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MEDICAL DECISIONMAKING FOR INCOMPETENT PERSONS: THE MASSACHUSETTS SUBSTITUTED JUDGMENT MODEL

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INTRODUCTION

In his book, *The Silent World of Doctor and Patient*,[1] Professor Jay Katz describes the apparently ingrained belief of physicians that patients are unequal partners in the medical decisionmaking process. Professor Katz contends that this insistence on authority has stifled any serious exploration of whether doctors and patients can interact with one another on the basis of greater equality. "Thus the idea of informed consent—of mutual decisionmaking—remains severely compromised" (p. 87).

A related context is that of medical decisionmaking for incompetent persons. In the next few pages, the authors will explore this area in terms of Massachusetts law, focusing particularly on extraordinary treatment situations. We believe that physicians' insistence on authority creates additional and unnecessary obstacles to meeting the legitimate treatment needs of incompetent patients. This traditional attitude on the part of the medical community, coupled with the continuing confusion on the part of both doctors and lawyers regarding the substituted judgment doctrine, poses the risk of seriously compromising the civil rights of incompetent persons.

Judges, in making substituted judgments for incompetent persons, are in an analogous position to that of competent patients in relation to their physicians. The judge's duty is to discover and implement the incompetent person's own values and preferences and not to

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1. J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

defer to physician authority as a conditioned response. Judges, like patients, can benefit from Professor Katz's model of effective, respectful conversation, albeit within the confines of a formal judicial proceeding.

I. THE SAIKEWICZ DECISION

A. *Significance of the Decision*

In 1977, the Massachusetts Supreme Judicial Court issued its landmark decision regarding potentially life-prolonging medical treatment for an incompetent person—*Superintendent of Belchertown State School v. Saikewicz.*[2] Factually, the case involved the question of whether chemotherapy should be administered to a mentally retarded person who suffered from leukemia and who was incapable, due to his profound mental retardation, of making a medical treatment decision.

The *Saikewicz* opinion rejected the idea that such decisionmaking responsibility should be delegated either to doctors or family members or guardians.[3] Instead, the supreme judicial court held that the trial court should make a so-called "substituted judgment" determination by substituting itself for the ward and attempting to ascertain his actual interests and preferences.[4] In essence, the supreme judicial court fashioned a judicial decisionmaking model to be applied in cases involving the question of whether life-prolonging treatment should be administered to incompetent persons.

The reaction of the medical community to *Saikewicz* was extremely negative. As one physician wrote, "[t]his astonishing opinion can only be viewed as a resounding vote of 'no confidence' in the ability of physicians and families to act in the best interests of the incapable patient suffering from a terminal illness."[5]

The supreme judicial court, however, did not view its decision as a "gratuitous encroachment on the domain of physicians."[6] From the authors' perspective, too much of the discussion of this judicial decisionmaking model has been couched in terms of lawyers or judges usurping the traditional role of physicians. Such narrow perspective misses the important considerations which underlie the *Saikewicz* opinion and the decisions following *Saikewicz* which have extended

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2. 373 Mass. 728, 370 N.E.2d 417 (1977).
3. *Id.* at 758, 370 N.E.2d at 434.
4. *Id.* at 752, 370 N.E.2d at 431.
5. Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508, 509 (1978).
6. *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 435.

the substituted judgment doctrine to other areas of medical care and treatment. A review of the basic tenets of these decisions underscores the important but different roles of the court, the medical community, and other players in extraordinary medical treatment cases.

B. *Judicial Analysis and Reasoning*

According to *Saikewicz*, one of the underlying principles of the substituted judgment doctrine is the constitutional right of an individual to privacy, a guaranty which encompasses the choice to accept or to refuse medical treatment.[7] This fundamental right extends "not only to competent patients but also to incompetent persons because the value of human dignity extends to both."[8]

It is important to note that a substituted judgment determination cannot be made until there is a judicial determination of incompetency by reason of an individual's minority,[9] mental illness,[10] or mental retardation.[11] A person is presumed to be capable of handling his or her affairs unless shown by the evidence presented to be incompetent.[12] The law protects an individual's right to accept or reject medical treatment, whether that decision is wise or unwise.[13] As set forth in the *Saikewicz* decision, once a determination of incompetency has been made, the role of the court is to substitute itself as nearly as possible for the incompetent person and to act on the same motives and considerations as would move the incompetent person. The court's role as substitute decisionmaker is subjective in nature—that is, the goal is to determine with as much accuracy as possible the wants and needs of the individual involved. This may or may not conform to what is thought wise or prudent by most people. The problems of arriving at an accurate substituted judgment in matters of life and death vary greatly in degree, if not in kind, in different circumstances.[14]

The *Saikewicz* court, in essence, forced conversation between the physician and the trial court about the incompetent's medical and nonmedical wants and needs. In doing so, the court established a formalized variant of Professor Katz's goal of self-reflective conversation

7. *Id.* at 738-39, 744-45, 370 N.E.2d at 424, 427.
8. *Id.* at 745, 370 N.E.2d at 427.
9. MASS. GEN. LAWS ANN. ch. 201, § 2 (West Supp. 1986).
10. *Id.* at § 6.
11. *Id.* at § 6A.
12. *Id.* at §§ 6 & 6A.
13. Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).
14. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 750-51, 370 N.E.2d 417, 430 (1977).

between doctor and patient. Both models are designed to eradicate a silent relationship between doctor and patient. Professor Katz proposes a decisionmaking process in which the parties concentrate on conscious and unconscious values affecting their positions on treatment, with hope leading both to recognize previously unspoken bases for the final decision (pp. iii-4, 150-55). Professor Katz's model addresses a silent world in which one party dominates and refuses to communicate to the other; the *Saikewicz* court addresses a silent world in which the parties cannot communicate with each other because of one's disability.

The supreme judicial court has established a process which seeks information similar to that Professor Katz wished to realize in his own model: the trial court and the doctor attempt to discover how the incompetent person would view the treatment options, with the court deciding which facts are important and using them to make a final decision. The *Saikewicz* court also demonstrated the same respect as Katz does for the sanctity of the patient's final decision, whether or not the decision seems reasonable to doctors or other similarly situated patients. As Professor Katz stated, "Although [respecting patients' ultimate decisions] may mean bowing at times to 'foolish' choices, they must be honored to protect the process of thinking about choices. . ." (p. 154). Katz and the *Saikewicz* court seem to agree that preserving a patient's right to self-determination begins with protection of the method through which the patient's wishes and needs are best expressed, regardless of the outcome.

Respect for the outcome in substituted judgment determinations, however, is not absolute until the final participant—the state—determines that the incompetent person's interests do not conflict with its own interests in the decision. The court must balance the individual's interests against potentially countervailing state interests, which have been defined as "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."[15] In *Saikewicz*, the supreme judicial court found no state interest or combination of interests sufficient to override the patient's decision, as determined by the trial court, to decline life-prolonging treatment.[16]

C. *Cases Following* Saikewicz

At this juncture, it is appropriate to underscore two related com-

15. *Id.* at 741, 370 N.E.2d at 425.
16. *Id.* at 744-45, 370 N.E.2d at 427.

ments made by the supreme judicial court in cases following *Saikewicz*. First, a substituted judgment decision is distinct from a decision by doctors as to what is medically in the "best interests" of the patient.[17] Secondly, medical advice and opinion are to be used for the same purposes and to the same extent that the incompetent individual would, if he or she were competent.[18] These comments and the *Saikewicz* decision clarify the respective roles of the trial judge and the treating physician. The judge is to probe the individual's values and preferences, while the physician is to present and explain treatment options. As Professor Katz commented,

> no single right decision exists for how the life of health and illness should be lived. Medical advances have led to a proliferation of treatment options and a better understanding of their benefits and risks. Alleviation of suffering can be accomplished in a variety of ways and alternative choices must be explained. Physicians alone cannot decide which treatment is best. The patient must be consulted (p. 102).

In cases of extraordinary medical treatment for incompetent persons, the court, in effect, stands in the place of the patient for the purpose of considering medical advice and opinion. Beyond this, the court must balance the patient's individual interests against potentially countervailing state interests.

From the authors' point of view, the role of the physician is neither diminished nor reduced in this process—unless one perceives such role as including ultimate decisionmaking responsibility for incompetent persons. In the case of *Rogers v. Commissioner of Department of Mental Health*,[19] the psychiatric profession argued that if a substituted judgment is to be required before there can be forcible administration of antipsychotic medication to involuntarily confined, incompetent patients, the decision as to substituted judgment should be made by a physician and not a judge. The supreme judicial court rejected this procedure, the so-called medical model, citing, among other things, the likelihood of conflicting interests on the part of physicians. Doctors, according to the opinion, are not only attempting to treat psychiatric patients but also to maintain institutional order. Thus, "the temptation to engage in blanket prescription of such drugs to maintain order and compensate for personnel shortages may be irresis-

17. *In re* Roe, 383 Mass. 415, 435, 421 N.E.2d 40, 52 (1981).

18. *Id.* at 435, 421 N.E.2d at 52; Rogers v. Comm'r of Dept. of Mental Health, 390 Mass. 489, 500, 458 N.E.2d 308, 317 (1983).

19. *Rogers*, 390 Mass. at 502, 458 N.E.2d at 317.

tible."[20] As Professor Katz comments, "The idea that doctors know what is in their patients' interest and therefore can act on their behalf without inquiry is so patently untrue that one can only marvel at the fervor with which the notion has been defended (p. 98). The supreme judicial court has repeatedly rejected any delegation of decisionmaking responsibility away from the court in extraordinary treatment situations.[21]

In the aftermath of *Saikewicz*, there have been a number of cases involving life-prolonging treatment issues. The supreme judicial court and appeals court consistently have applied the substituted judgment doctrine on behalf of mentally incompetent persons or minor children.[22] The supreme judicial court and appeals court have also extended the substituted judgment doctrine and judicial decisionmaking responsibility to other areas of extraordinary medical care and treatment, including sterilization,[23] antipsychotic medication,[24] and artificial maintenance of nutrition and hydration.[25] In dicta, Massachusetts courts have also included electroconvulsive therapy and psychosurgery.[26]

Thus far, courts have defined extraordinary medical treatment on a case-by-case basis. In *In re Spring*, the supreme judicial court suggested a number of factors to be considered in determining whether a prior court order is needed with respect to medical treatment for incompetent patients.[27]

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20. *Id.* at 504 n.19, 458 N.E.2d at 318 n.19.

21. *See infra* notes 22-25.

22. Custody of a Minor, 375 Mass. 733, 379 N.E.2d 1053 (1978) (order continuing chemotherapy for minor child over parental objection); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980) (order withholding hemodialysis from incompetent person); Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (approval of "no-code" order for minor child with serious cardiac problems); *In re* Hier, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984) (order withholding surgical procedure necessary to provide ward with adequate nutrition support).

In Comm'r of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979), the court ordered hemodialysis for a competent individual who was refusing treatment. The critical factor in this case was the patient's status as a prison inmate and the state's overriding interest in upholding orderly prison administration.

23. *In re* Moe, 385 Mass. 555, 432 N.E.2d 712 (1982).

24. Rogers v. Comm'r of Dept. of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983); *In re* Roe, 383 Mass. 415, 421 N.E.2d 40 (1981).

25. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986).

26. *Roe*, 383 Mass. at 437, 421 N.E.2d at 53.

27. These factors include the following:

> the extent of impairment of the patient's mental faculties; whether the patient is in the custody of a State institution; the prognosis without the proposed treatment; the prognosis with the proposed treatment; the complexity, risk, and nov-

II. THE JUDGE'S ROLE

In *The Silent World of Doctor and Patient*, Professor Katz commented on the tendency of patients to defer to doctors with "unquestioning compliance, unilateral trust, and verbal silence" (p. 100). There is a similar tendency on the part of trial judges, when confronted with a substituted judgment determination, to question their roles in making such a decision. A not infrequent comment on the part of judges is, "I'm not a doctor. I have no business making a medical decision." This perspective misses the critical point that the trial judge's role is to stand in place of the ward and attempt to ascertain the incompetent person's actual values and preferences. The conditioned response of deferring to the authority of physicians is perhaps best illustrated by the following dialogue excerpted from the trial transcript in *Saikewicz*. Admittedly, the trial court judge was presiding over what was at that time a novel and rather extraordinary proceeding.

> THE COURT: There is evidence that chemotherapy treatment is apparently the only treatment, but by giving it to him he may have some discomfiture at the time of the treatment that may prolong his life.
> DR. DAVIS: That is one thing and if they don't give it to him at all, then he may die in a matter of days or weeks.
> THE COURT: That is the choice I have to make.
> DR. DAVIS: That is it. I don't know. I don't have that deep knowledge.
> THE COURT: I am inclined to give treatment.
> DR. JONES: One thing that concerns me is the question about his ability to cooperate. I think it's been made clear that he doesn't have the capability to understand the treatment and he may or may not be cooperative, therefore greatly complicating the treatment process. . . . That has to be weighed, whether [the treatment] could be administered.
> THE COURT: Dr. Davis, do you agree?
> DR. DAVIS: I think it's going to be virtually impossible to carry out the treatment in the proper way without having problems. You have to see him. When you approach him in the hospital, he flails

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> elty of the proposed treatment; its possible side effects; the patient's level of understanding and probable reaction; the urgency of decision; the consent of the patient, spouse, or guardian; the good faith of those who participate in the decision; the clarity of professional opinion as to what is good medical practice; the interests of third persons; and the administrative requirements of any institution involved.

In re Spring, 380 Mass. 629, 636-37, 405 N.E.2d 115, 121 (1980).

> at you and there is no way of communicating with him and he is quite strong; so he will have to be restrained and that increases the chances of pneumonia, to restrain him if he can't be up and around.
> MR. MELNICK [Court-appointed guardian for Saikewicz, who concurred in the physicians' determination to withhold treatment]: With no treatment he may live longer; with treatment, the treatment itself may terminate his life sooner. There is some risk because of the toxic nature of the treatment, so in effect, by ordering the treatment there is a possibility that you may shorten his life and there is a chance that you may be prolonging it.
> THE COURT: Maybe I should change my judgment.
> DR. DAVIS: One other factor. Though we will get a remission, we are not through at that point. He'd have to be under medical care weekly and continue treatment and he may be in the hospital for four to five weeks initially and will have to be coming back on a regular basis. That enters the picture.
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> * * * *
>
> THE COURT: Do I have to form a written judgment?
> MR. ROGERS: Yes, I will draft it.
> THE COURT: After a full hearing with medical specialists and doctors being present and their testimony being taken, the Court determines and adjudges that chemotherapy treatment should not be given at this time.[28]

The *Saikewicz* line of decisions now provides both guidance and instruction for the trial court judge. For example, in the *Roe* opinion, the supreme judicial court identified six factors to be considered by the judge in making a substituted judgment determination. These include: "(1) the ward's expressed preferences regarding treatment; (2) his religious beliefs; (3) the impact upon the ward's family; (4) the probability of adverse side effects; (5) the consequences if treatment is refused; and (6) the prognosis with treatment."[29] This criteria is not exclusive, but rather provides a basic framework for the judge's inquiry. The *Roe* decision also states, "In this search, procedural intricacies and technical niceties must yield to the need to know the actual values and preferences of the ward."[30]

In the *Moe* decision, the supreme judicial court developed detailed and specialized criteria for the trial court judge to apply in sterilization cases.[31] The supreme judicial court stressed that the judge

28. R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 155-57 (1979).
29. *Roe*, 383 Mass. at 444, 421 N.E.2d at 57.
30. *Id.*
31. *Moe*, 385 Mass. at 567-70, 432 N.E.2d at 721-22.

must exercise the utmost care in reviewing all of the evidence presented. "The judge must enter detailed written findings indicating those persuasive factors that determine the outcome. We are persuaded that a conscientious judge . . . will give serious and heedful attention to all stages of the proceeding."[32]

In *Saikewicz*, the supreme judicial court indicated that the trial judge may, at any stage in the proceedings, "avail himself or herself of the additional advice or knowledge of any person or group," including medical experts or medical ethics committees or panels.[33] Although such information may be considered by the court whenever available and useful, the judge may not delegate to any individual or group the ultimate decisionmaking responsibility. According to the supreme judicial court, "such questions . . . seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[34]

III. THE APPOINTMENT OF A GUARDIAN AD LITEM AND/OR COUNSEL

To assist further the trial judge, the supreme judicial court has indicated that a guardian ad litem should be appointed to represent the interests of the proposed ward.[35] At a minimum, the guardian ad litem must ensure that all viewpoints and alternatives to the relief requested are presented to the court.[36] In addition, there apparently has been some continuing confusion regarding the guardian ad litem role, specifically, whether the guardian ad litem is to conduct an independent investigation for the court or to act as counsel for the ward. Following the *Rogers* decision, the Probate and Family Court Department issued procedures which call for the appointment of counsel in all antipsychotic medication cases.[37] The appointment of a guardian ad litem remains discretionary with the court. The procedures clarify the respective roles of counsel and guardian ad litem, with counsel representing the proposed ward and acting as his or her

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32. *Id.* at 572, 432 N.E.2d at 724.

33. *Saikewicz*, 373 Mass. at 757-58, 370 N.E.2d at 434.

34. *Id.* at 759, 370 N.E.2d at 435.

35. *Id.* at 757, 370 N.E.2d at 433.

36. *Id.*

37. OFFICE OF THE CHIEF JUSTICE, PROBATE AND FAMILY COURT DEPARTMENT, OUTLINE OF PROCEDURES FOR CASES BROUGHT PURSUANT TO ROGERS V. COMM'R. OF MENTAL HEALTH (1984). The Office issued these procedures on May 10, 1984, and they are available at each Massachusetts Registry of Probate.

advocate, and the guardian ad litem serving as an independent investigator for the court.

IV. The Adversarial Nature of the Proceedings

The authors have received comments from both physicians and counsel for the Commonwealth to the effect that the appointment of counsel renders these proceedings unnecessarily adversarial.[38] From our perspective, however, effective assistance of counsel serves only to protect the important interests of the ward. At a minimum, counsel for the ward can ensure that the court has before it a complete picture of the case. For example, upon cross-examination of the treating physician, counsel can probe alternatives to the recommended treatment or pose questions regarding the patient's alleged incompetency. The use of independent medical experts can also prove invaluable in this regard.[39] For the treating physician, the only discomfort may be some very direct questioning regarding his or her evaluation and recommended treatment. The reality is that most physicians have very legitimate reasons for their treatment recommendations, and the substituted judgment doctrine does no more than require them to articulate such reasons. This is the judicial version of "respectful conversation" with the physician. In addition, physicians are not the only witnesses in these proceedings. Family members may testify as to their involvement with the patient and their position regarding treatment. Frequently, the patient will take the witness stand and articulate his or her preference regarding recommended treatment. Additional witnesses might include psychologists, social workers, or laypersons who have direct involvement with the patient. Although most of the questioning is conducted by respective counsel, the trial judge, as substitute decisionmaker, should not hesitate to question any or all of the witnesses, particularly if there is a need for additional information regarding the substituted judgment criteria or clarification or elaboration of previous testimony.

V. Effectiveness of the Massachusetts Model

A further criticism of the Massachusetts substituted judgment

38. The authors have handled over two hundred antipsychotic medication cases and numerous other cases involving a variety of extraordinary medical treatment issues.

39. In Guardianship of a Mentally Ill Person with the Authority to Administer Antipsychotic Medication, No. 85-0018 Civ. (Mass. App. Ct. 1985), the Massachusetts Appeals Court held that an indigent patient in a *Rogers* guardianship proceeding is entitled to the assistance of a medical expert at the Commonwealth's expense.

model, voiced by both doctors and lawyers, is that the requirement of prior judicial approval has created an extremely cumbersome process.[40] Admittedly, many medical decisions must be made on an urgent or at least expedited basis. The supreme judicial court addressed this issue in several of its decisions following *Saikewicz*.

To begin with, physicians may act in emergency situations. In *Roe*, the supreme judicial court accepted the dictionary definition of emergency, *i.e.*, "an unforeseen combination of circumstances or the resulting state that calls for immediate action."[41] The supreme judicial court, however, added an important qualification:

> We . . . emphasize that in determining whether an emergency exists in terms of requiring 'immediate action,' the relevant time period to be examined begins when the claimed emergency arises, and ends when the individual who seeks to act in the emergency could, with reasonable diligence, obtain judicial review of his proposed actions. This time period will, of course, be brief. . . .[42]

In *Rogers*, the supreme judicial court pointed to the Commonwealth's statutory and regulatory scheme regarding the use of antipsychotic medications as chemical restraints in emergency situations. The *Rogers* opinion also allowed forcible treatment with antipsychotic medication of incompetent persons to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness."[43]

Reading *Roe* and *Rogers* together, it is our view that although physicians may act in emergencies, they are not relieved from proceeding to court if extraordinary medical treatment is to be rendered on an ongoing basis.

The supreme judicial court has stressed that expedited procedures exist on the trial court level to handle urgent medical cases.[44] Massachusetts General Law, chapter 201 and Rule 29B of the Probate Courts provide for the appointment of a temporary guardian by a probate judge.[45] The Massachusetts trial court has also developed the Judicial Response System, which makes judges available after normal

40. *See, e.g.*, Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499, 500 (1978).

41. *In re* Roe, 383 Mass. 415, 440, 421 N.E.2d 40, 54 (1981).

42. *Id.* at 441, 421 N.E.2d at 55.

43. Rogers v. Comm'r of Dept. of Mental Health, 390 Mass. 489, 511, 458 N.E.2d 308, 322 (1983).

44. *In re* Spring, 380 Mass. 629, 642, 405 N.E.2d 115, 123 (1980).

45. MASS. GEN. LAWS ANN. ch. 201 (West Supp. 1986); Mass. P. Ct. R. § 29B (1987).

working hours and on weekends and holidays.[46] Thus, judges are accessible around the clock to handle urgent medical matters.

VI. JUDICIAL AND MEDICAL RESOURCES

Following the *Rogers* decision, the Department of Mental Health estimated that several thousand cases would be filed seeking judicial authorization to administer antipsychotic medication to mentally ill and mentally retarded persons in the Department's care.[47] A number of the divisions of the Probate and Family Court Department are now experiencing difficulty handling the sheer volume of cases. With the passage of recent legislation, the District Court Department has also begun to hear *Rogers*-type cases.[48] In the authors' view, it is imperative that the Chief Administrative Justice of the Trial Court, along with the Chief Justices of the District Court and Probate and Family Court Departments, allocate additional resources to those divisions of the trial court which presently are facing particularly heavy case loads. These resources should include, at a minimum, the assignment of additional judges and support staff and the allocation of funds to provide monitoring of court-ordered treatment. The monitoring of treatment by guardians, if available, or by the court itself is an essential aspect of the *Rogers* decision.[49] Consideration also should be given to scheduling special sessions or appointing masters for the purposes of handling antipsychotic medication cases. In the absence of adequate judicial resources, it will be impossible to comply with the requirements of *Rogers*.

Professor Katz mentioned the economic arguments raised by physicians, admitting that "greater fidelity to disclosure and consent will be costly both in physicians' time and patients' fees" (p. 201). In cases involving extraordinary medical care for incompetent patients, the resource commitment on the part of physicians is a very legitimate concern, particularly as the judicial hearings may require the appearance and testimony of physicians. Some doctors, however, have opted to simply avoid the court process altogether.[50] There is reportedly widespread noncompliance with the *Rogers* decision on the part of

46. Information regarding the Judicial Response System may be obtained from the respective Registries of Probate.

47. R. Ames, *Rogers*—Implications for Administration of Antipsychotic Medication (Dec. 16, 1983) (Massachusetts Department of Mental Health memorandum).

48. 1985 Mass. Acts 344.

49. *Rogers*, 380 Mass. at 504 n.20, 458 N.E.2d at 318 n.20.

50. Interview with Jeffrey MacKenzie, Esq., Massachusetts Department of Mental Health Legal Office, in Northampton, Massachusetts (January 21, 1986).

physicians in both the community and institutional settings.[51] Thus, many incompetent mentally ill and mentally retarded persons are being treated with antipsychotic medication without the benefit of a substituted judgment determination. Such practice not only violates the legal rights of mentally disabled persons, but also may import severe consequences for treating physicians. In *Harnish v. Children's Hospital Medical Center*,[52] the Massachusetts Supreme Judicial Court adopted, for the first time, the doctrine of informed consent. The opinion stated in relevant part, that "a physician's failure to divulge in a reasonable manner to a competent adult patient sufficient information to enable the patient to make an informed judgment whether to give or withhold consent to a medical or surgical procedure constitutes professional [medical] misconduct. . . ."[53] In our view, a physician's failure to obtain the court's "informed consent" by way of a substituted judgment before rendering extraordinary medical treatment to an incompetent person constitutes similar medical misconduct, and may result in the initiation of malpractice litigation.

Compliance with the law is only one issue, however, and those doctors unwilling to adhere to the *Saikewicz* line of decisions are presumably aware that they may be sanctioned. Apart from this, we suggest that representatives from both the medical and legal professions begin to explore together existing resource problems and perhaps consider whether legislative action in the form of revisions or amendments to the law is, in fact, desired.

VII. THE *BROPHY* DECISION

Recently, the supreme judicial court issued its opinion in the controversial and highly-publicized case of *Brophy v. New England Sinai Hospital, Inc.*[54] The *Brophy* decision is a further example of the application of the Massachusetts substituted judgment model. In this case, the supreme judicial court decided that food and water may be withheld from a patient who is in a persistent vegetative state but not terminally ill.[55] The court's balancing of Mr. Brophy's individual interests and preferences against specifically identified state interests is worth reviewing in some detail.

At the trial court in *Brophy*, the presiding judge found that if Mr.

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51. *Id.*
52. 387 Mass. 152, 439 N.E.2d 240 (1982).
53. *Id.* at 154-55, 439 N.E.2d at 242.
54. 398 Mass. 417, 497 N.E.2d 626 (1986).
55. *Id.* at 441, 497 N.E.2d at 639.

Brophy were competent, his choice would be to forego the provision of food and water and thereby terminate his life.[56] Despite this finding, the trial court concluded that the state's interest in the preservation of life outweighed Mr. Brophy's individual interest and preference to decline treatment.[57] The trial court also concluded that it would be "ethically inappropriate to cause the preventable death of Brophy by the deliberate denial of food and water, which can be provided to him in a noninvasive, nonintrusive manner which causes no pain and suffering. . . ."[58]

In reversing the trial court decision, the supreme judicial court balanced Mr. Brophy's substituted judgment to reject treatment against three potentially countervailing state interests: (1) the preservation of life, (2) the prevention of suicide, and (3) the maintenance of the ethical integrity of the medical profession.[59] Regarding the state's interest in the preservation of life, the supreme judicial court indicated that "the State's interest in life encompasses a broader interest than mere corporeal existence. In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve. The law recognizes the individual's right to preserve his humanity, even if to preserve his humanity means to allow the natural processes of a disease or affliction to bring about a death with dignity."[60] Thus, the supreme judicial court concluded that the state's interest in the preservation of life did not overcome Brophy's right to discontinue treatment.[61]

The supreme judicial court also rejected the state's interest in the prevention of suicide as an applicable consideration.[62] The court noted "[a] death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient."[63]

Finally, regarding the ethical integrity of the medical profession, the supreme judicial court concluded that as long as the defendant hospital was not forced to withhold food and water from the patient,

56. Brophy v. New England Sinai Hosp., Inc., No. 85E0009G1 (Norfolk Division, Probate and Family Court Department, Oct. 21, 1985).

57. *Id.*

58. *Id.* at 42.

59. *See infra* notes 60-64.

60. *Brophy*, 398 Mass. at 434, 497 N.E.2d at 635.

61. *Id.* at 439, 497 N.E.2d at 638.

62. *Id.*

63. *Id.* (quoting Rasmussen v. Flemming, No. 2 CA-CIV 5622, slip op. at 11-12 (Ariz. Ct. App. June 25, 1986) (quoting *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738, 743 (1983))).

the integrity of the medical profession is not violated.[64] The supreme judicial court noted that there is substantial disagreement in the medical community over the appropriate medical action.[65] The supreme judicial court remanded the case to the trial court for a new judgment to be entered ordering the hospital to assist the guardian in transferring the patient to a different facility or to his home where the patient's wishes could be effectuated.[66]

CONCLUSION

Professor Katz urges that, "[a]bove all, physicians and patients must learn to converse with one another" (p. xxi). In cases of extraordinary medical treatment for incompetent persons, Massachusetts has created a judicial model which, in effect, forces conversation between the physician and trial court regarding a patient's medical needs and individual preferences. We have described, in part, the criteria and mechanics of the Massachusetts model, as defined by the supreme judicial court and appeals court, and some of the practical problems involved with the model, such as inadequate judicial and medical resources. In so doing, it is our hope that judges, lawyers, and doctors can understand and cooperate better in this important decisionmaking process. Throughout the article, we have tried to convey what we consider to be the fundamental principle underlying the Massachusetts substituted judgment model—that of individual autonomy and the "emphasis away from a paternalistic view of what is 'best' for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved. . . ."[67] As participants in this symposium, we have been fascinated by the numerous parallels between Professor Katz's thesis and many of the basic tenets expressed in the *Saikewicz* line of decisions.

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64. *Id.* at 439-41, 497 N.E.2d at 638-39.
65. *Id.* at 440 n.38, 497 N.E.2d at 638-39 n.38.
66. *Id.* at 441, 442, 497 N.E.2d at 639-40.
67. *Id.* at 431, 497 N.E.2d at 633.