</sup> Part II.B then applies this paradigm to *Chance v. Bon Secours Hospital* and proposes setting aside *Williams v. Peninsula Regional Medical Center* to ultimately hold Dr. Bell liable and prevent further expansion of physician immunity following the death of a foreseeably suicidal patient.<sup>100</sup> Part II.C advocates that the Maryland legislature amend the health articles to clearly remove physician immunity following a reckless breach of the duty explored in Part II.A.<sup>101</sup> Finally, Part II.D examines the benefits and harms of the standard and changes advocated throughout this analysis and finds that jurisprudence favors saving potential lives over the potentially implicating liberty interests.

### **A. Preventing Patient Suicide: Foreseeability Creates Liability**

When suing for medical malpractice based on the suicide of a patient, the decedent's estate must establish that the physician (1) owed a duty of care to the patient, (2) breached the duty, (3) the breach of duty was the legal and proximate cause of the patient's death.<sup>102</sup> Patients and physicians are parties to a "special relationship" that creates an affirmative duty of care.<sup>103</sup> Physicians may be found liable for the suicide of their patients where the harm was foreseeable, even if the patient was not in the custody of a treatment facility at the time of death.<sup>104</sup> This attendant liability, however, may encourage physicians to petition for substantially more involuntary admissions than they would otherwise, therefore unnecessarily infringing on preeminent liberty interests.<sup>105</sup> Part II.A.1 surveys how different courts treat the duty owed by physicians to their suicidal patients and Part II.A.2 explores how foreseeability impacts this duty. Finally, Part II.A.3 discusses procedural changes to the involuntary admission process that may reduce unnecessary admissions.

#### *1. Physicians Owe a Duty of Care to Their Patients to Prevent Self-Harm*

The special relationship between physicians and their patients is one of the few relationships that create a duty to take affirmative action, which some jurisdictions find includes the duty to protect patients from self-harm.<sup>106</sup> The Sixth Circuit, applying

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<sup>99</sup> See *infra*, Part II.A.3.

<sup>100</sup> See *infra*, Part II.B.

<sup>101</sup> See *infra*, Part II.C.

<sup>102</sup> *Crise v. Maryland Gen. Hosp., Inc.*, 212 Md. App. 492, 520–21, 69 A.3d 536, 553 (Md. Ct. Spec. App. 2013) (citing *Sterling v. Johns Hopkins Hosp.*, 145 Md.App. 161, 802 A.2d 440 (Md. Ct. Spec. App. 2002)); *Jacobs v. Flynn*, 131 Md. App. 342, 749 A.2d 174 (Md. Ct. Spec. App. 2000)). The standard of care in Maryland is "the degree of care or skill expected of a reasonably competent health care provider in the same or similar circumstances." *Id.* at 521 (citing *Shilkret v. Annapolis Emergency Hosp. Assoc.*, 276 Md. 187, 349 A.2d 245 (Md. 1975)).

<sup>103</sup> See *infra*, Part II.A.1.

<sup>104</sup> See *infra*, Part II.A.2.

<sup>105</sup> See *infra*, Part II.A.3.

<sup>106</sup> See *supra*, note 59, and accompanying text.



Tennessee law, in *MacDermid v. Discover Financial Services*,<sup>107</sup> held that there are three scenarios where a wrongful death action following suicide is permitted:

(1) where defendant's negligence causes 'delirium' or 'insanity' that results in self-destructive acts; (2) where defendant is the decedent's custodian, and defendant knows or has reason to know that the decedent might engage in self-destructive acts; [or] (3) where defendant and decedent have a legally recognized 'special relationship,' such as a physician-patient relationship, and defendant knows or has reason to know that the decedent might engage in self-destructive acts.<sup>108</sup>

For patients suffering from suicidal thoughts or tendencies, the physician must take appropriate steps to prevent the impending self-harm or risk incurring liability.<sup>109</sup> While this article focuses on involuntary admissions, where appropriate, as one such step in protecting patients, "[t]he duty at issue is not, properly speaking, a duty to involuntarily commit. It is a much broader duty, which may, in particular cases, entail a duty to commit."<sup>110</sup>

The duty of physicians to protect others is so paramount that the Supreme Court of California extended this duty beyond patients to foreseeable victims of their patients' violence in *Tarasoff v. Regents of University of California*.<sup>111</sup> This holding indicates that not only is a physician's duty to protect others clearly recognized, but that the action required to protect others in the face of anticipated human-inflicted violence must be a real and calculated attempt to prevent danger. The physicians in *Tarasoff* notified police when the outpatient indicated his desire to kill the decedent, but the court suggested that this action was insufficient and the physicians should have warned the decedent directly.<sup>112</sup>

Applying this paradigm to patients suffering from suicidal ideation, the victim would be the patient herself.<sup>113</sup> If the treating physician determines through patient evaluation that the patient exhibits a high likelihood of suicide and the patient meets all statutory

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<sup>107</sup> 488 F.3d 721 (6th Cir. 2007).

<sup>108</sup> *Id.* at 736 (citing *Rains v. Rains v. Bend of the River*, 124 S.W.3d 580, 593–94 (Tenn. Ct. App. 2003)). See also *Stevens v. MTR Gaming Group, Inc.*, 788 S.E.2d 59, 67 (W. Va. 2016) (“[A]bsent a special relationship between the parties giving rise to a specific duty to prevent the decedent’s suicide, the act of taking one’s own life is generally regarded as a supervening act that breaks the chain of causation”).

<sup>109</sup> See *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App. 2012) (holding that “while [the physician had no duty to guarantee that [his patient] did not attempt suicide, he had a long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of ... his patient.”).

<sup>110</sup> *Id.*

<sup>111</sup> 551 P.2d 334, 340 (Cal. 1976) (holding “[w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”).

<sup>112</sup> *Id.* at 341.

<sup>113</sup> See *supra*, note 60.

requirements for involuntary commitment, the physician must apply for a commitment to discharge the duty to prevent self-harm.<sup>114</sup> The court recognized the inherent privacy concerns that exist when psychiatrists are required to disclose conversations with patients, but found that “public interest in safety from violent assault” outweighed the preservation of “the open and confidential character of psychotherapeutic dialogue.”<sup>115</sup> The California Supreme Court, while essentially mandating that physicians take steps to protect even non-patients, noted that this duty should be limited to instances where it is “necessary to avert danger to *others*.”<sup>116</sup> However, a patient’s display of suicidal behavior and conduct meeting the requirements for involuntary commitment should outweigh privacy concerns and trigger the duty to prevent the foreseeable suicide.<sup>117</sup>

Physician liability, like that exhibited in *Tarasoff*, may not be solely predicated on whether the patient was in the custody of a treatment facility.<sup>118</sup> Rather than focusing on custody, the analysis should question whether the physician failed to provide the requisite standard of care and whether that breach was a proximate cause of the patient’s suicide.<sup>119</sup> California law “recognize[s] that psychiatrists owe a duty of care, consistent with standards in the professional community, to provide appropriate treatment for potentially suicidal patients, whether the patient is hospitalized or not. . . . Indeed, it would seem almost self-evident that doctors must use reasonable care with *all* of their patients in diagnosing suicidal intent and implementing treatment plans.”<sup>120</sup> Other jurisdictions, such as Illinois and Hawaii, refuse to find liability in the absence of custody.<sup>121</sup>

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<sup>114</sup> *Tarasoff*, 551 P.2d at 345.

<sup>115</sup> *Id.* at 346–47.

<sup>116</sup> *Id.* at 346 (emphasis added).

<sup>117</sup> *Id.* at 347 (citing CAL. EVID. CODE § 1024 (West 1967)) (finding a statutory exception to the confidentiality privilege where “the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”).

<sup>118</sup> Prosenjit Poddar, as an outpatient, was never in civil commitment; he was briefly detained by police and then released from custody. *Id.* at 339.

<sup>119</sup> *Edwards v. Tardif*, 692 A.2d 1266, 1270 n.7 (Conn. 1997).

<sup>120</sup> *Kockelman v. Segal*, 61 Cal. App. 4th 491, 501 (Cal. Ct. App. 1998). However, the court noted it does not “endorse a rule which imposes an absolute duty on a psychiatrist to prevent a patient’s suicide. . . . [O]nly that a psychiatrist’s duty of care to a patient, which may include taking appropriate suicide prevention measures if warranted by all of the circumstances, is not negated by the patient’s status as an outpatient.” *Id.* at 503.

<sup>121</sup> See e.g., *Winger v. Franciscan Med. Ctr.*, 701 N.E.2d 813, 820 (Ill. App. 3d. 1998) (finding liability only where “the [suicide] arose from the plaintiff’s mental state (e.g., severe depression), the act of suicide was foreseeable, and the plaintiff was in the custody or control of the physician or hospital at the time he acted.”); *Lee v. Corregedore*, 925 P.2d 324, 337 (Haw. 1996) (refusing to hold state veterans’ services counselor liable for suicide of outpatient as “[p]ublic policy considerations weigh against imposing a duty on all counselors to prevent the suicides of noncustodial clients, because the imposition of such a broad duty could have a deleterious effect on counseling in general.”).

## 2. Foreseeability May Require Involuntarily Admission as a Means of Discharging the Duty to Protect Against Self-Harm

When coupled with the special physician-patient relationship, foreseeability of self-harm is the most significant factor in establishing the duty to prevent a patient's suicide and whether the physician's obligation to apply for involuntary commitment is triggered.<sup>122</sup> Similar to the dangerousness evaluation upon admission, the patient must show signs of suicidal thoughts or tendencies in order for the physician to effectively appreciate her condition and (1) treat her, or (2) unreasonably fail to treat her and be susceptible to liability.<sup>123</sup> Where the patient is not exhibiting signs of suicidal thoughts or tendencies, courts are rightfully reluctant to impose liability.<sup>124</sup>

Conversely, where a patient suffers from suicidal ideation or previously attempted suicide, courts may choose to impose liability. One example of the judiciary's willingness to impose physician liability for suicide cases is *Wyke v. Polk County School Board*.<sup>125</sup> In *Wyke*, a thirteen year old boy twice attempted to commit suicide at school, and his school was aware of the attempts.<sup>126</sup> After the first attempt, the Dean of Students called the child into his office and recited Bible verses for the student.<sup>127</sup> The school did nothing after the second attempt.<sup>128</sup> Unfortunately, no representative of the school system informed the child's mother of the suicide attempts, and he later hanged himself from a tree in the backyard of his home.<sup>129</sup> The Eleventh Circuit held the school liable for its failure to warn the child's mother, stating:

[The child] did not merely seem unhappy. [He] did not merely talk about committing suicide. He twice tried to hang himself from the rafters in the school's restroom. The workings of the human mind are truly an enigma, but we do not believe ... that a prudent person would have needed a crystal ball

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<sup>122</sup> *Edwards v. Tardif*, 692 A.2d 1266, 1269 (Conn. 1997) (holding "suicide will not break the chain of causation if it was a foreseeable result of defendant's tortious act.").

<sup>123</sup> *Jacoves v. United Merch. Corp.*, 11 Cal. Rptr. 2d 468, 478 (Cal. Ct. App. 1992) (stating that "[i]f those who are caring for and treating mentally disturbed patients know of facts from which they could reasonably conclude that the patient would be likely to self-inflict harm in the absence of preventative measures, then those caretakers must use reasonable care under the circumstances to prevent such harm from occurring."); *Runyon v. Reid*, 510 P.2d 943 (Okla. 1973) (holding pharmacist not liable for refilling a non-refillable prescription used by decedent to commit suicide because there was nothing to make the pharmacist aware of the intended use).

<sup>124</sup> *Fleming v. HCA Health Services of Louisiana, Inc.*, 691 So.2d 1216, 1219 (La. 1997) (holding that where no parties in contact with decedent perceived that he was suicidal, hospital was not liable for his death by suicide where the circumstances did not appear to warrant providing "emergency medical services").

<sup>125</sup> *Wyke v. Polk Cty. Sch. Bd.*, 129 F.3d 560 (11th Cir. 1997), *certified question withdrawn*, 137 F.3d 1292 (11th Cir. 1998).

<sup>126</sup> *Id.* at 564-65.

<sup>127</sup> *Id.* at 564.

<sup>128</sup> *Id.* at 565.

<sup>129</sup> *Id.*

to see that [he] needed help and that if he didn't get it soon, he might attempt suicide again.<sup>130</sup>

The *Wyke* court described the special relationship between schools and children, noting that this relationship imposed a supervisory duty.<sup>131</sup> The court further reasoned that the school's duty created an obligation to warn parents whose children experience emergency health problems such as suicidal ideation, explaining that "[t]he failure to discharge those obligations can subject the school to possible liability for reasonably foreseeable injuries."<sup>132</sup> Notably, the Maryland Court of Appeals came to the same conclusion when it addressed the foreseeability of student suicide: "[f]oreseeability is the most important variable in the duty calculus and without it there can be no duty to prevent suicide."<sup>133</sup>

The Maryland judiciary should adopt the position taken by jurisdictions that impose liability on a physician who failed to treat a patient with reasonable care when it was foreseeable that the patient would attempt to commit suicide.<sup>134</sup> Some jurisdictions impose liability even where the state generally treats suicide as an intervening act that breaks the chain of causation. *Edwards v. Tardif* is illustrative.<sup>135</sup> The Supreme Court of Connecticut noted the common law rule that death by suicide is an unforeseeable act that supersedes a defendant's liability in a wrongful death action.<sup>136</sup> The court then noted that many jurisdictions do not consider suicide a superseding act "if it was a foreseeable result of the defendant's tortious act" or if "suicide was one of the foreseeable risks that made the physician's antecedent conduct negligent."<sup>137</sup>

Some courts even go so far as to impose liability for a breach of duty in instances where suicide is foreseeable irrespective of the individual's behavior.<sup>138</sup> For example, the Supreme Court of Idaho imposed physician liability when a patient committed suicide after he was "negligently misinformed...that he was HIV negative and subsequently subjected to the medical negligence of [another doctor]."<sup>139</sup> Such cases indicate that where self-harm is foreseeable, courts will recognize that affirmatively taking action to

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<sup>130</sup> *Id.* at 574.

<sup>131</sup> *Id.* at 572–73.

<sup>132</sup> *Id.* at 574.

<sup>133</sup> *Eisel v. Bd. of Educ. of Montgomery Cty.*, 324 Md. 376, 386, 597 A.2d 447, 452 (Md. 1991). This case involved a school counselor failing to protect a student from self-harm despite the foreseeability of suicide, and the court ultimately held that "school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent student's suicidal intent." *Id.* at 393.

<sup>134</sup> *See e.g.*, *Peterson v. Reeves*, 727 S.E.2d 171, 175 (Ga. Ct. App 2012) (holding physician liable for the failure to involuntarily commit his foreseeably suicidal patient).

<sup>135</sup> 692 A.2d 1266, 1270 (Conn. 1997).

<sup>136</sup> *Id.* at 1269.

<sup>137</sup> *Id.* at 1269–70.

<sup>138</sup> *I.e.*, where circumstances objectively would create a foreseeable likelihood of suicide, regardless of how the patient subjectively feels or behaves.

<sup>139</sup> *Cramer v. Slater*, 204 P.3d 508, 516 (Idaho 2009) (applying the Restatement (Second) of Torts § 457 where "subsequent medical negligence is generally foreseeable, including instances where the injury complained of stems from an original negligent act failing to properly diagnose and treat").

protect the patient from suicide is the reasonable course of action and the absence of such action will make the physician susceptible to liability.<sup>140</sup> Circumstances may arise where involuntary commitment is the most reasonable response to foreseeable patient suicide.<sup>141</sup> However, across-the-board assignment of liability to physicians who fail to act is undermined by the amorphous and sometimes inaccurate task of diagnosing a potential suicide.<sup>142</sup>

### *3. Procedural Changes to Balance the Increased Liability Which may Lead to Over-Commitments*

The possibility of liability for not treating a patient that subsequently commits suicide may incentivize healthcare providers to unnecessarily commit patients arriving in the hospital on emergency petitions or other seemingly exigent circumstances.<sup>143</sup> As indicated by the shift to deinstitutionalization in the 1960s and 1970s, the constitutional right to liberty trounces attempts to palliate mental illness with involuntary commitments.<sup>144</sup> The Maryland courts and legislature rightfully emphasized the importance of this right and established procedural safeguards to protect it.<sup>145</sup>

Any increase in medical malpractice litigation that has the potential to unnecessarily deprive individuals of their right to liberty warrants a change in procedural due process to counterbalance the harm. Instating a stricter dangerousness requirement is one

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<sup>140</sup> See e.g., *Keeton v. Fayette County*, 558 So.2d 884, 887 (Ala. 1989) (explaining that where the “[c]ounty voluntarily undertook a duty beyond that which the law imposed,” it became obligated to act with due care, and therefore was susceptible to liability for the foreseeable suicide of a juvenile in its custody. The court explained that “foreseeability of a decedent’s suicide is legally sufficient ... if the deceased had a history of suicidal proclivities, or manifested suicidal proclivities in the presence of the defendant, or was admitted to the facility of the defendant because of a suicide attempt.”).

<sup>141</sup> See *supra*, note 60.

<sup>142</sup> *Maggie Murray, Determining A Psychiatrist’s Liability When A Patient Commits Suicide: Haar v. Ulwelling*, 39 N.M. L. REV. 641, 659 (2009).

<sup>143</sup> Emergency petitions are the procedural vehicle by which the involuntary admission process begins. See e.g., MD. CODE ANN., HEALTH-GEN. § 10-622(b) (West 2016) (permitting health care professionals that have examined the person, peace officers that have observed the person’s behavior, or “any other interest person” to file an emergency petition for the evaluation of an individual the petitioner believes is mentally ill and poses a danger to self or others); MD. CODE ANN., HEALTH-GEN. § 10-625(a) (West 2016) (mandating that “[i]f an emergency evaluatee meets the requirements for an involuntary admission and is unable or unwilling to agree to a voluntary admission ... the examining physician shall take the steps needed for involuntary admission of the emergency evaluatee to an appropriate facility, which may be a general hospital with a licensed inpatient psychiatric unit.”). For a brief discussion on applications for involuntary admission and petitions for emergency evaluations in Maryland, see *J.H. v. Prince George’s Hosp. Ctr.*, 233 Md. App. 549, 582, 165 A.3d 664, 684 (Md. Ct. Spec. App. 2017).

<sup>144</sup> See *supra*, notes 21–27, and accompanying text.

<sup>145</sup> *Anderson v. Solomon*, 315 F.Supp. 1192 (D. Md. 1970) (identifying procedural deficiencies prior to the adoption of Maryland’s current involuntary admission procedures). These included the lack of: (1) a hearing “at a reasonable point in time;” (2) involvement of an independent agency to look out for the individual’s interests; and (3) physician certification regarding the need for treatment. *Id.* at 1194–95. Following the *Anderson* case, the Maryland legislature implemented new involuntary admission procedures that became effective in 1973. MARR 10.04.03.03G (1974).

such check on erroneous involuntary admissions. Currently, under § 10-617(a) of the Health—General Article, a physician may only involuntarily admit a patient if the patient fulfills five criteria. For example, “the individual [must] present[] a danger to the life or safety of the individual or of others.”<sup>146</sup> The statutes governing involuntary admissions, however, are silent as to the degree of dangerousness required.<sup>147</sup> As a counterbalance, Maryland could adopt the overt act requirement as evidence that the individual poses a danger to self or others, or heighten the evidentiary standard to clear and convincing.<sup>148</sup> Requiring a clearer showing of dangerous behavior or intentions reduces the risk that a physician will unnecessarily commit patients on an involuntary basis.<sup>149</sup> For example, under Alabama law, a physician must present clear and convincing evidence to support an involuntary commitment, or “conclud[e] that continued custody is necessary.”<sup>150</sup>

If the dangerousness requirement were to be narrowed so far as to only be satisfied by an executed violent act, involuntary admissions may become under inclusive and inadvertently “superimpos[e] criminal concepts into the civil commitment proceedings.”<sup>151</sup> In an amicus brief for *Addington v. Texas*<sup>152</sup> the American Psychiatry Association (“Association”) advocated against tightening the dangerousness requirement.<sup>153</sup> The Association asserted that “one dramatic result of [narrowing the dangerousness standard] has been that many seriously mentally ill people have ‘escaped’ civil commitment only to find themselves abandoned by society,” and that this could be

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<sup>146</sup> MD. CODE ANN., HEALTH-GEN. § 10-617(a) (West 2016). The other four criteria are: “(1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; [3] the individual is unable or unwilling to be admitted voluntarily; [and (4)] there is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.” *Id.* This must also be certified by one physician and either a psychologist or psychiatric nurse practitioner, or two physicians, and then later reviewed at a hearing before an administrative law judge if the patient remains in treatment for ten days. MD. CODE ANN., HEALTH-GEN. § 10-615 (West Supp. 2015).

<sup>147</sup> *In re J.C.N.*, No. 1021, 2017 WL 3634282, at \*5 (Md. Ct. Spec. App. Aug. 24, 2017) (remarking that since the type of harm required to satisfy the dangerousness requirement is unspecified, the standard of proof during an administrative hearing is substantial evidence, rather than clear and convincing evidence).

<sup>148</sup> See e.g., CAL. WELF. & INST. CODE § 5300(c) (West Supp. 1983); MINN. STAT. ANN. § 253B.02 (West Supp. 2017). See also Zachary Groendyk, “It Takes A Lot to Get into Bellevue”: A Pro-Rights Critique of New York’s Involuntary Commitment Law, 40 FORDHAM URB. L.J. 549, 576–78 (2012) (surveying Circuit court differences on the degree of dangerousness required to involuntarily commit mentally ill individuals).

<sup>149</sup> David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 247 (1984) (analyzing jurisdictional differences in the dangerousness requirement and finding that most “have a more relaxed standard which merely requires evidence that the individual poses a substantial risk of harm to himself or others.”).

<sup>150</sup> ALA. CODE § 22-52-37 (West 1975).

<sup>151</sup> *Project Release v. Prevost*, 551 F. Supp. 1298, 1305 (E.D.N.Y. 1982), *aff’d*, 722 F.2d 960 (2d Cir. 1983).

<sup>152</sup> *Addington v. Texas*, 441 U.S. 418 (1979).

<sup>153</sup> Brief for American Psychiatry Ass’n as Amici Curiae Supporting Respondents at 8, *Addington v. Texas*, 441 U.S. 418 (1979) (No. 77-5992).

lessened by relaxing the standard of proof to prevent “effectively shut[ting] the door on the sensible application of *parens patriae* civil commitment.”<sup>154</sup> In *Addington*, the Supreme Court ultimately held that “given the uncertainties of psychiatric diagnosis,” the constitutional minimum is a “greater than the preponderance-of-the-evidence standard” because a higher standard may prevent states from providing their residents with crucial mental health treatment.<sup>155</sup> Additionally, studies indicate that physicians often fail to honestly adhere to the dangerousness requirement and “will use an assessment of dangerousness as a post-hoc justification for treatment.”<sup>156</sup>

Calls for increased medical malpractice litigation are further tempered by the challenge of establishing proximate cause between failure to involuntarily commit a patient and the subsequent suicide. The Maryland judiciary may elect to impose liability only if a short period of time passes between the patient’s release and suicide (for example, forty-eight hours).<sup>157</sup> Where the time frame is longer, the link between the release and death would be attenuated and unlikely to establish liability.<sup>158</sup>

Furthermore, Maryland requires expert testimony by other physicians when assessing duty breaches in medical malpractice actions, which are currently based on a negligence standard.<sup>159</sup> By requiring expert testimony, the physician’s actions are less likely to be inadvertently scrutinized by the jury based on a reasonable person standard. Instead, the expert clarifies whether the conduct was appropriate given “the degree of care or skill expected of a reasonably competent health care provider in the same or similar circumstances.”<sup>160</sup>

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<sup>154</sup> *Id.* at 8–9.

<sup>155</sup> *Addington*, 441 U.S. at 432–33.

<sup>156</sup> William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 279–80 (2010).

<sup>157</sup> *Chance v. Bon Secours Hospital*, No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017) (death occurred the day after release); *Williams v. Peninsula Reg’l Med. Ctr.*, 440 Md. 573, 103 A.3d 658 (Md. 2014) (death occurred the same day as release); *Foster v. Charter Med. Corp.*, 601 So. 2d 435, 438 (Ala. 1992) (death occurred hours after release); *Tabor v. Doctors Memorial Hosp.*, 563 So.2d 233 (La. 1990) (death occurred the day after release).

<sup>158</sup> *Farwell v. Un*, 902 F.2d 282, 290 (4th Cir. 1990) (refusing to find proximate cause for a physician’s failure to prevent a patient’s suicide that occurred nine days after the physician originally treated him).

<sup>159</sup> *See supra*, note 102.

<sup>160</sup> *See supra*, note 102. *See also* *Almonte v. Kurl*, 46 A.3d 1, 19 (R.I. 2012) (stating that “expert testimony was necessary to inform the fact-finder as to an expert’s opinion concerning whether or not [the physician’s] failure to commit [the patient] was a proximate cause of his death by suicide.”); *Thompson v. Patton*, 6 So.3d 1129, 1141–42 (Ala. 2008) (remarking that “proximate causation in this case was not an issue that could be determined without expert testimony.”); *Wilkins v. Lamoille County Mental Health Services, Inc.*, A.2d 245, 252 (V.T. 2005) (holding “that the standard-of-care and causation elements of professional negligence claims . . . be proved by expert testimony, and this is no less true of claims relating to the negligent treatment or assessment of patients at risk of committing suicide.” (citation and internal quotation marks omitted)); *Estate of Joshua T. v. State*, 840 A.2d 768, 772 (N.H. 2003) (“Assessing the causal link between [negligence] and [an adolescent patient’s] death, without the assistance of expert testimony, is simply beyond the capacity of an average juror and would amount to speculation, especially considering [the patient’s] self-destructive behavior and suicide attempts”); *Moats v. Preston County Commission*, 521 S.E.2d 180,



The failure to involuntarily admit a foreseeably suicidal individual should be adjudicated based on a reckless failure to act standard rather than a negligence or gross negligence standard. Physicians cannot be expected to prevent all patients' suicide attempts; they must retain the leeway to make decisions based on their best medical judgment without pressure to involuntarily commit a patient solely to avoid liability.<sup>161</sup> By requiring a higher level of injurious conduct to predicate fault, a physician is less likely to be found liable for merely misdiagnosing the patient or releasing the patient based on a spurious belief that the patient's condition sufficiently improved.<sup>162</sup>

## **B. Application to Chance and Inapplicability of Williams**

### *1. Dr. Bell Breached the Duty of Care Owed to Brandon When He Released Him and Therefore Chance v. Bon Secours Hospital Should Be Affirmed*

The Court of Appeals should affirm *Chance v. Bon Secours Hospital* and find that Dr. Bell's failure to keep decedent Brandon Mackey in treatment was a breach of duty, significantly contributing to his death.<sup>163</sup> Dr. Bell was the primary physician treating Brandon each time he was committed to Bon Secours Hospital; he diagnosed Brandon with two different mental illnesses and prescribed an antipsychotic medication that takes weeks to become effective.<sup>164</sup> Dr. Bell was aware of Brandon's condition and, as Dr. Cascella testified, it was likely that Brandon still suffered from suicidal ideation after only three days on the medication Risperdal.<sup>165</sup> Given Brandon's history of mental illness and the unreasonably short amount of time that Brandon was committed, it was foreseeable that he would once again attempt to commit suicide after being released.<sup>166</sup> Even if Maryland adopted the overt act requirement, Brandon's case still warranted

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188 (W. Va. 1999) (remarking that “[t]his case involves complicated medical issues, specifically, the manner and method of protecting someone who is suicidal. While there may be some circumstances where an expert is not needed, such as where a loaded gun is left in the presence of a mentally-ill person, that is not the case here. [Health center’s] potential liability arises from its duties in relation to the involuntary commitment process. Despite the plaintiff’s attempt to characterize this case as simply a failure to report [the patient’s] suicidal tendencies, we believe that determining whether [health center] deviated from the standard of care involves more complex issues that are not within the common knowledge of lay jurors.”); *Edwards v. Tardiff*, 692 A.2d 1266, 1269 (1997) (requiring expert testimony to establish medical malpractice following the suicide of a patient); *Kanter v. Metropolitan Medical Center*, 384 N.W.2d 914, 916 (Minn. Ct. App. 1986) (noting “[i]n a psychiatric ward the potential tendencies of patients suffering from mental illness are not so easily determined by one without special training and knowledge.”).

<sup>161</sup> *Champagne v. United States*, 513 N.W.2d 75, 79 (N.D. 1994) (noting “medical providers are not insurers; their duty is to act reasonably under the circumstances of each case.”).

<sup>162</sup> *Chance v. Bon Secours Hospital* was adjudicated on a negligence standard. No. 2259, 2017 WL 1716258 (Md. Ct. Spec. App. May 2, 2017).

<sup>163</sup> *Id.* at \*6 (reversing trial court grant of motion for judgment notwithstanding the verdict in favor of respondents and remanding “for disposition of the alternative motion for a new trial.”).

<sup>164</sup> *Id.* See also, note 88.

<sup>165</sup> *Chance*, slip op. at \*3.

<sup>166</sup> *Id.* at \*5. Mary C. Barovica, *Fact Sheet*, NATIONAL ALLIANCE ON MENTAL ILLNESS 6 (Feb. 2007), <http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Risperdal.pdf> (estimating that “improvement of some symptoms may be noticed in some patients within a few weeks. The full benefit ... may not be seen for 4–6 weeks.”).



involuntary admission because his pre-admission behavior<sup>167</sup> demonstrated that he posed a danger to himself.<sup>168</sup> Brandon's suicide a day after discharge, combined with Dr. Cascella's expert testimony, established that Brandon's early release from treatment caused his death and indicated that Dr. Bell's conduct did not meet the standard of care owed to his patient.<sup>169</sup>

## 2. *Williams Should Be Overruled or Differentiated from Chance*

*Williams v. Peninsula Regional Medical Center* should be overruled because the Maryland General Assembly only intended to provide a liability exemption to physicians making an affirmative decision to involuntarily admit a patient; thus, Dr. Bell is not immune. The *Williams* court instructed that “[t]he cardinal rule of statutory interpretation is to ascertain and effectuate the intent of the Legislature.” Following this analysis, the court determined that the legislature intended physician immunity to “extend beyond a decision to admit” and also encompassed the decision not to admit.<sup>170</sup> In analyzing the legislative intent, the court read the relevant provisions in conjunction with the entire involuntary admissions section of the Maryland mental health laws, concluding “that the General Assembly referred to all of Part III, including restrictions on admittance [in § 10–617], when establishing the prerequisites to qualifying for immunity, demonstrates its intent that the immunity extend beyond a decision to admit.”<sup>171</sup>

The court's analysis, however, fails to address a significant dissimilarity between CJP § 5-623(b) and subsections (c) and (d). Subsection (b), plainly and in conjunction with subparts (c) and (d), indicates that the Maryland General Assembly intended for physician immunity to exclude actions beyond a physician's affirmative choice to involuntarily admit a patient.<sup>172</sup> CJP § 5-623 states, in part:

(b) A person who in good faith and with reasonable grounds applies for involuntary admission of an individual is not civilly or criminally liable

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<sup>167</sup> Brandon slit his wrists prior to his first admission and made another suicide attempt that led to his second admission. *Chance*, slip op. at \*1.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.* at \*5.

<sup>170</sup> *Id.* at 580, 583 (quoting *Kushell v. Dep't of Natural Res.*, 385 Md. 563, 576, 870 A.2d 186, 193 (2005)). First, the court looked to the canons of statutory construction and stated: “[W]e begin with the normal, plain meaning of the language of the statute. If the language of the statute is unambiguous and clearly consistent with the statute's apparent purpose, our inquiry as to legislative intent ends ordinarily and we apply the statute as written, without resort to other rules of construction.... We, however, do not read statutory language in a vacuum, nor do we confine strictly our interpretation of a statute's plain language to the isolated section alone. Rather, the plain language must be viewed within the context of the statutory scheme to which it belongs, considering the purpose, aim, or policy of the Legislature in enacting the statute.” *Id.* at 580–81 (quoting *Lockshin v. Semsler*, 412 Md. 257, 275–76, 987 A.2d 18, 28–29 (Md. 2010)).

<sup>171</sup> *Id.* at 582–83.

<sup>172</sup> MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014). *See also* MD. CODE ANN., HEALTH-GEN. § 10-618 (West 2016) (granting immunity to anyone that “applies for involuntary admission of an individual ... under § 5-623(b) of the Courts and Judicial Proceedings Article”).

for making the application under Title 10, Subtitle 6, Part III of the Health-General Article.

(c) A facility or veterans' administration hospital that, in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action.

(d) An agent or employee of a facility or veterans' administration hospital who, in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action.<sup>173</sup>

Subsection (b) specifically addresses any individual that applies to involuntarily admit a patient into treatment. The legislature intended to insulate applications for involuntary admission from legal consequences. If, as the Court of Appeals held, subsection (b) should be interpreted in light of subsections (c) and (d), and thus provide immunity for the same actions, then subsection (b) effectually would provide immunity for “compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article.”<sup>174</sup> The *Williams* court stated that “a health care provider acts in compliance with Part III when a good faith evaluation leads to commitment, but it also acts in compliance with Part III when the conclusion of a good faith evaluation is that a less restrictive form of intervention than commitment is warranted.”<sup>175</sup> If compliance with Part III is the decisive factor in determining physician liability, then the legislature would have worded subsection (b) to contain the “who acts in compliance with...Part III” language found in the other provisions instead of singling out the affirmative choice to seek an involuntary commitment. If subsection (b) was intended to grant immunity to anyone “who acts in compliance with...Part III,” the legislature would not have differentiated the choice to apply for an involuntary admission from all other involuntary admission provisions. Rather, the legislature could have simply written a single subsection that states: “Any party, including a facility or veterans' administration hospital and their agents and employees, who in good faith and with reasonable grounds, acts in compliance with the provisions of Title 10, Subtitle 6, Part III of the Health-General Article is not civilly or criminally liable for that action.”

By adding subsection (b), the choice to apply for involuntary admission was removed from subsections (c) and (d); otherwise physicians would receive immunity under the Court of Appeals determination that subsection (d) protects physician discretion as in compliance with Part III.<sup>176</sup> The rationale that they are differentiated in order to sever the parties—hospitals and their agents/employees from public actors—also fails.<sup>177</sup> If

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<sup>173</sup> MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014).

<sup>174</sup> *Id.*

<sup>175</sup> *Williams*, 440 Md. at 583 (quoting *Williams v. Peninsula Reg'l Med. Ctr.*, 213 Md.App. 644, 75 A.3d 359 (Md. Ct. Spec. App. 2013)).

<sup>176</sup> *Id.* at 584.

<sup>177</sup> Subpart (b) addresses “anyone” while (c) and (d) address facilities, veterans' administration hospitals, and their agents and employees.

the legislature meant to separate physician actors from public actors, physician actions would receive immunity under subsection (d), not subsection (b). It is highly unlikely that the General Assembly contemplated this distinction because subsection (d) exempts agents and employees of mental health facilities and veterans' administration hospitals from liability. If lawmakers meant to make the hospital personnel–public distinction, contractor physicians would fall on the public side since they are independent actors (not agents or employees).<sup>178</sup> By separating “any party” in subsection (b) from “facilities” in subsection (c) and “medical personnel” in subsection (d), lawmakers intended to provide immunity to all actors with an interest in applying for an involuntary admission. The legislature denied physicians broad immunity under subsection (d), leaving the door open for medical malpractice suits based on the failure to admit a patient. The General Assembly could have insulated physician discretion several ways if it intended to do so by including language in subsection (b) that indicated the choice to not admit was likewise protected, using the familiar “acts in compliance with...Part III” language, stating in subsection (d) that compliance with Part III includes discretion on admission determinations, or creating one all-encompassing provision whereby everyone is immune. The Assembly's failure to do so demonstrates intent to expose admission denials amounting to a breach of care to liability.

Rather than overrule *Williams*, the Court of Appeals may elect to distinguish it from *Chance*. In *Williams*, the court extended immunity to the physician based on the apparent purpose of CJP § 5-623. The court stated that CJP § 5-623 protects physician discretion to involuntarily admit mentally ill patients.<sup>179</sup> However, *Chance* did not involve Dr. Bell's choice to admit Brandon. *Williams* differs because Brandon was already in treatment, but received an early release despite a new diagnosis and medication regimen.<sup>180</sup> The physician in *Williams* evaluated the decedent in a triage setting, failing to fully appreciate the seriousness of his patient's condition. His decision against admittance was nonetheless protected because, per the Court of Appeals, shielding physician discretion is a critical matter of public policy and the apparent intent behind CJP § 5-623.<sup>181</sup> In contrast, Brandon was already involuntarily admitted when Dr. Bell evaluated him outside of an emergency room or any other exigent circumstances such as in *Williams*.<sup>182</sup> Dr. Bell's breach of duty did not arise in relation to Brandon's admittance into treatment. Instead, the breach occurred in relation to Brandon's discharge; the Court of Appeals may find this factor dispositive in the inapplicability of *Williams* and, therefore, choose to not further extend immunity.<sup>183</sup> The provision plainly confers immunity for the affirmative decision to involuntarily admit mentally ill patients and *Williams* protects the decision not to admit them. If *Williams* were applied here, *Chance* would stand for an entirely different protected action not contemplated by the legislature—the choice to release

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<sup>178</sup> MD. CODE ANN., CTS. & JUD. PROC. § 5-623 (West 2014).

<sup>179</sup> 440 Md. 573, 584, 103 A.3d 658, 665 (Md. 2014).

<sup>180</sup> See *supra*, notes 167 and 168.

<sup>181</sup> *Williams*, 440 Md. at 584.

<sup>182</sup> See *supra*, note 167.

<sup>183</sup> See *supra*, note 171.

a patient prematurely.<sup>184</sup> As such, Dr. Bell's conduct should be susceptible to liability because *Williams* is not applicable when determining liability for a physician's decision to prematurely release patients from treatment.

### C. Prioritize Patient Life and Amend CJP § 5-623

Amending CJP § 5-623 to clearly withhold immunity from physicians that breach the standard of care owed to foreseeably suicidal patients will likely preserve the lives of Maryland residents suffering from suicidal ideation. While the liability attendant to stripping this immunity creates an increased risk of erroneously involuntarily admitting patients, changes to the front end of mental health treatment and services will reduce this potential for error.<sup>185</sup> By adopting a clear position on involuntary admissions, the Maryland legislature would save the judiciary from having to balance the benefits and harms of such treatment.<sup>186</sup> This, in turn, would provide definite expectations in the standard of care that physicians owe Maryland residents suffering from suicidal ideation and provide recourse to decedents' families when this duty is breached.<sup>187</sup>

#### *1. Legislative Over-Commitment Concerns Should be Resolved with Increased Community Mental Health Resources*

Endeavoring to ward off medical malpractice suits, the legislative change suggested above may make physicians more susceptible to liability and compel them to more frequently apply for involuntary admissions.<sup>188</sup> Adopting changes to outpatient care may prevent a spike in involuntary admission applications and reduce the number of mentally ill individuals arriving in the emergency room. The Maryland Department of Health offers several community services for mental health, including group homes, psychiatric rehabilitation services, and outpatient mental health clinics.<sup>189</sup> By increasing the availability of community based treatment centers, mentally ill individuals can seek help in unrestricted environments.<sup>190</sup> In particular, additional group homes would significantly reduce the number of involuntary commitments. Homeless mentally ill individuals are repeatedly cycled through commitment—known as the revolving door

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<sup>184</sup> MD. CODE ANN., CTS. & JUD. PROC. § 5-623(b) (West 2014). *See supra*, notes 174–180, and accompanying text.

<sup>185</sup> *See infra*, Part II.C.1.

<sup>186</sup> *See infra*, Part II.C.2. *See also* David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 242 (1984) (advocating that the legislature, not the judiciary, is the appropriate party to address “existing overinclusiveness and underinclusiveness problems.”).

<sup>187</sup> *Id.*

<sup>188</sup> *See supra*, notes 142–144, and accompanying text.

<sup>189</sup> *Mental Health*, MD DEP'T OF HEALTH, MARYLAND.GOV (last visited Nov 4, 2017), <https://health.maryland.gov/ohcq/mh/Pages/home.aspx>.

<sup>190</sup> The importance of available outpatient care and alternative treatment options is reflected in the statutory mandate that a mentally ill patient be involuntary admitted only if there is not available less restrictive alternative. *See supra*, note 43.

problem—and are often unable to find placement in assisted living units due to lack of funding, forcing hospitals to temporarily provide for their care.<sup>191</sup>

Alternative options include moving the administrative hearing up from ten days, or implementing an administrative review very early in the hospitalization process.<sup>192</sup> Another way to stave off unnecessary involuntary admissions is through the adoption of a case management system. The system would ensure the availability of an impartial third party during a suicidal patient's hospital stay, providing an administrative party that could help locate less restrictive environments or other treatment resources if the patient's condition progresses to no longer warrant involuntary admission.<sup>193</sup> Because Maryland permits an emergency facility to hold an emergency evaluatee for up to thirty hours, the provision of a case manager could significantly reduce involuntary admissions by readily providing administrative intervention and easing the search for alternative resources prior to the patient's formal involuntary admission.<sup>194</sup> This would decrease the likelihood of litigation because (1) accessible treatment creates less need for involuntary commitment, and (2) Maryland courts are highly unlikely to impose liability on a physician following the death of an outpatient.<sup>195</sup>

## *2. The Maryland Legislature Should Adopt a Clear Position on Involuntary Admissions Because Deprivation of Liberty and Potential for Death are Issues Too Sensitive to be Decided by the Court System*

Relying on the judicial system to determine the obligations and immunities of health care professionals when treating suicidal patients impermissibly threatens the lives of Maryland residents by establishing the standard of care post-hoc and failing to strike the balance desired by the Maryland General Assembly and Maryland residents.<sup>196</sup> Similar

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<sup>191</sup> Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 *NEW ENG. L. REV.* 39, 48–49 (2014) (noting that “the revolving door problem” is the result of a lack of funding and “resources in state mental health systems [that cannot] support the needs of an expanding population of deinstitutionalized outpatients.”); U.S. DEP’T OF HOUS. AND URBAN DEV., OFF. OF CMTY. PLANNING AND DEV., *THE 2010 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS 18* (2011), <https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf> (estimating that over a quarter of people living in homeless shelters suffer from serious mental illnesses).

<sup>192</sup> MD. CODE ANN., HEALTH-GEN. § 10-615 (West Supp. 2016).

<sup>193</sup> This would particularly suit the homeless, non-dangerous population that routinely gets cycled through the hospital rather than placed in an environment that treats not only their mental health but also meets their housing needs. Boldt, *supra* note 191, at 48–49.

<sup>194</sup> MD. CODE ANN., HEALTH-GEN. § 10-624(b)(4) (West 2014).

<sup>195</sup> MD. CODE ANN., HEALTH-GEN. § 10-617(a)(5) (West 2016) (forbidding the involuntary admission of a mentally ill individual if there is a less restrictive alternative treatment available); *Eisel v. Bd. of Educ. of Montgomery Cty.*, 324 Md. 376, 382, 384 (Md. 1991) (stating “[l]iability against therapists for outpatient suicides is rarely imposed ... and some commentators have suggested that liability under these circumstances should never be imposed.” While the counselor in this case was found liable, the court distinguished this scenario from cases where a patient commits suicide while in the custody of a treatment facility, and found dispositive that the victim was an adolescent and had her father been warned, “he could have exercised his custody and control, as parent,” and prevented her death).

<sup>196</sup> This is particularly evidenced in *Williams* where the Court of Appeals based part of its reasoning on a historical analysis of the legislative proposals to the involuntary admission process. 440 Md.

to the concern in three New Jersey companion cases addressing the constitutionality of forced life-sustaining medical care, Maryland's General Assembly should address the use of involuntary admissions in an attempt to preserve the lives of suicidal patients.<sup>197</sup> In *Matter of Farrell*,<sup>198</sup> the Supreme Court of New Jersey was reluctant to address the delicate issue sub judice and aptly stated:

Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, . . . medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.<sup>199</sup>

The serious consequences associated with involuntary admissions include shifting mentally ill people into the criminal justice system, forcing physicians to experience cognitive dissonance, and harrowing the boundary between autonomy and life. Instead of allowing the court to scrutinize these factors in an ad hoc court setting, the Maryland legislature must examine and factor these concerns into a scrupulous law that establishes a set of expectations for both physicians and patients.<sup>200</sup>

#### **D. The Balance Between the Competing Interests and Harms Favors Physician Liability for The Failure to Not Utilize Involuntary Admissions to Treat Foreseeably Suicidal Patients**

The current statutory scheme, combined with the physician immunity conferred under *Williams v. Peninsula Regional Medical Center*, fails suicidal patients and their families because it results in higher rates of suicide and bars families from bringing wrongful death claims. When a family member suffers from a severe mental illness that perverts their cognizance of reality and impedes their ability to seek help, available treatment options are limited to: (1) persuading the sick family member to voluntarily admit themselves into inpatient treatment; (2) filing an emergency petition to get the sick family member evaluated at a hospital and applying for involuntary admission if the sick family member meets admission criteria; (3) attempting to cajole the sick

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573, 584–86 (Md. 2014).

<sup>197</sup> *Matter of Farrell*, 529 A.2d 404 (N.J. 1987); *Matter of Peter*, 529 A.2d 419 (N.J. 1987); *Matter of Jobe*, 529 A.2d 434 (N.J. 1987).

<sup>198</sup> *Matter of Farrell*, 529 A.2d 404 (N.J. 1987).

<sup>199</sup> 529 A.2d 404, 408 (N.J. 1987) (quoting *In re Conroy*, 486 A.2d 1209 (1985) (alteration in original)). The court ultimately held that the right to self-determination is paramount when the patient is competent and informed. *Id.* at 412.

<sup>200</sup> Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 *PSYCHIATRY* 30, 31, 38 (2010) (asserting that psychiatrists, when contemplating involuntarily committing their patients, must balance beneficence with nonmaleficence, including respect for autonomy on one hand and the “grave need of treatment” on the other, whereby repercussions arise such as “a shift of people with mental illness from asylums to prisons, and creation of an epidemic of homelessness among persons with mental disorders” when civil commitments give way to deinstitutionalization).



family member into outpatient care; or (4) doing nothing.<sup>201</sup> However, convincing an individual suffering from depression and suicidal ideation to voluntarily seek inpatient or outpatient treatment becomes less likely as the mental illness becomes more profound.<sup>202</sup> When a foreseeably suicidal patient commits suicide shortly following discharge, in addition to the devastating loss of life, the family is unlikely to recover through litigation or insurance because suicide typically renders an insurance contract void.<sup>203</sup>

On the other hand, liberty should not be casually implicated because it is a fundamental constitutional right.<sup>204</sup> The liberty interest includes freedom from custody, freedom from “stigmatizing consequences” and freedom from “mandatory behavior modification as a treatment for mental illness.”<sup>205</sup> Jurisprudence demands use of involuntary commitments only where the interest of the state in preserving life outweighs the individual’s right to freedom and self-determination.<sup>206</sup> The state, however, has an interest in also *reducing* the number of hospital admissions in order to curtail Medicaid spending, limit medical malpractice insurance payouts, and preserve judicial and mental health resources for “cases of genuine need.”<sup>207</sup> Moreover, insulating physician discretion—and reducing the risk of unnecessary involuntary admissions—allows physicians to work without making decisions based solely on the desire to avoid liability.<sup>208</sup> Notably, there are large discrepancies in the accuracy of psychiatric dangerousness predictions; physicians are

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<sup>201</sup> *Id.* at 31 (observing that “[w]hen an individual is suffering from a severe mental illness that grossly distorts his perception of reality, it is often clear that he or she has lost the usual capacity for making decisions in his or her best interest.”). Maryland is one of few states that does not offer outpatient commitment as a treatment option. Boldt, *supra* note 191, at 81.

<sup>202</sup> See *infra*, text accompanying note 86. This is increasingly less likely to be successful if the individual is homeless, lacking a familial support system, and without means to afford care or transportation to treatment facilities. See *supra*, Boldt, note 191.

<sup>203</sup> *Williams*, 440 Md. at 584; *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 286 (1876) (holding that “[i]f [insurance companies] are at liberty to stipulate against hazardous occupations, unhealthy climates, or death by the hands of the law, or in consequence of injuries received when intoxicated, surely it is competent for them to stipulate against intentional self-destruction, whether it be the voluntary act of an accountable moral agent or not.”); *Fister ex rel. v. Allstate Life Ins. Co.*, 366 Md. 201, 211, 783 A.2d 194, 200 (Md. 2001) (stating “[t]he Maryland Legislature enacted a provision which forbids insurance companies from excluding policy coverage for deaths caused in a specified manner except under five specific circumstances, of which suicide is one.”).

<sup>204</sup> *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972) (vacated on other grounds) (holding “[t]he power of the state to deprive a person of the fundamental liberty to go unimpeded about his or her affairs must rest on a consideration that society has a compelling interest in such deprivation.”).

<sup>205</sup> *Vitek v. Jones*, 445 U.S. 480, 494 (1980).

<sup>206</sup> See *supra*, notes 21–32, and accompanying text.

<sup>207</sup> *Parham v. J. R.*, 442 U.S. 584, 604 (1979); Cynthia Shirk, *Medicaid and Mental Health Services* 3 (Nat’l Health Policy Forum, Background Paper No. 66, 2008), [https://www.nhpf.org/library/background-papers/BP66\\_MedicaidMentalHealth\\_10-23-08.pdf](https://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf) (“Medicaid is the largest payer of mental health services in the United States”).

<sup>208</sup> *Williams v. Peninsula Reg’l Med. Ctr.*, 440 Md. 573, 584, 103 A.3d 658, 665 (Md. 2014) (“Cloaking health care providers in immunity both when they decide in favor of and when they decide against admittance amounts to sound public policy, consistent with the General Assembly’s intent.”).

not insurers of an individual's behavior.<sup>209</sup> As the *Williams* court aptly pointed out, the involuntary commitment process would not have rigorous requirements if physicians were encouraged "to err on the side of involuntary admittance in order to receive statutory immunity and avoid liability."<sup>210</sup>

Implication of the liberty interest, however, is protected with "layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected."<sup>211</sup> Even when the state has an interest in civilly committing a mentally ill individual, the state must nonetheless protect the patient's due process rights. In *Addington v. Texas*<sup>212</sup> the Supreme Court recognized that:

One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed.<sup>213</sup>

By providing physicians who fail to involuntarily commit foreseeably suicidal patients with a liability exemption, Maryland falls short in protecting its mentally ill population.<sup>214</sup> While freedom from restraint should be safeguarded, the countervailing interests in preserving life and providing mental health treatment are paramount.<sup>215</sup> Adoption of robust procedural safeguards will protect patients' liberty interests while providing physicians the necessary flexibility to involuntarily commit suicidal patients.<sup>216</sup> Under the protection of these procedural safeguards, the reckless failure to use involuntary admissions as a treatment option, where reasonably required, should qualify as a breach of physician duty of care.

### III. CONCLUSION

Physicians have a special relationship with their patients that create a duty to protect them from self-harm. Physicians may discharge this duty by applying suicidal patients for involuntary admission.<sup>217</sup> Foreseeability of suicide is the strongest factor triggering use

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<sup>209</sup> Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 21–22 (1999).

<sup>210</sup> *Williams*, 440 Md. at 587, 103 A.3d at 666 (Md. 2014).

<sup>211</sup> *Addington v. Texas*, 441 U.S. 418, 428–29 (1976).

<sup>212</sup> *Id.*

<sup>213</sup> *Id.* at 429 (internal citations omitted).

<sup>214</sup> Some commentators argue that not imposing the duty advocated throughout this article "would be 'tantamount to strict non-liability.' ... [whereby a physician] could intentionally fail to treat the [patient] without any legal consequences." See Murray, *supra* note 142, at 661 (internal citations omitted).

<sup>215</sup> See *supra*, notes 50–58, and accompanying text.

<sup>216</sup> Additional safeguards than those previously explored throughout this article include "a guardian ad litem appointment, professional recommendations, open hearings, and the usually well-seasoned perspective of the probate judge." Judge Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIPIAC PROB. L.J. 36, 38 (2006).

<sup>217</sup> See *supra*, Parts I.A.1.



of involuntary admissions over less restrictive treatment options. Failure to involuntarily admit a suicidal patient, or continue admittance for a patient still at risk of suicide, should result in liability adjudicated under a recklessness standard.<sup>218</sup> While this duty increases the risk of erroneous involuntary admissions, lawmakers can mitigate this risk by finding proximate cause only in cases where the suicide occurred a short time after the patient's release from care and through the adoption of procedural changes, including quick performance of the patient's administrative hearing and creation of an administrative case manager for each potentially suicidal patient.<sup>219</sup> The present statutory scheme in Maryland provides liability exemption to anyone that applies for involuntary admission. *Williams v. Peninsula Regional Medical Center* extends the exemption to include physicians that elect not to admit patients.<sup>220</sup> The Court of Appeals, however, should not apply *Williams* to *Chance v. Bon Secours Hospital*. The General Assembly did not intend to create this immunity, and *Williams* applies to the choice not to admit while *Chance* is about early release from admission.<sup>221</sup> In *Chance*, the physician violated the standard of care owed to his patient by releasing him after only three days on a new, slow-acting medication regime. Additionally, the physician's decision to release his patient ignored the patient's two recent suicide attempts and new mental illness diagnosis. Considering these facts, the Court of Appeals should affirm the Court of Special Appeals and find that Dr. Bell was negligent.<sup>222</sup>

The Maryland legislature should amend CJP § 5-623 to affirmatively recognize the duty to prevent a patient from foreseeably committing suicide and remove the existing liability exemption for physicians recklessly breaching their duty of care by failing to involuntarily commit a suicidal patient.<sup>223</sup> This legislative change would prevent further ad hoc judicial influence altering the standard of care owed to mentally ill patients. The legislative modification should be accompanied by improvements to outpatient mental health services in order to offer treatment options better suited to meet the needs of Maryland residents.<sup>224</sup> While the constitutional right to freedom demands preservation, interests in preserving life, providing mental health treatment, and protecting existing procedural safeguards eclipse the risk of erroneous commitments and override the right to self-determination where the patient is foreseeably suicidal.<sup>225</sup>

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<sup>218</sup> See *supra*, Parts I.A.2.

<sup>219</sup> See *supra*, Parts I.A.2.

<sup>220</sup> See *supra*, notes 76–82, and accompanying text.

<sup>221</sup> See *supra*, Parts II.B.1 and II.B.2.

<sup>222</sup> See *supra*, Part I.A.3.

<sup>223</sup> See *supra*, Part II.C.

<sup>224</sup> See *supra*, Parts II.C.1 and II.C.2.

<sup>225</sup> See *supra*, Part II.D.







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