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# Judges as Medical Decision Makers: Is the Cure Worse than the Disease

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# THE THIRTY-SECOND MARSHALL FUND LECTURE

## JUDGES AS MEDICAL DECISION MAKERS: IS THE CURE WORSE THAN THE DISEASE?

ALAN A. STONE\*

In the short time available to me, I shall examine and criticize three of the many judicial decisions in the area of law and medicine. Those of you who like to think of the law as reason and justice tempered by mercy will be offended by what I have to say; but I shall be evenhanded. Those of you who think of medicine as science and art tempered by compassion will also be offended. My justification for the critical and polemical thesis I shall present is my deep and growing conviction that in law, as often as in medicine, the cure can be worse than the disease. There is a word in medicine for cures that create diseases—the word is iatrogenic. Law needs a similar word; let me suggest juridicogenic.<sup>1</sup>

Any discussion of the role of the judiciary in medical decisionmaking in the twentieth century must begin with the abortion decisions: *Roe v. Wade*<sup>2</sup> and *Doe v. Bolton*.<sup>3</sup> One aspect of those decisions is relevant to my particular thesis. I quote a crucial sentence from Justice Blackmun's decision in *Wade*: "For the stage, prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."<sup>4</sup> Although we have come to know the abortion decision as freedom of choice versus right to life, we find Justice Blackmun writing not that the state must yield to the woman's choice but to the physician's "medical judgment." I assure you this is not just a sentence taken out of context. Earlier in his opinion, Blackmun had written that the attending physician before extra-uterine viability is free to "determine . . . that, in his medi-

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<sup>1</sup> Juridicogenic is an incorrect neologism since it combines Latin and Greek terms. Its use is justified only on the premise that its meaning will be more obvious than the correct form, critogenic, which has been previously suggested by my colleague, Thomas Butheil, M.D.

<sup>2</sup> 410 U.S. 113 (1973).

<sup>3</sup> 410 U.S. 179 (1973).

<sup>4</sup> 410 U.S. at 164.

cal judgment, the patient's pregnancy should be terminated."<sup>5</sup> The language of the decision throughout misleadingly suggests that some crucial sort of medical judgment is involved not only in how the abortion is performed but whether the pregnancy "should be terminated."

Justice Burger in his brief comment to the abortion decisions chose to emphasize this very same crucial and misleading point.

I do not read the Court's holdings today as having the sweeping consequences attributed to them by the dissenting Justices; the dissenting views discount the reality that the vast majority of physicians observe the standards of their profession, and act only on the basis of careful deliberated medical judgments related to life and health. Plainly, the Court today rejects any claims that the Constitution requires abortions on demand.<sup>6</sup>

What was the reality that Justice White in dissent had discounted? Implied by Blackmun and explicit in the words of Burger were the crucial and false notions that the reality of medical standards and medical judgment would keep the woman's right to an abortion from becoming abortion on demand, abortion as a routine form of birth control. Professor Noonan, a bitter critic of the abortion decision, refers to this aspect of the decision as the "doctor as heroic figure."<sup>7</sup>

Some have attributed Blackmun and Burger's "heroic doctor" misleading language to political or personal motives or even to sugar-coated hypocrisy. There are even professional cynics steeped in constitutional law and court watching who suggest Machiavellian duplicity on Burger's part. Burger, they say, is waiting for another Reagan appointee so that with a majority he will then write: I never approved abortion on demand and since that is what it became I now join with those who reject *Wade* and *Bolton*.

As a psychiatrist, I am in the unusual position of insisting that we take the Justices' words at their face value. Of course, the Chief Justice turned out to be completely wrong: the consequences predicted by the dissent were as accurate as any judicial prediction can be. As Justice White correctly interpreted the decision, "any woman is entitled to an abortion at her request if she is able to find a medical advisor willing to undertake the procedure."<sup>8</sup> As Justice White predicted, abortion has become a routine alternative method of birth control. If we take Justice Blackmun's and Burger's words about medical judgment at face value, we can only assume that they were quite misled about the medical profession, its medical standards, and the medical judgments that were and would be

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<sup>5</sup> *Id.* at 163.

<sup>6</sup> *Doe v. Bolton*, 410 U.S. at 208.

<sup>7</sup> See J. NOONAN, A PRIVATE CHOICE: ABORTION IN AMERICA IN THE SEVENTIES 38-40 (1979).

<sup>8</sup> *Doe v. Bolton*, 410 U.S. at 221.

applied to abortion. It was Blackmun and Burger who were out of touch with reality if they honestly believed what they wrote.<sup>9</sup>

My point is not that the abortion decisions were wrong or right as a matter of law or morality. My point is that to the extent these opinions involved factual inferences about medical standards and medical practice—inferences which suggested a context for the decision, inferences which suggested more limited consequences of the decision, inferences which suggested the realities of medical practice—to that extent, the decision was quite misleading.

I claim that such misleading statements about medical realities are not uncommon when judges make medical decisions. I also claim that the result of such misleading statements by judges is costly. The credibility of the courts is undermined in the eyes of the medical profession, and the credibility of the medical profession is undermined in the eyes of the public. The result is greater public distrust of both law and medicine. A loss of faith in both professions is the result of the vicious circle of counterproductive moves set in motion by these flawed decisions. I shall of course deal today with cases that make this point. I offer a critical perspective of juridicogenic decisions, not a survey of the judicial literature on law and medicine. However, I do want to claim that the cases I shall cite are among the most important law and medicine decisions on anyone's list.

Before I leave the abortion decision I want to say a few more words about the *Bolton* opinion. In *Wade*, Blackmun had used the phrase "attending physician" to describe the doctor who would make the abortion decision. This conjures up an earlier time when patients actually had a personal physician who attended them at bedside both at home and in the hospital, but is certainly an inapt phrase for describing doctors who perform abortion procedures in clinics.

Typically the pregnant woman is greeted by a nurse, a social worker, or an abortion counselor. The "medical decision" is made with them. She meets the doctor typically only after she is "prepped and in the stirrups." The physician is more appropriately characterized as a technician in an assembly line than an attending physician. There are certainly exceptions to this practice, but the picture I describe will certainly be familiar to the vast majority of the participants in this example of "deliberated medical judgments related to life and health." Doctors, of course, still use the phrase "attending physician" but with a different meaning. As Victor Fuchs has written of contemporary medical practice, my heart can get a

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<sup>9</sup> Justice Blackmun has had a long professional association with the Mayo Clinic. His experience may be with doctors who if not "heroic" are men and women holding to the highest ethical standards of the profession. Still, it is unclear how the highest ethical standards would or should influence the medical decision to perform a procedure which is both legal and acceptable (as Justice Blackmun took great pains to point out) to medical ethics.

doctor, my liver can get a doctor, my head can get a doctor, but I cannot get a doctor.<sup>10</sup> The nostalgic image of the doctor-patient relationship is important in *Bolton* because there the Supreme Court had a great deal to say about the importance of the privacy of the doctor-patient relationship. The Court made this privacy seem as sacred to law as the privacy of the marriage bed. We shall see how much respect subsequent courts have had for the privacy of the doctor-patient relationship as cases were decided in the name of privacy.

The next case I shall discuss is the Massachusetts Supreme Judicial Court's decision *Superintendent of Belchertown State School v. Saikewicz*.<sup>11</sup> This was the Massachusetts Court's alternative to the New Jersey Supreme Court's Karen Quinlan decision. *Quinlan*, granting the right of a comatose patient to refuse extraordinary care, left the actual medical decision to the doctors who would take into account any expressed preferences of the patient in consultation with the family and the hospital ethics committee.<sup>12</sup> This decision was generally applauded by the medical profession, but we should note that mandatory review by an ethics committee means the loss of the very kind of privacy that *Bolton* tried to protect. Massachusetts rejected the *Quinlan* approach and reached the high-water mark in judicial intervention in medical decisionmaking. In the *Saikewicz* decision, Massachusetts made the judge the hands-on decisionmaker, deciding when to pull the plug on the terminally-ill patient. The Massachusetts case may be less well known to you than *Quinlan* or the abortion cases, so I shall provide more detail.

Joseph Saikewicz was a severely retarded sixty-seven year old inmate of Belchertown, a state institution for the mentally retarded. During medical evaluation that was itself the result of a federal class action right to treatment case, it was discovered that Joseph Saikewicz had a serious form of leukemia which the doctors predicted would kill him in a few months whether treated or not. Saikewicz had spent nearly his entire life in the state institution. He had no relatives to whom the doctors could turn for guidance about his preferences. In fact, Joseph Saikewicz never possessed the mental capacities necessary to formulate any preferences about accepting or refusing extraordinary treatment of a terminal illness. Apparently, the doctors were not eager to treat him; treatment would involve taking him to a general hospital, sedating him and/or restraining him for long periods while drugs would be given intravenously and intrathecally. The treatment would be painful and would cause suffering; and, given his mental disability, it would be impossible to communicate with the patient to explain the reasons for the painful treatment. At best,

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<sup>10</sup> V. FUCHS, WHO SHALL LIVE? 67-70 (1974).

<sup>11</sup> 373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>12</sup> *In re Quinlan*, 70 N.J. 10, 54, 355 A.2d 647, 671, cert. denied, 429 U.S. 922 (1976).

treatment would extend Joseph Saikewicz's life only a few months.<sup>13</sup> The doctors turned to the probate court and asked the judge to take the responsibility for withholding treatment. I have no doubt that this was because they were functioning within the regime of a federal judge whose court retained jurisdiction over all of the state's institutions for the mentally retarded. They were therefore as concerned about their own legal obligations and possible liabilities as they were about their clinical and ethical responsibilities to Joseph Saikewicz. As Professor Robert Burt of Yale has pointed out in his excellent book, *Taking Care of Strangers*, it is interesting to note that in both the Karen Ann Quinlan and Saikewicz cases, the doctors who testified in court made no effort to see how the proposed medical procedure would work.<sup>14</sup> The expert neurologists who testified in *Quinlan* did not disconnect the respirator or attempt to wean her from the machine in order to evaluate her response. The Supreme Court of New Jersey fully expected Karen Quinlan to die;<sup>15</sup> her years of continued existence were an ironic commentary on judicial wisdom and medical expertise in the adversarial process. Similarly, the expert oncologists did not try to medicate Joseph Saikewicz and take him to the general hospital. Nor did they even consider treating him in the medical ward of the state institution.

When doctors see the threatening shadows of the law, they forget that they are doctors with personal responsibility; they act to minimize their own risks; they often call in their lawyers and do what they are told; they often behave very much like bureaucrats. Indeed there is a high correlation between the increasing judicial and legislative intervention in medicine and the increasing bureaucratization of medical care. For every legal intervention another committee is created. Thus, by casting what seem like threatening shadows, the courts have influence far beyond their actual decisions on medical practice. Juridicogenic cures contribute to the bureaucratization of medical care.

The judge in the *Saikewicz* case could not easily say that an ordinary or reasonable person would refuse the treatment. The oncologists testified that in their experience almost everyone accepted the treatment even when told that the benefits were meager.<sup>16</sup> The hearing transcript reveals that on that basis the judge was in fact about to order that the treatment be given when the medical experts once again emphasized the difficulties of communication, the suffering involved in the treatment, and Joseph Saikewicz's assumed inability to tolerate what would be happening to him. The judge reversed ground at the last moment and ruled that the

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<sup>13</sup> *Saikewicz*, 373 Mass. at 729-35, 370 N.E.2d at 419-22.

<sup>14</sup> R. BURT, *TAKING CARE OF STRANGERS* 153-58 (1979).

<sup>15</sup> See 70 N.J. at 54, 355 A.2d at 671.

<sup>16</sup> *Saikewicz*, 373 Mass. at 733-34, 370 N.E.2d at 421.

treatment need not be given.<sup>17</sup> Joseph Saikewicz died of leukemia; like Karen Quinlan, he was completely unaware of the controversy surrounding him.

What is important for our purposes is the way the Massachusetts Supreme Judicial Court subsequently fashioned their juridicogenic formula for the right of terminal patients to refuse treatment. As I have suggested, they could not apply a reasonable person test to justify the *Saikewicz* decision; if a reasonable person is a person who does what most people in that situation would do, Saikewicz should have been given the treatment. Further, they could not easily decide the case by a best interest test. They might have said that in the circumstances of *Saikewicz* it was in the best interest of a mentally retarded person to refuse a treatment which non-retarded persons would accept; but that might start the court down the slippery slope of "quality of life," and sound like discrimination against the mentally retarded. The Massachusetts court was also unwilling to follow the New Jersey *Quinlan* precedent. In its judicial wisdom, the court decided that the right of all incompetent terminally ill patients to refuse life-sustaining treatments should not be delegated to doctors, relatives, and ethics committees. They concluded that only in an adversarial hearing with a legal guardian for the patient and a guardian ad litem to argue for treatment would the potentially conflicting interests of patients, families, and doctors be properly confronted.<sup>18</sup> It is ironic that the court looked to the right of privacy as one of the basic justifications for this complex and intrusive legal process. Adversarial due process would be the American way of death, at least in Massachusetts. The court made no mention of the impact of its decision on the doctor-patient relationship or the cost of privacy.

Having decided that momentous question which put an end to the right of such patients to die in peace and medical privacy, the court reached out for a legal formula to apply in the adversarial hearing that would accent the positive theme of patients' rights while empowering judges to exercise those rights. The court adopted the standard of substituted judgment or proxy consent; the judge alone could exercise this proxy consent.<sup>19</sup> After an adversarial hearing, the judge would make the medical decision by attempting to decide what the incompetent patient would himself decide if competent.<sup>20</sup> In a subsequent similar case in New York, a medical expert was asked by a judge to help him decide this very question: What would a mentally retarded person want if he knew he had cancer of the bladder, if he could fully understand the risks and benefits

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<sup>17</sup> Transcript at 43, *In re Saikewicz*, No. 45596 (Mass. P. Ct. Hampshire County May 13, 1976), reprinted in R. BURT, *supra* note 14, at 156-57.

<sup>18</sup> *Id.* at 755-59, 370 N.E.2d at 432-35.

<sup>19</sup> *Id.* at 751, 370 N.E.2d at 431.

<sup>20</sup> *Id.* at 752-53, 370 N.E.2d at 431.

of cancer treatment, and if he could understand the effects of his mental retardation on the treatment process. The expert answered: "Your Honor, that is like asking me if it snowed all summer, would it be winter?"<sup>21</sup> This wonderful answer captures the absurdity of imposing legal formulas on the complex real world of medical decisionmaking—an absurdity which the Supreme Judicial Court of Massachusetts could not see, so mesmerized was it by its own recitation of legal incantations which appeal to the all-powerful libertarian notion of individual autonomy and the panacea of due process.

Due process is to some judges what tranquilizing drugs are to some psychiatrists—they solve the judge's and the doctor's problem even if they do not address the real difficulty. The judge must exercise the patient's autonomous choice; only in this way can the patient's rights be served. The idea is logical but logic is sometimes pushed to absurdity when applied by judges to the realities of the medical world. Joseph Saikewicz was a classic example; he did not have the capacity to develop preferences—how could a judge know what his preferences would be? Judges are not fools, of course, and the supreme judicial court recognized that in a case like *Saikewicz*, the subjective proxy consent might come close to being an objective test.<sup>22</sup> Nonetheless, the court offered specific guidelines to help judges decide what they thought would be in the person's mind, if he had a mind.<sup>23</sup> This gave a semblance of clear and simple rules for making what is in reality an ambiguous and difficult decision.

*Saikewicz* was not limited to incompetent mentally retarded persons in state mental institutions as it could have been by a less activist court. In one bold and arrogant step applauded by civil libertarians, probate judges in Massachusetts were given the authority to preside over death. Ivan Illich, a priest and radical critic of modern medicine, has described the medical profession as a priesthood presiding over and denying natural death.<sup>24</sup> I wonder whether he would count it an advance of civilization to impose on the medical priesthood a judicial College of Cardinals. The cost of dying in America is staggering; estimates are that eleven percent of Medicare is expended on dying.<sup>25</sup> The financial costs are only one part of the picture.

The *Saikewicz* decision, as interpreted by lawyers to doctors, required the doctors to postpone any decisions to forego or terminate treatment and to keep all incompetent dying patients in Massachusetts alive, no matter how futile the treatment, while they rushed about getting consul-

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<sup>21</sup> *In re Storar*, 52 N.Y.2d 363, 380, 420 N.E.2d 64, 72-73, 438 N.Y.S.2d 266, 275, *cert. denied*, 454 U.S. 858 (1981).

<sup>22</sup> *See Saikewicz*, 373 Mass. at 750-51, 370 N.E.2d at 430-31.

<sup>23</sup> *Id.* at 752-55, 370 N.E.2d at 431-32.

<sup>24</sup> I. ILLICH, *LIMITS TO MEDICINE* 201-08 (1976).

<sup>25</sup> V. FUCHS, *HOW WE LIVE* 199 (1983)(citing J. LUBITZ, M. GORNICK & R. PRIHODA, *USE AND COSTS OF MEDICARE SERVICES IN THE LAST YEAR OF LIFE* (1981)).



tations and their lawyers rushed about arranging for the required legal hearing and the judicial proxy decision. *Saikewicz*, the lawyers said, applied to deformed premature infants (anticipating the Baby Doe regulations) as well as to senile and comatose adults. Many physicians commented on the resulting pattern of overtreatment and undertreatment. If treatment had begun doctors were afraid to stop the treatment without prior court approval. And it was said that in some cases, treatment was never initiated in order to avoid legal entanglements. Doctors cannot be absolved of their responsibility for such iatrogenic harms but neither can courts be absolved of their responsibility for the juridicogenic harms such decisions produce. Remember the language in these decisions about privacy; guardians were to be appointed in every case. Lawyers and expert witnesses were to conduct adversarial hearings. The hospital and its lawyers became concerned about the hospital's liability in light of *Saikewicz*; they felt the need to police their physicians in addition to any court proceedings—the patient's "attending physician" had to report to the Death Committee—specialists, nurses, and ethicists had to be consulted. In short, as happens so often in law, where due process has been, bureaucracy follows and here in the name of privacy, privacy was lost.

The *Saikewicz* decision stood for two powerful principles. First, courts not doctors should make these decisions about life and death. Second, those judicial decisions should reflect what the patient himself would choose. As to the first principle, the court's decision was greeted with resounding approval by some health lawyers concerned about patients' rights, and it was greeted by outrage and derision by almost all physicians. The vicious circle I described earlier in this talk began; the medical profession lost a great deal of its respect for the court. For example, the editor of the *New England Journal of Medicine* openly criticized and condemned the court.<sup>26</sup> The public became confused and suspicious about both professions; families were bewildered. The realities, the costs, and the logistics of death with due process were soon recognized, and the Massachusetts courts backed away from *Saikewicz* as applied to dying patients.

First in the appellate case *In re Dinnerstein*,<sup>27</sup> and then in *In re Spring*,<sup>28</sup> the Supreme Judicial Court of Massachusetts came close to the New Jersey approach in *Quinlan*. I believe the aggressive step forward and the two steps backward had undermined the credibility of both the court and the medical profession. Earl Springs, an elderly man with renal failure, was the subject of the second step back. His right to refuse kidney dialysis treatment became a struggle between a right to life nurse on the

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<sup>26</sup> Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508 (1978).

<sup>27</sup> 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

<sup>28</sup> 380 Mass. 629, 405 N.E.2d 115 (1980).

one side and his relatives on the other. Were his relatives letting him die to save money? Did he want to die? Was he really incompetent? Did the right to life nurse, who had no responsibility for Earl Springs, invade his privacy? These questions were argued and reargued in the courts and played out in the media as a public spectacle that even Earl Springs' death did not end. When my former colleague, then Justice Braucher, of the supreme judicial court, wrote the *Springs* decision, he reached for a crafty compromise. Doctors need not turn to the courts in every case, but they must accept any civil or criminal liability that might follow from their actions and decisions.<sup>29</sup> On the other hand, he opined that when such medical decisions are made in accord with professional standards and with proper consultations, liability seemed highly unlikely.<sup>30</sup> This is what *Saikewicz* had meant all along, the court is there only when needed. But the need is determined by fear of legal liability. I know of doctors who advise families with elderly parents who suffer from chronic recurring ailments, such as congestive heart failure, as follows: "Look, if you think it is time for your parent to die, do not bring them to the emergency room; if you do, I will treat them. I do not allow my patients to die unless the treatment is entirely futile." I doubt that the Supreme Judicial Court of Massachusetts had in mind such juridicogenic consequences and I doubt that families given such advice are left with a sense of confidence in either the medical or the legal profession. Now lawyers may justly claim that this advice is not what the court intended, nor does it follow from what the court actually wrote. But iatrogenic harms do not follow from what doctors intend or from what is actually written in medical texts. The medical maxim that guards against iatrogenesis is *primum non nocere*; judges who make medical decisions might do well to consider the same maxim.

Now it is important to emphasize that I believe that in all of the cases I have described there are deep and profound moral problems created by new biotechnology, and when I teach these cases to my students, I explore these moral problems, and I find that we have no moral consensus because we inevitably reach the slippery slope of "quality of life." However each of you would solve these moral problems, my purpose today is only to suggest that judges have not yet come up with good legal cures for these difficult moral problems.

Thus far I have said nothing about judicial decisionmaking in my own medical specialty of psychiatry. In this last part of my talk I shall turn to that subject briefly. While Massachusetts doctors, lawyers, and judges were struggling with *Saikewicz*, a case involving the right of psychiatric patients to refuse drug treatment was making its way through the Massa-

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<sup>29</sup> *Id.* at 637, 405 N.E.2d at 121.

<sup>30</sup> *Id.* at 638-39, 405 N.E.2d at 121-22.

chusetts Federal Court.<sup>31</sup> Civil libertarian lawyers argued that involuntary civilly committed patients had a constitutional right to refuse antipsychotic drugs except in emergencies when they were imminently violent.<sup>32</sup> An activist federal district judge did all that he could to get the Department of Mental Health and the libertarian lawyers to find a compromise. Perhaps to press the Department of Mental Health, he issued a temporary restraining order against involuntary drug treatment;<sup>33</sup> however, the Department of Mental Health could find no compromise. To psychiatrists, an acute psychotic episode is itself an emergency, and I believe that anyone who has spent a few days in a mental hospital or in the same room with an acutely psychotic person would agree. Furthermore, despite the fact that antipsychotic drugs can be and have been abused as chemical restraints, when properly prescribed, they are highly efficacious. In fact, antipsychotic drugs are perhaps the only psychiatric treatment with proven efficacy. To psychiatrists, the idea that someone was crazy enough to be involuntarily committed, but then has the right to refuse the only efficacious treatment seemed like the kind of law and justice one finds in the novels of Franz Kafka.

Unfortunately, it was difficult to formulate these views into a good legal argument. The Massachusetts law of civil commitment had been reformed under the influence of civil libertarians whose views were that the law should be purged of all psychiatric concepts and should be replaced by objective legal criteria emphasizing acts rather than status. So reformed, the Massachusetts civil commitment statutes said nothing about acute psychosis or incompetence to make medical decisions. The plain language of the statute indicated that a committed patient might be dangerous to self or others but still competent to refuse treatment. The attorney general's office nonetheless attempted to argue, as a matter of statutory interpretation, that the need to be involuntarily confined should be equated with incompetence, an argument that was unacceptable to the court.<sup>34</sup> Clearly, the idea of forcing treatment on a presumably competent patient was alien to common law and constitutional theory. The plaintiffs' lawyers also made much of the significant side effects associated with antipsychotic drugs.<sup>35</sup> Thus in this worst case scenario a potentially dangerous drug was being foisted on a presumably competent, although involuntarily committed, patient.

The district court judge held that there was a constitutional right to refuse treatment except in emergencies characterized by imminent vio-

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<sup>31</sup> *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *vacated*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>32</sup> *Id.* at 1352.

<sup>33</sup> *Id.* at 1353.

<sup>34</sup> *Id.* at 1353, 1361-62.

<sup>35</sup> *Id.* at 1359-60.

lence.<sup>36</sup> As to the psychiatrists' concerns that they could not know when a patient was imminently violent, he observed in a footnote that many professions had difficult tasks.<sup>37</sup> An acute psychosis was not an emergency in his view, and the patient's refusal of treatment could only be overcome by a competency hearing and the appointment of a guardian who would then, as you can anticipate, make a proxy decision.<sup>38</sup> Thus, the guardian could, in theory at least, choose to honor the incompetent involuntarily committed patient's refusal of the only available efficacious treatment. As to the argument that it then took three weeks to schedule a competency hearing, the judge opined that the state courts could easily rectify the logistics.<sup>39</sup> Lurking in the judge's decision was the idea that respect for individual autonomy includes the right to be psychotic at state expense and he said as much. I consider the decision of this court to be one of the most misguided, injudicious, juridicogenic opinions in the entire case law of law and psychiatry. The judge's original temporary restraining order demonstrated a total disregard for professional standards of care, or the potential harms to psychotic patients who refused needed treatment. He needlessly and heedlessly turned the clock of mental health care back thirty years. His temporary restraining order and his ultimate decision left the psychiatric profession muttering that the judge was out of touch with reality. Case reports began to appear of patients whose treatable psychotic disorder went untreated month after month. Again the cycle of public dissatisfaction with law and psychiatry was set in motion. The toll of juridicogenic harms will never be tallied, but the cost in human suffering, the economic cost to the state, and the morale cost to public sector psychiatry are all too real to be ignored. The decisions *Rogers v. Okin*,<sup>40</sup> *Mills v. Rogers*,<sup>41</sup> and mercifully at last, *Rogers v. Commissioner of the Department of Mental Health*<sup>42</sup> went up through the First Circuit to the Supreme Court, back to the First Circuit, and then to the Massachusetts Supreme Judicial Court for interpretation of applicable state law. That court had backed away from *Saikewicz* in the manner I have described, but now in the context of psychiatry, it reasserted the entire *Saikewicz* procedure making the judge and not a guardian the proxy decisionmaker.<sup>43</sup> Think of it, doctors, if they are not afraid of liability, can now after consultation with relatives and ethics committees either provide aggressive treatment or pull the plug on incompetent terminal pa-

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<sup>36</sup> *Id.* at 1364-65.

<sup>37</sup> *Id.* at 1369 n.36.

<sup>38</sup> *Id.* at 1362-65.

<sup>39</sup> *Id.* at 1363.

<sup>40</sup> 478 F. Supp. 1342 (D. Mass. 1979), *vacated*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.* *Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>41</sup> 457 U.S. 291 (1982).

<sup>42</sup> 390 Mass. 489, 458 N.E.2d 308 (1983).

<sup>43</sup> *Id.* at 496-507, 458 N.E.2d at 312-19.

tients without a due process hearing, but psychiatrists cannot treat involuntarily committed mental patients without both a competency hearing and, if the patient is found incompetent, a proxy consent by a judge.

Thus, the Massachusetts Supreme Judicial Court went even further than the Federal Court's misguided decision, closing its eyes to the juridicogenic harms, it locked the mental health system into procedures which emphasized the libertarian view of rights and individual autonomy and ignored the needs of patients and the costs of human suffering. What can it mean to speak of individual autonomy when the person is trapped in a terrifying web of delusions and hallucinations? How does the right to be psychotic advance the goal of individual autonomy in a free society? The juridicogenic harms of such decisions are now visible in the streets of every major city as the homeless mentally ill exercise their autonomy by sleeping in the streets and by rummaging for food in trash cans. Can the public have respect for law or for psychiatry when they witness this triumph of the libertarian theory of rights and this disregard for the needs and the suffering of the mentally ill?

Let us now consider the role of the judge as proxy consentor or medical decisionmaker in the case of mental patients. The judge, when he or she determines that the involuntarily committed patient is legally incompetent to make medical decisions, is asked to consider six factors:

- 1) any expressed preference by the patient;
- 2) any religious preferences;
- 3) the impact of the decision on the family as it would influence the patient;
- 4) the possibility of adverse side effects;
- 5) prognosis without treatment from the unique perspective of the patient; and
- 6) prognosis with treatment—while not conclusive, a good prognosis enhances the likelihood that the patient would accept treatment.

With these factors in mind, judges in Massachusetts are expected to make psychiatric decisions. Again, consider the costs involved: there are the court costs, the time of the doctors and lawyers, and if the judge refuses to order drug treatment, there is the added cost to the state of weeks of unnecessary confinement at an estimated cost of \$200 a day. Since our state hospitals, now sharply reduced in beds, are filled to capacity, there is also the cost involved in depriving other patients of needed treatment or the alternative of dumping untreated patients back on the streets.

One must ask how judges could make these psychiatric decisions. How can a judge, to whom the patient is a total stranger and who knows little or nothing about drugs and mental illness, assess the preferences, the impact of family suffering on the patient, and the prognosis with and without treatment from the unique perspective of the patient? The short answer, I believe, is that they cannot, and anecdotal evidence suggests two typical patterns of judicial decisionmaking. First, they decide whether the patient is competent or not. If not competent, they routinely order the

drug treatment. Thus after costly and time-consuming delays, proxy consent is a myth in their court. A second pattern is for the judges to routinely require the treating psychiatrist to answer the six questions. Thus, after all is said and done, these judges put the ball back in psychiatry's court after forcing us to play the legal game by their complicated and costly legal rules. Elsewhere, I have argued that ethical psychiatrists should refuse to accept clinical responsibility for patients when judges exercising proxy consent determine that incompetent patients should not be given what the psychiatrist in good faith believes to be essential treatment—I consider such a situation court-ordered malpractice.<sup>44</sup>

Remember, we are not talking about mentally ill persons who are walking the streets; however the civil commitment statute is worded, we are considering only those mentally ill patients who were so disturbed that, unlike the thousands of mentally ill who live in the streets, they were hospitalized. Elsewhere, I have described a model civil commitment statute which makes incompetence a necessary criterion for civil commitment.<sup>45</sup> This approach is not without problems, but surely it is a more sensible remedy than the *Saikewicz/Rogers* formula fashioned by the Massachusetts Supreme Judicial Court.

I want to make one final general comment. Health care now consumes eleven percent of the gross national product.<sup>46</sup> Health care costs are what make American cars cost more than Japanese cars. Unless aggregate costs are controlled, Medicare will be bankrupt by 1990.<sup>47</sup> This will happen as the number of elderly people entitled to Medicare steadily increases. Government is desperate to control the aggregate cost of health care. As lawmakers seek to control costs, the medical industry is being both regulated and deregulated at the same time. Government is creating incentives to force doctors to consider the aggregate cost of health care in deciding what is appropriate treatment for individual patients. This poses terrible ethical problems which good economists, Lester Thurow for one, point out cannot be solved by economists.<sup>48</sup> Equally true is that these ethical problems cannot be solved by doctors, their own code of ethics give no clear guidance. Will they be solved by judges? Based on my own reading and studying I cannot be sanguine about the ability of judges to solve these problems without substantial juridicogenic harm. Some courts proceed more sensibly than others. In my opinion, *Quinlan* is much better than *Saikewicz*. One thing seems clear, however, decisions like

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<sup>44</sup> A. STONE, *Psychiatric Abuse and Legal Reform: Two Ways to Make a Bad Situation Worse*, in *LAW, PSYCHIATRY AND MORALITY* 133-56 (1984).

<sup>45</sup> A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 65-79 (1975).

<sup>46</sup> Freeland & Schendler, *Health Spending in the 1980's; Integration of Clinical Practice Patterns with Management*, *HEALTH CARE FINANCING REV.*

<sup>47</sup> BOARD OF TRUSTEES, *FEDERAL HOSPITAL INSURANCE TRUST FUND (1983 ANNUAL REPORT)*, H.R. Doc. No. 75, 98th Cong., 1st Sess. 46 (1983).

<sup>48</sup> See L. THUROW, *DAANGEROUS CURRENTS* 24-27 (1983).

*Saikewicz* and *Rogers* and the growth of malpractice liability give doctors a clear message—ignore the aggregate cost of health care in treating individual patients. These judicial messages directly contradict the legislative message of cost control. These mixed legal messages will set the stage for an ethical crisis in law and medicine over the next decade for which there will be no easy answers. The law and the courts will surely play a large part in dealing with this crisis: law and medicine will have to learn to live together or everyone will pay the price of increased loss of confidence in both professions.