IN THE COURT OF APPEALS OF MARYLAND

No. 36, September Term, 2017

LEROY C. BELL, JR., M.D. and BON SECOURS HOSPITAL BALTIMORE, INC.

Petitioners,

v.

PATRICIA CHANCE, Individually and as Personal Representative of the Estate of BRANDON MACKEY,

Respondents.

Appeal from the Court of Special Appeals of Maryland
No. 2259, September Term, 2014
and
Circuit Court for Baltimore City, Maryland
(The Honorable Lawrence Fletcher-Hill, Judge)

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY

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QUESTION PRESENTED

In a wrongful-death action based on a suicide, is a defendant psychiatrist who discharged the decedent during the observation period and before an involuntary commitment hearing entitled to civil immunity under Health General Article §10-618 and *Williams v. Peninsula Regional Medical Center*, 440 Md. 573, 103 A.3d 658 (2014)?

INTEREST OF *AMICI CURIAE*

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including Maryland, and in every medical specialty. The AMA Litigation Center is the voice of America's medical profession in legal proceedings across the country. The mission of the Litigation Center is to represent the interests of the medical profession in the courts. It brings lawsuits, files amicus briefs and otherwise provides support or becomes actively involved in litigation of general importance to physicians.

MedChi, The Maryland State Medical Society, is a statewide, non-profit association of Maryland physicians. It is the largest physician organization in Maryland. MedChi, formally known as The Medical and Chirurgical Faculty of Maryland, was founded in 1799 by an act of the Maryland General Assembly. Today, MedChi's mission

is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health. Both AMA and MedChi support reforms to the medical liability system, including as provided by the General Assembly to provide immunity over the decision of mental health provers of whether or not to release a patient who has been confined, but not involuntarily committed to a mental health facility. Immunity protects the sanctity of this decision-making process in ways that advance patient rights and care.

The lower court's ruling to subject the psychiatrist who treated a patient during the required observation period to liability for not involuntarily committing Mr. Mackey has implications well-beyond this case. It will adversely impact the ability of psychiatrists to follow their good faith, reasoned medical judgment and encourage psychiatrists to involuntarily commit individuals who they believe do not meet medical criteria for being committed. As a matter of law and public policy, psychiatrists and mental health institutions must be provided statutory immunity due them under existing Maryland law.

STATEMENT OF THE CASE

This appeal arises out of a medical malpractice and wrongful death action alleging that Dr. Bell and Bon Secours Hospital are liable for the suicide of Mr. Brandon Mackey. A jury trial resulted in a verdict for Plaintiffs, and the trial judge granted Defendant's motion to vacate the jury verdict under the Maryland laws discussed herein. The Court of Special Appeals overturned this ruling. Defendants filed a Petition for Writ of Certiorari, which the Court granted. *Amici* adopt the remainder of Petitioner's Statement of the Case to the extent relevant to the arguments herein.

STATEMENT OF FACTS

On April 1, 2011, Mr. Brandon Mackey was presented to the emergency department at St. Agnes Hospital following a possible suicide attempt. An involuntary commitment certificate was filled out by the attending physician, and Mr. Mackey was transferred to Bon Secours Hospital and treated by Dr. Bell during the mandated observation period that precedes an involuntary commitment hearing. The record demonstrates that Dr. Bell regularly saw Mr. Mackey during this period, diagnosed his mental health ailments, and initiated a treatment plan. *See* Br. of Pet'r at 3. The record also shows that Mr. Mackey complied with taking his medications, never attempted to harm himself, denied being suicidal, and was vocal about wanting to be released from the hospital. *See id.* Dr. Bell and the staff at Bon Secours documented Mr. Mackey's improvement during the observation period. It was Dr. Bell's medical judgment that Mr. Mackey no longer met the criteria for being involuntary committed. He developed an out-patient treatment plan with Mr. Mackey and discharged him to his mother's home on April 9, 2011. The next day, Mr. Mackey tragically took his own life.

SUMMARY OF THE ARGUMENT

The Maryland General Assembly and this Court have bestowed immunity upon mental health professionals who, based on their good faith medical judgments, decide against involuntarily committing a patient to a mental health facility precisely because of situations like the one at bar. When a patient commits suicide even after all due care was taken, there is a tendency to blame the health care providers who discharged the patient. After all, if they played it safe and erred on the side of forcibly committing the patient,

the patient would not have been able to take his own life. The Court has already determined that such a perverse incentive is not and ought not be Maryland law.

In *Williams v. Peninsula Regional Medical Center*, the Court recognized the importance of Maryland's mental health code that "extends immunity to health care institutions and their agents who evaluate an individual as part of the involuntary admission process," including when they choose not to admit someone to involuntary confinement. 440 Md. 573, 582, 103 A.3d 658 (2014). This statement equally describes Petitioners Dr. Bell and Bon Secours Hospital as it did the defendants in *Williams*. Because Dr. Bell and Bon Secours Hospital evaluated Mr. Mackey as part of the involuntary admission process, the statutory immunity should cover the claims at bar. They determined that Mr. Mackey was not a candidate for involuntary admission "in good faith and with reasonable grounds." Md. Code, Cts. & Jud. Proc. § 5-623 (setting forth the standard for statutory immunity). As the Court explained in *Williams*, given an individual's due process right to be free from being involuntarily committed, "it would make little sense to give health care providers an incentive to err on the side of involuntary admittance in order to receive statutory immunity." *Id.* at 587.

The Court of Special Appeals denied Petitioners this immunity, effectively limiting statutory immunity to only those mental health care providers, as in *Williams*, who sign involuntary admittance certificates to initiate the application process. Such a narrow and unfounded interpretation of the immunity statute makes little sense. Clearly, the psychiatrist who treats a patient during the observation period and is responsible for making the final medical judgment on involuntary admittance must also receive statutory

immunity. They are similarly situated to the mental health care providers in *Williams*; both fulfill essential roles in the required process for deciding whether to involuntarily commit a patient to a mental health facility. *See* Md. Code, Health-Gen. § 10-101 (defining admission to include the entire "process by which an individual is accepted as a resident" of a mental health facility); Md. Code Regs. 10.21.01.07(C)(1) (requiring a psychiatrist evaluation before involuntarily admittance). To rule otherwise would undermine the very purpose of the immunity statute and this Court's ruling in *Williams*. Providing immunity only to mental health providers who fill out the initial application would be for naught if the psychiatrists who treat the patients during the observation period now have the improper incentive to err on the side of involuntary admittance.

Further, the psychiatrist who evaluates and treats a patient during the observation period has the primary responsibility for mental health determination as to whether the patient meets the involuntary admittance criteria. No person is better situated to weigh the factors in an objective, thorough manner.[1] When, in good faith, a treating psychiatrist believes a patient no longer satisfies the criteria for involuntary admittance, he is obligated to release the patient from confinement. Outside influencers, such as liability, relatives, and insurers, must not invade this decision. *See* James R. Roberts, M.D., *The Risks of Discharging Psych Patients Against Medical Advice*, Emergency Medicine News, Vol. 38 Iss. 7 (July 2016) ("Many practical and logistical pressures are placed on psychiatric patients from family, police, lack of shelter or personal resources.").

[1] As discussed herein, the initial application can be started by physicians who are not specially trained in psychiatry, as well as non-physician mental health professionals.

In this case, Dr. Bell chose against involuntarily committing Mr. Mackey in favor of an outpatient care plan. There is no evidence Dr. Bell acted for any reason other than his sincere assessment of what he thought best for Mr. Mackey. Psychiatrists cannot be guarantors of their decisions. They must be willing to choose not to involuntarily commit a patient with serious mental health issues, but who is not believed to be a present danger to himself or others. *See Williams*, at 667 (finding liability must not stop one from "properly exercising their discretion and following the stringent requirements before taking away someone's liberty"). For these reasons, *amici* respectfully urge the Court to reverse the ruling below and hold that immunity applies in this case.

ARGUMENT

I. PROVIDING IMMUNITY TO MENTAL HEALTH PROVIDERS FOR NOT INVOLUNTARILY COMMITTING PATIENTS PROTECTS CONSTITUTIONAL DUE PROCESS RIGHTS

In *Williams*, this Court documented the legal, moral and mental health imperatives that developed over the past several decades not to involuntarily commit a patient unless necessary to protect his or her safety, or the safety of others. 440 Md. at 585. This trend marks a significant and welcome departure from previous practice. For much of American history people with mental illnesses were put in prisons, shelters for the poor, or asylums. During this era of institutionalization, "the societal view in America was that persons with mental illness lacked the capacity to make decisions." Megan Testa, M.D. and Sarah West, M.D., *Civil Commitment in the United States*, Psychiatry Vol. 7 No. 10 (2010). They were denied their basic right to liberty, as judges would lock up the mentally ill and families could purchase the confinement of unwanted relatives. *See id.* at

32. By the 1950s, the rolls at state asylums swelled to more than 500,000 people.

It was around this time that the outlook toward mental health started to change, leading to fundamental shifts in the public policies toward patients. In 1951, the National Institute of Mental Health published the "Draft Act Governing Hospitalization for the Mentally Ill" to facilitate procedures, like those currently used in Maryland, to protect the due process rights of mental health patients. The focal point of this model bill was the "psychiatrists' decision-making power on the issue of civil commitment." Testa and West, *supra* at 32-33. Congress enacted the Mental Health Study Act in 1955 to establish the Joint Commission on Mental Illness and Health. *See* E. Fuller Torrey, M.D., *Out of the Shadows, Confronting America's Mental Illness Crisis*, appendix (1997). In 1963, President Kennedy signed the Community Mental Health Centers Act to facilitate treating individuals in their communities, not through forced commitment, with the stated goal of cutting the number of institutionalized individuals in half. *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960's*, 9 Ohio. St. J. Crim. L. 53, 53 (2011).

The Supreme Court, in a series of rulings in the 1970s, found that mental health patients did not lose their constitutional rights. Most importantly, it recognized that being involuntarily committed to a mental institution was a "massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), and that people with mental illnesses retain their due process rights under the Fourteenth Amendment to control their own destiny, *see O'Connor v. Donaldson*, 422 U.S. 563 (1975). Consequently, the state bears the burden of proving by clear and convincing evidence that a person is a present danger to

him or herself, or others, and therefore must be involuntarily committed. *See Addington v. Texas*, 441 U.S. 418 (1979); *see also Lake v. Cameron*, 267 F. Supp. 155 (D.C. Cir. 1967) (establishing that mental health care providers must use the "least restrictive treatment" over involuntary admittance when possible).

At the same time, courts and legislatures around the country began establishing legal regimes to focus mental health treatment from involuntary admittance to community-based outpatient programs. *See J.H. v. Prince George's Hops. Ctr.*, 233 Md. App. 549, 570, 165 A.3d 664, 677 (2017) (tracking the change from "social control by compelling treatment to an emphasis on individuals' constitutionally protected right to liberty"); *Williams v. Wallis*, 734 F.2d 1434, 1438 (11th Cir. 1984) ("The mental health system's institutional goal . . . favors release."); 16 Del. C. § 5005(c) ("If the examining psychiatrist at the hospital determines that the involuntary patient no longer meets the criterial for provisional admission . . . the hospital shall immediately discharge the person."); Conn. Gen. Stat. § 17a-502 (same); W. Va. Code § 27-5-11(f) (same).

Patient advocacy groups and the medical community welcomed this sea change in legal and social attitudes because they believed that out-patient treatment plans were generally better for the mentally ill than involuntary commitment. *See* Mental Health America, *Position Statement 22: Involuntary Mental Health Treatment* (2013) ("Persons with mental health conditions can and should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery."); Justin M. Johnson & Theodore A. Stern, *Involuntary Hospitalization of Primary Care Patients*, Prim. Care Companion CNS

Disord. 16.3 (2014). (Involuntary admissions should be "considered carefully and coercion used only in acute crises."). "[M]ental health treatment and services can only be effective when the consumer embraces it, not when it is coercive and involuntary." *Id.* [2]

Maryland was at the forefront of this national trend. *See* Report to the Governor, Commission to Prepare Substantive Changes, As Necessary, in the Mental Health Laws of the State of Maryland (Jan. 27, 1969) ("This is a time of great change in the laws relating to Mental Health, not just in Maryland but nationwide."). In 1973, Maryland's Department of Mental Health and Hygiene issued regulations, including establishing a mandatory hearing before someone could be involuntarily committed. *See* Md. Code Regs. 10.21.01.09 (1978). When the General Assembly was unsatisfied with the progress of deinstitutionalization, it formed the Joint Oversight Committee on Deinstitutionalization to develop policies that would achieve these goals. *See* First Report of the Joint Oversight Committee on Deinstitutionalization (Dec. 1980).

Through multiple statutory enactments and judicial rulings, Maryland law now properly and squarely emphasizes the due process rights of mentally ill patients and the need to find the least restrictive path for treating them. The center piece of this regime is a "mandated multi-step process before an individual's involuntary admission," which is to be used as the last resort. *Williams*, at 584-85. Two qualified individuals must start the application process by signing certificates for involuntary admission; these

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[2] This national effort to reduce involuntarily committing mental health patients worked. By the 1990s, involuntary commitments were reduced to only 30,000 people. *See* 5 Wiley Encyclopedia of Forensic Sci.–Behavioral Sci. *Entry on Civil Commitment* (2009).

certificates can be signed by non-psychiatrists, including a non-specialist physician and a psychiatric nurse practitioner. *See* Md. Code, Health-Gen. § 10-615. This is followed by a required observation period to further evaluate and treat the patient. *See* Md. Code, Health-Gen. § 10-632. A hearing must be held within ten days of initial confinement to determine if the patient continues to meet the criteria for involuntary admittance and does so by clear and convincing evidence. Mental health facilities are forbidden from admitting a patient unless he or she meets these criteria, and not all such individuals must be admitted. *See* Md. Code, Health-Gen. § 10-617.[3]

In Maryland and other states, a key component of this legislative and regulatory regime has been providing immunity from civil liability to the individuals vested with determining whether to admit a patient involuntarily to a mental health facility. *See* Winsor C. Schmidt, *Critique of the American Psychiatric Association's Guidelines for State Legislation on Civil Commitment of the Mentally Ill*, 11 New. Eng. J. Crim. & Civ. Confinement 11, 24 (1985) (observing immunity "militat[es] against the otherwise inherent tendency to limit patient freedom"); David Starrett, M.D., et al, *Involuntary Commitment To Outpatient Treatment, American Psychiatric Association*, 26 (1987) (noting immunity is essential to providing providers the ability to treat patients with plans outside of involuntary in-patient holds). Maryland enacted its immunity provision in 1982 so that "[a] person who in good faith and with reasonable grounds applies for

[3] The criteria require that a patient (1) has a mental disorder; (2) needs inpatient care or treatment; (3) presents a danger to the life or safety of himself or others; and (4) is unwilling or unable to be admitted voluntarily. Also, (5) there must be no available less restrictive form of intervention that is consistent with the patient's welfare and safety.

involuntary admission of an individual is not civilly or criminally liable for making the application." Md. Code, Cts. & Jud. Proc. § 5-623(b); Md. Code, Health-Gen. § 10-618.[4]

In Williams, this Court carefully evaluated the Maryland's immunity provision, finding that it is essential for protecting "the discretion of health care providers tasked with deciding whether to involuntarily admit an individual." 440 Md. at 587.

II. PSYCHIATRISTS TREATING A PATIENT DURING THE MANDATED OBSERVATION PERIOD MUST RECEIVE THE SAME IMMUNITY AS THOSE WHO START THE INVOLUNTARY ADMITTANCE PROCESS

The individuals who make substantive medical determinations as to whether a patient should be involuntarily admitted to a mental health facility – from the filling out of the initial certificates to the required observation period before the administrative law judge hearing – must be provided immunity in order to give effect to Maryland's statutory regime. In *Williams*, the Court recognized that the Maryland statute conveys immunity to individuals who first met with the patient at a hospital emergency room and, after a preliminary evaluation, decided against starting the involuntary admittance process. *See* 440 Md. at 576. Here, the treating psychiatrist who conducted a multi-day, lengthy evaluation of the patient during the mandated observation period decided against

[4] For examples of other states with statutory immunity provisions, see Alaska Stat. § 47.30.815 (1981); Ark. Code. § 20-47-227 (1989); Cal. Gov. Code § 854.8 (1963); Ga. Code. § 37-3-4 (1981); Ind. Code. Ann. § 12-26-2-6 (1992); Iowa Code § 229.22 (1981); Ky. Code. § 202A.301 (1982); La. Rev. Stat. § 28:63 (1977); Md. Health-Gen Code. Ann. § 10-618 (1982); Mo. Rev. Stat. § 632.440 (1980); N.D. Cent. Code § 25-03.1-42 (1977); 50 Pa. Stat. § 4405 (1966); Tex. Mental Health Code § 571.019 (1991); Wash. Code. § 71.05.120 (1973); W. Va. Code § 27-5-2 (1992); Wis. Stat. § 51.15 (1985).

such involuntary admittance. Petitioners Dr. Bell and Bon Secours Hospital are no less deserving of immunity than the providers in *Williams*.

The submission of involuntary admittance certificates from front line health care providers does not start an irreversible process that must end with a state hearing. It creates an observation period for a psychiatrist, such as Dr. Bell in the case at bar, to evaluate the concerns asserted in the certificates and determine whether there is a lessor restrictive treatment plan that can help the person avoid involuntary admittance. *See* Md. Code Regs. 10.21.01.02. During this period, which can last no longer than ten days, the patient is confined, but not involuntarily committed. See *Furda v. State*, 193 Md. App. 371, 997 A.2d 856 (Md. Ct. Spec. App. 2010) (affirming that Maryland Code clearly distinguishes "observation status" from "involuntary admission"). A patient stays in observation status until the psychiatrist determines that the patient should be discharged, admits the patient voluntarily, or seeks involuntary admittance. Should the psychiatrist choose involuntary admittance, an administrative law judge holds a hearing to determine whether the legal criteria has been met for depriving a patient of his or her due process right to liberty. *See J.H.*, 233 Md. App. at 584 (citing Md. Code Regs.10.21.01.07F).

The purpose of the administrative law judge hearing, therefore, is to determine whether the psychiatrist's recommendation for involuntary admittance is supported by clear and convincing evidence; it is not to determine whether a person should be admitted over the objection of a psychiatrist. *See Williams v. Wilzack*, 319 Md. 485, 496, 573 A.2d 809 (Md. 1990) (explaining the role of the administrative law judge is to ensure legal protections are met). To be clear, if the psychiatrist believes that the medical

criteria have not been met, as in the case at bar, there is no reason for a hearing. The judge must defer to the "judgment exercised by a qualified professional" on the medical diagnosis. *Id.* (quoting *Youngberg v. Romeo*, 457 U.S. 307, 322, n. 29 (1982)). "[N]either judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." *Parham v. J.R.*, 442 U.S. 584, 607 (1979).

Here, there is no dispute that the initial certificates were filled out in good faith, and that Mr. Mackey may very well have been a candidate for involuntary admittance when initially confined and referred to Dr. Bell. When Dr. Bell concluded during the observation period that, in his medical judgment, Mr. Mackey no longer met two of the five criteria required for involuntary confinement, he no longer had the option to seek involuntary confinement. *See* Md. Code Regs. 10.21.01.07(C)(2) (stating the physician/facility "shall immediately release the individual" if he or she no longer satisfies all five criteria); *O'Conner,* 422 U.S. at 574-575 (requiring a person be released when grounds for involuntary commitment no longer exist). Instead, he developed, with the input of Mr. Mackey, an out-patient treatment plan that he believed would provide Mr. Mackey the clinical care he needed without compromising his freedom.

The General Assembly provided immunity to individuals in Dr. Bell's position because no psychiatrist or other physician can be a "guarantor of the success" of his or her medical judgments. In the practice of medicine, physicians know that a plaintiff could almost always find someone to testify that he or she would have recommended a different course of treatment. However, "differences of medical opinion are not inconsistent with the exercise of due care." *Campbell v. United States*, 904 F.2d 1188

(7th Cir. 1990). In situations like the one at bar, discharging or committing an individual is equally based on the assumption that psychiatrists can predict future behavior. *See Due Process for All – Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. Chi. L. Rev . 633, 638 (1967). Unless a psychiatrist is absolutely certain that a patient must be involuntarily committed, psychiatry must not be used as a tool for depriving someone of his or her right to liberty. *See id.*

Without immunity, though, there is a tendency to judge such a psychiatric decision through hindsight or positive outcome bias: because the patient committed suicide, the decision to discharge him must have been wrong. *See Kortus v. Jensen*, 195 Neb. 261, 270 (1976) (providing initial research into hindsight biases in medical malpractices cases). "In the context of medical litigation, the existence of these biases suggest that it may be difficult for finders of fact to evaluate fairly (e.g., without reference to whether the decision, in retrospect, turned out to be the right choice)." Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 Tort & Ins. L. J. 895, 905 (2007) (observing the difficulty of a fair trial or disqualify an opposing expert who will testify that he or she would have reached a different conclusion.). "The hindsight bias has particularly detrimental effects in the domain of medical decision making," such as the one at bar, that involve "important, highly consequential situations." Hal R. Arkes, *The Consequences of Hindsight Bias in Medical Decision Making*, 22(5) Curr. Directions in Psych. Sci. 356, 359 (2013).

Thus, in order to give effect to the General Assembly's decision to protect the involuntary admittance process from civil liability, as well as this Court's ruling in

Williams, the Court must find that the statutory immunity governs this case. Conveying immunity to the health care providers who initiate the involuntary admittance process, but not the psychiatrists who evaluate the patient to determine whether to continue the involuntary admittance process will cause the legislation to fail. Without immunity, psychiatrists in Dr. Bell's situation would be wrongly incentivized to advance involuntary admittance against their medical judgment.

III. PROVIDING TREATING PSYCHIATRISTS WITH IMMUNITY FROM CIVIL LIABILITY WHEN THEY DECIDE, IN GOOD FAITH, AGAINST INVOLUNTARY ADMITTANCE ADVANCES PATIENT CARE

In addition to the legal arguments above, it also is in the best health care interest of patients that they are voluntarily – not involuntarily – committed to their treatment plans. Studies have shown that forcing patients into involuntary admittance could have long-term negative effects on their care. *See, e.g.*, Dinah Miller, M.D. and Annette Hanson, M.D., *Committed: The Battle over Involuntary Psychiatric Care* xviii (1st ED. 2016). Mental health patients have refused help out of fear of losing their civil rights and being involuntary committed. *See id.* In one survey, 77 percent of previously admitted patients "would not want to be committed again, even if they were imminently dangerous to themselves or others." *Id.* Involuntary commitment makes them feel vulnerable, stigmatized, discriminated against, and as if "their integrity has been violated." Justin M. Johnson & Theodore A. Stern, *Involuntary Hospitalization of Primary Care Patients*, Prim. Care Companion CNS Disord. 16.3 (2014).

By contrast, patients report being most receptive to care in a "climate of trust, genuine interest, and understanding." *Id.* "A voluntary psychiatric admission . . . allows

the patient to acknowledge a desire for help, and increase patient involvement and personal responsibility for his disease. Essentially, he has bought into the treatment plan. . . . [I]t is clearly the best scenario." James R. Roberts, *The Risks of Discharging Psych Patients AMA,* Emergency Medicine News, Vol. 38 Iss. 7 (July 2016).

Further, history has shown that when medical specialists are subject to excessive liability, it reduces access to quality care. *See* Haskel, *supra.* Mental health patients cannot afford for quality psychiatrists to refuse to engage in the involuntary admittance process, leave practice, or regularly err on the side of committing them to mental health facilities. Treating psychiatrists who engage in the involuntary admittance process must be given the immunity that the General Assembly enacted to govern this process.

CONCLUSION

For these reasons, this Court should reverse the ruling of the Court of Special Appeals and hold that Petitioners Dr. Bell and Bon Secours Hospital are immune from civil liability for the decision not to involuntarily commit Mr. Mackey under Health-General § 10-618 and Cts. & Jud. Proc. § 5-623(b).

Respectfully submitted,

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CERTIFICATE OF WORD COUNT AND COMPLIANCE WITH RULE 8-504

1. This brief contains 4422 words, excluding the parts of the brief exempted from the word count by Rule 8-503.

2. This brief complies with the font, spacing, and type size requirements stated in Rule 8-112.

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CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of November, 2017, two copies of the foregoing Brief of *Amici Curiae* were sent by first class U.S. mail, postage prepaid, to the following:

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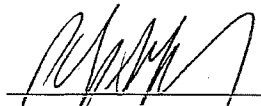

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