

evaluation or questioned his competency. By posting bond, proceeding with trial, and affirmatively engaging with counsel and the court (e.g., confirming he understood charges and trial decisions), Mr. Wilkins demonstrated readiness for trial. Further, after his release on bond, Mr. Wilkins could have sought an outpatient evaluation or requested modification of the order, but he took no action.

The majority distinguished statutory rights under § 15A-1002 from constitutional due process protections. Although constitutional competency claims require “substantial evidence” of incompetence and cannot be waived, statutory rights can be waived through inaction. Citing *Young*, the court emphasized that defendants must proactively raise statutory claims during trial. In this case, Mr. Wilkins’s pre-trial behavior (e.g., mood swings) did not outweigh his subsequent conduct affirming competence.

Dissent

Justice Earls, joined by Justice Riggs, dissented, stating that statutory duties to Mr. Wilkins were ignored. According to the dissent, the trial court and the state failed to enforce the evaluation order. The sheriff never transported Mr. Wilkins, and the court did not follow up, violating § 15A-1002’s mandate to ensure that evaluations are completed. The court indicated that waiver presupposes competence.

Inferring waiver from Mr. Wilkins’s trial conduct is circular, as competency itself was never assessed after it was raised. A defendant cannot knowingly waive rights if incompetence is suspected, but not evaluated. Further, in distinguishing prior case law, the dissent noted that cases like *Young* involved completed evaluations, whereas here, the statutory process “collapsed” because of institutional failures. The majority improperly shifted the burden to Mr. Wilkins to remedy the state’s noncompliance.

The dissent emphasized that § 15A-1002 places the responsibility on courts, not defendants, to resolve competency questions once they are raised.

Discussion

The *Wilkins* case underscores crucial problems in mental health law. First, with respect to statutory versus constitutional rights, the majority’s strict waiver doctrine for statutory claims contrasts with constitutional protections, which require hearings if substantial evidence of incompetence exists. This creates a gap for defendants who initially raise concerns but later fail to follow through, as they may

lose statutory safeguards, even if underlying mental health concerns persist.

Additionally, the problem of procedural compliance versus substance is highlighted when systemic failures undermine statutory intent, such as when evaluations are ordered but not enforced. Courts risk depriving defendants of protections by prioritizing procedural finality over substantive oversight.

Jails often lack the resources to address inmates’ mental health crises. Mr. Wilkins’s pretrial behavior (threats, mood swings) signaled potential mental illness, yet his release and subsequent “normal” conduct were regarded as conclusive and illustrative of competency. These factors risk overlooking episodic or situational incompetence. Defense counsel may need to consistently renew competency motions, even after the initial court orders are issued. Prosecutors and courts would benefit from establishing tracking systems to ensure evaluations are conducted, especially following custody changes.

The case emphasizes the tension between judicial efficiency and the protection of vulnerable defendants. Although the majority prioritizes finality, the dissent cautions against presuming competence without evidence, especially when the system itself fails to adhere to mental health protocols.

Qualified Immunity Protections for Mental Health Providers

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Pennsylvania’s Medical Providers Can Be Held Civilly Liable When Denying a Patient’s Verbal Request for Voluntary Inpatient Psychiatric Admission

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Key words: gross negligence; qualified immunity; Mental Health Procedures Act (MHPA); civil commitment; malpractice

In *Matos v. Geisinger Medical Center*, 334 A.3d 288 (Pa. 2025), the Pennsylvania Supreme Court examined the scope of qualified immunity protections for

health care providers under the state’s Mental Health Procedures Act (MHPA). This statute governs the rights and treatment of individuals with mental illness and provides legal protections for providers, such as immunity from ordinary negligence, when care is provided according to the Act’s procedures, including a valid written petition for inpatient treatment. The court ruled that, for voluntary inpatient treatment, an individual’s verbal request for admission is sufficient to trigger a duty of care under the MHPA.

Facts of the Case

Westly Wise, who was diagnosed with bipolar disorder, a traumatic brain injury, and problematic use of alcohol and drugs, had a long history of mental health challenges and impulse control problems. Although he underwent voluntary inpatient psychiatric stays and outpatient treatment, he continued to struggle with stability. In 2007, Mr. Wise “blacked out” and “snapped,” leading to a violent stabbing of his then live-in girlfriend and the mother of his two children. He pleaded guilty to simple assault and served a 21-month jail sentence.

In 2011, Mr. Wise lost his best friend, faced financial difficulties, and began drinking alcohol and using drugs again. He started experiencing severe anxiety, perceptual disturbances, and suicidal thoughts, which caused him to seek help at Geisinger Medical Center’s emergency room for voluntary inpatient psychiatric admission. There, a psychiatric physician’s assistant evaluated and discharged him home with instructions to abstain from drugs and alcohol, take vitamins, establish care with a psychiatrist, and call the county’s behavioral health crisis line if his symptoms worsen.

Three days later, Mr. Wise, who continued to experience severe agitation and hallucinations, was taken to Alley Medical Center by his father out of concern that Mr. Wise might harm himself or others. A physician’s assistant examined Mr. Wise and released him home with a refill of his prescribed medication but without arranging additional mental health treatment. That evening, Mr. Wise returned to his shared apartment with Jessica Frederick and their daughter. Mr. Wise fatally stabbed Ms. Frederick and tried to end his own life with a medication overdose. The administrator of the decedent’s estate filed a lawsuit against both medical centers and the medical personnel involved in the care for Mr. Wise for wrongful death and gross negligence in refusing inpatient treatment for Mr. Wise.

The defendants unsuccessfully filed three separate joint motions for summary judgment. They first argued that they owed no duty to the decedent, Ms. Frederick. But the trial court rejected this claim based on the Supreme Court of Pennsylvania’s 1990 decision in *Goryeb v. Commonwealth Department of Public Welfare*, 575 A.2d 545 (Pa. 1990), which established liability for gross negligence under the MHPA in mental health treatment decisions where foreseeable harm occurs.

In two additional motions for summary judgment, the defendants made arguments based on *Leight v. University of Pittsburgh Physicians, UPMC*, 202 A.3d 103 (Pa. Super. Ct. 2018) (*Leight I*) and *Leight v. University of Pittsburgh Physicians, UPMC*, 243 A.3d 126 (Pa. 2020) (*Leight II*). The defendants argued that Mr. Wise’s evaluations were outside the scope of the MHPA. They cited a prior court decision, which held that the MHPA did not apply to voluntary outpatient treatment. The defendants argued that the MHPA did not apply to Mr. Wise because he was evaluated on an outpatient basis from their emergency rooms and was never admitted as an inpatient. They added that Mr. Wise’s request for admission never qualified as an MHPA evaluation because he did not submit the request in writing. The trial court denied the defendants’ second and third motions for summary judgment.

The Pennsylvania Supreme Court granted review to consider whether *Leight II* should be interpreted to require a person requesting voluntary inpatient treatment to formally initiate the process *via* written application.

Ruling and Reasoning

The Pennsylvania Supreme Court upheld the superior court’s decision that the *Leight II* case did not apply and that the MHPA’s liability and immunity provisions are relevant when a patient verbally requests voluntary inpatient psychiatric admission. In a 6-1 ruling, the court explicitly stated that a written request is not always necessary to activate MHPA obligations. The court clarified that “the duty of medical personnel . . . begins at the moment the [patient] initiates the examination and treatment process by requesting inpatient treatment from an approved facility” rather than when a written consent form is signed (*Matos*, p 309).

The court examined the structure of Form MH-781, Pennsylvania’s written consent for voluntary inpatient treatment, noting that, even if such a form were required for voluntary admission, sections of

the form, such as the “Initial Evaluation and Treatment Plan,” involve collaborative input from both the patient and the medical provider and are not typically something the patient could complete alone. Additionally, the court agreed with the administrator’s argument that patients in mental health crises might not have the wherewithal to complete such a form prior to coming to the emergency room or ask for it at the time of evaluation.

Dissent

Justice Wecht dissented, raising concern that the assumption that verbal requests for voluntary inpatient psychiatric admission are a valid pathway for the MHPA could be seen as an extralegal interpretation of the state’s civil commitment laws. Justice Wecht also noted that Section 110(a) of the MHPA explicitly mentions that all nonprivately funded applications for commitment-related paperwork are “to be in writing” to comply with the Section 110(b) (1978) requirement to submit all applications to the county administrator. Furthermore, Justice Wecht said that broadening the scope of liability for mental health providers could lead to a potential increase in defensive medicine practices and inpatient psychiatry admissions.

Discussion

The Pennsylvania Supreme Court’s decision in *Matos* has significant implications for forensic psychiatrists and psychiatric practice. The case underscores the amorphous and ever-shifting boundaries that define the standard of care for psychiatric evaluations in the ambulatory setting. When assessing standard-of-care testimony, factfinders need to determine what constitutes reasonable care, which may involve balancing best practice guidelines from professional societies and the varying health care system-specific or state-specific regulations. Before *Matos*, medical providers could potentially rely on technical defenses to avoid liability, such as requiring paperwork to establish a duty of care. *Matos* thus lowers the litigation threshold for plaintiffs.

Although the court did not specify whether Mr. Wise’s hospital discharge plans amounted to ordinary negligence or gross negligence, this will be a key concern if the case returns to trial. An expert witness will need to understand state-specific negligence standards and the thresholds that trigger a duty of care. Pennsylvania has specific statutory language that designates malpractice liability under a gross negligence and willful misconduct standard, providing additional protection for health care providers (50 Pa. Cons. Stat. § 7114

(2024)). In contrast, malpractice liability in California generally follows the ordinary negligence standard, as demonstrated in *Gonzalez v. Paradise Valley Hospital*, 3 Cal. Rptr. 3d 903 (Cal. Ct. App. 2003).

Overall, *Matos* offers a reminder for psychiatric practitioners to consistently stay informed about their specific jurisdiction’s civil commitment laws and negligence standards. When providing treatment to individuals with mental health conditions who are at high risk for self-harm or harm to others, a probable standard of care that can be protective might include thorough and up-to-date documentation of the risk assessment, along with medical decision-making rationale.

Providing Gender-Affirming Care to Minors

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Banning Gender-Affirming Care for Minors Does Not Violate the Equal Protection Clause of the Fourteenth Amendment

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Key words: gender dysphoria; puberty blockers; gender-affirming care; hormone therapy; Fourteenth Amendment; equal protection

In *United States v. Skremetti*, 145 S. Ct. 1816 (2025), the U. S. Supreme Court held that a Tennessee statute that prohibited health care providers from providing surgery, hormones, or puberty blockers to treat distress related to discordance between a minor’s sex and asserted identity did not violate the Equal Protection Clause of the Fourteenth Amendment. The Court ruled that the statute did not classify based on sex and did not require heightened scrutiny under the Equal Protection Clause. The Court also found that the statute survived rational basis review.

Facts of the Case

Tennessee passed the Prohibition on Medical Procedures Performed on Minors Related to Sexual