Guardianship and the Right to Refuse Treatment: A Critique of the Roe Case

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"[N]either judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments."[1]

"You can degrade people by taking care of them, and you can degrade people by not taking care of them and I see no simple answers to such questions."[2]

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Issues surrounding the right to refuse treatment continue to provoke debate.[3–11] Recently, the Massachusetts Supreme Judicial Court (SJC) has considered one aspect of these issues: guardians' authority to permit antipsychotic medication for incompetent, noninstitutionalized wards.[12] That case, *In the Matter of the Guardianship of Richard Roe, III,* addresses fundamental questions but resolves them unsatisfactorily. We believe the opinion fails because of two problems: judicially, the Court unwisely extends the decision beyond the facts of the immediate case; and clinically, it relies on inaccurate, biased psychiatric information.

"Richard Roe," an outpatient with schizophrenia, was temporarily hospitalized for evaluation following criminal charges (attempted unarmed robbery, and assault and battery). At a probate court hearing, the judge had appointed the ward's father as guardian for his son. Relying on *Rogers v. Okin,*[13,14] the Court determined, *inter alia,* that as a guardian he had "the inherent authority to consent to forcible administration of antipsychotic drugs for his ward."[12] The guardian *ad litem*[a] raised objections to this order, ultimately appealing the case to the SJC. The court held that the original guardianship appointment should stand. However, the guardian would not be permitted to consent to medication for his noninstitutionalized ward

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absent an emergency[b]; and only a judge, using a substituted-judgment standard, could authorize forcible administration of antipsychotic medication.[c]

This case sets in opposition some aspects of law, with its emphasis on rights, and of psychiatry, with its emphasis on treatment. This paper examines the dilemmas faced in the *Roe* case and attempts to identify the legal and clinical difficulties implicit in this decision.

Legal Problems

Several problems of legal conception mar the *Roe* opinion, the first of which concerns the jurisdiction of the court. At the probate hearing, it was found that the guardian was not seeking antipsychotic medication for his ward but only the authority to order such medication if the ward's mental condition changed. The SJC recognized the hypothetical nature of the claim and reprimanded the lower court's decision as "premature," even adding that "(s)trictly speaking, this conclusion is sufficient to dispose of this case."[12] Yet the SJC failed to heed its own admonition and proceeded to enumerate elaborate guidelines for a case that was not at issue. The court argues that its analysis of the guardianship question is justified, since the issue may arise later in this case or in other proceedings.[12] While the Court may be correct in its prediction, the time for legal inquiry is when the dispute does arise — and not before.[15d] By waiting until a concrete case is presented before the court, a legal decision can take into account the specific array of facts as they exist (rather than as the court supposes they exist), and a decision can accurately capture the nuances particular to that case. Such a practice also enhances the long-held judicial maxim that cases ought to be decided on the narrowest grounds. When a decision is rendered on a specific case, the precise facts will fix the boundaries of the decision.

Related to the "narrowest grounds" principle is the "smallest change" canon. That is, legal decisions should lie close to precedent; significant deviation from existing law must be explicitly and thoroughly justified. The *Roe* decision represents a significant departure from prior law as it substantially alters the authority guardians previously held[16,17] and conflicts with *Rogers*' affirmation of guardians' power to order the medication.[13,14] The SJC supports this new stance by reference to the court's superior capacity to uphold patients' rights and preferences. But this argument does not sufficiently distinguish between the outcomes in *Rogers* and in the current

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[a]A court-appointed attorney with broad, informal investigative power.

[b]A further point of contention is the definition of an emergency. Its precise meaning is unsettled: in *Rogers*, the District Court provided a very narrow definition, while the Appellate Court gave a broad one. The SJC, adding to the confusion, cited a narrow definition from a Webster's dictionary. With this plethora of meanings, it is unclear when the provisions of each case apply.

[c]If the court concludes that the ward, if competent, would reject medication, there are very limited circumstances where state interests are compelling enough to override the refusal right.

[d]The Court in *Hathaway* stated: "Courts exist primarily to decide actual cases and controversies and not to create ex nihilo a system of social justice, general welfare, and private happiness."[15]

case. The Court may believe that the difference between the two cases is that in *Rogers*, the defendants were institutionalized, while in *Roe*, the ward was an outpatient. If Roe's outpatient status is the basis of the Court's decision, then it ought to say so explicitly and explain its reasons. It would be useful to make the distinction clear on clinical grounds (for example, are outpatients likely to be less dysfunctional than inpatients and better able to express their treatment preferences to a court?) and to explain its authority in arriving at such a conclusion. Without this sort of analysis, the *Roe* decision fails to justify the important changes it has mandated, changes that alter the care of large numbers of patients.[e]

While precedent can provide valuable guidance in the formation of judicial rulings, it is essential that the precedential reference be carefully chosen, to ensure that the compared cases are apposite. The *Roe* opinion, however, overlooks this principle in its assignment of the treatment decision to the Court. It cites the *Saikewicz*[19] case and the first *Rogers*[13,14] decision as support for this authority, but neither case provides an appropriate comparison. First, the *Saikewicz* case involved withholding chemotherapy (a very different treatment from antipsychotic medication) from a profoundly retarded man who was likely to die regardless.[19] The prognosis for Roe, on the other hand, appeared much more favorable as medication might well restore his competence, thus suggesting that medical knowledge of risks and benefits should hold more leverage in this case. Second, it cited the *Rogers* District Court decision, but that decision affirmed the authority of the guardian to permit medication and did not give it to the court.

The SJC also states that, for purposes of treatment refusal, it considers antipsychotic medication the same as it does psychosurgery and electroconvulsive therapy.[12] However, this pronouncement directly contradicts the provisions of the Massachusetts General Laws, c. 123, which clearly distinguishes antipsychotic medication from the latter treatments.[20f] The provision holds that for psychosurgery and electroconvulsive therapy, patients have the right to refuse treatment, but for antipsychotic medication, no such right is stated. Although it is difficult to imagine the Court is challenging the Massachusetts General Laws, if it does intend to reverse the law, it must do so explicitly, with far more specific and thorough reasoning than that provided in the *Roe* opinion.

Finally, the SJC could have explored innovative extralegal procedures in the guardianship/treatment area. Such options, detailed elsewhere,[3,21] might involve an independent psychiatrist in a quasi-judicial hearing in the

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[e]In addition, the SJC's new position on guardians and medication appears to violate the principle of *stare decisis*, that is, that federal decisions should supersede state decisions when the issue is federal or constitutional (right to refuse treatment and privacy).[18] However, the *Roe* decision conflicts with *Rogers*, a federal case.[14] While it could be argued that the SJC's ruling is permissible because the procedure it requires is stricter than that in *Rogers*, in this case the strictness continuum is not clear and (in the absence of an explicit argument on that ground) the SJC should comply with the federally mandated procedure. Principles of comity further suggest that the SJC should accede to the federal decision.

[f]Clinically, these treatments are very different and deserve differential consideration.

treatment setting. This procedure preserves the benefits of judicial determination (impartiality, protection from abuse) without sacrificing the advantages of guardianship (personal familiarity with the patient, expediency, and convenience). The *Roe* Court chose the procedure with the highest costs to courts, psychiatrists, guardians, and patients. Good legal decisions, however, should seek solutions that avoid negative consequences to the participating parties. The extralegal arena potentially provides a fertile ground in this regard.

Unfortunately, there is little judicial precedent for satisfactory solutions to the right-to-refuse-treatment problem, although some cases initially have appeared promising. In a previous critique, one of us (MJM) noted that the approach of the Court of Appeals toward restrictions on forcible medication in *Rogers* was "reasonable."[3] Since that observation was made, our opinion has changed as we have had further opportunity to study the decision. The Court of Appeals "affirmed in part (and) reversed in part" the District Court's opinion. When the Commonwealth petitioned the Court of Appeals for clarification regarding this ambivalent posture, none was forthcoming. Thus, the most pernicious effect of the District Court's holding — the commitment/treatment discontinuity — continues.[22,23] Second, it appears that the Court of Appeals opinion flies in the face of federalism by imposing its unwarranted supervision on the state.[24] Numerous cases with this conflict of law dilemma have upheld states' jurisdiction;[25–27] in keeping with this principle, the Court of Appeals should have suspended its federal supervision. Finally, since it is true, as the Court of Appeals noted, that the precise constitutional source of the right to refuse treatment is unclear, it cannot be assumed that the right exists. On the contrary, the fact that the textual source is unclear suggests that this right, if it exists at all, has no constitutional foundation.[24]

Clinical Problems

The legal problems in the *Roe* case are deeply troubling, but even more disconcerting is the clinical misinformation upon which the decision is predicated. While it is difficult for courts to develop expertise on psychiatric phenomena, as long as the court arrogates the responsibility for making medical decisions, it has a duty to seek accurate information from reputable sources. Unfortunately, the SJC's decision appears to neglect this responsibility.

The Court's discussion of the effects of antipsychotic medication is rife with exaggeration and unsupported allegation. The second page of the opinion states: "the proposed medication is an antipsychotic drug — a powerful, mind-altering drug which is accompanied by often severe and sometimes irreversible adverse side effects." This statement focuses entirely on the negative side of the medication without mention of the substantial positive effects. The language is clearly derived from the first *Rogers* opinion, whose biased portrayal of medication has been criticized.[22,23,28,29]

Later, the SJC refers to the antipsychotic medication as "extraordinary medical treatment" and adds:

> (antipsychotic) drugs are powerful enough to immobilize mind and body. Because of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects . . .we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.[12]

The equation of antipsychotic medication with other, extreme treatment modalities is startling and unwarranted, as is the labeling of antipsychotic drugs as "extraordinary" (used in the same sense as in the phrase "extraordinary measures to prolong life"). In fact, the drugs proposed in the *Roe* case (Haldol and Prolixin) are not only among the most commonly used antipsychotic drugs but also among the safest.[30,31]

Similarly, in its examination of the effects of the drugs, the Court presents only the (exaggerated) negative side effects of the medication. It is true that these medications have attendant risks and that the incidence of tardive dyskinesia is greater than one would wish.[32–34] What the Court appears to ignore is the crippling "side effects" of untreated schizophrenia and other severe mental disorders. The longer a patient remains untreated, the more the chance of recovery becomes diminished.[35] Several times in the opinion the Court refers to antipsychotic medication as "mind altering," stating that the drugs may "undermine the foundations of personality."[12] These terms are unsupported and, from a medical perspective, incorrect.[9] The drugs are "mind altering" in the way that eyeglasses are "vision altering": they improve some dysfunction, helping to restore the person to his prior health.[28] More accurately, it is the psychosis that is "mind altering," and medication is "mind liberating."[3,23,24] Before the advent of antipsychotic drugs, thousands of psychiatric patients were confined permanently to mental hospitals, with little hope of recovery.[3,36] It is troubling to see the Court so staunchly defending the patient's right to self-determination, at the same time that it is depriving the patient of the chance of recovering not only his or her health and autonomy[37,38] but also even the very competence whose loss has occasioned the entire issue. It has been suggested that treatment should be imposed when the gains in personal liberty resulting from the treatment outweigh the restrictions on liberty resulting from that treatment.[37] Though this prescription may not be the determinative one for all right-to-treatment cases, it does recognize that both the devastating effects of untreated psychosis and the possibility of restored mental health ought to be considered in treatment cases.

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[9]Legal experts, too, have noted the Court's distorted view of antipsychotic medication. In a footnote the SJC stated, "Nevertheless, we do not foreclose reconsideration of these issues when and if it can be shown that the characteristics of antipsychotic drugs have changed." The Massachusetts Attorney General has accepted this challenge in a petition for rehearing, commenting that if one compares the true pharmacological facts about the medication to the Court's one-sided presentation, it seems the drugs indeed have changed.[24]

Another disturbing aspect of the clinical discussion in *Roe* is its reliance on legal, not psychiatric, references for data on the use of antipsychotic drugs. The most frequently cited work in this discussion is Robert Plotkin's "Limiting the Therapeutic Orgy," a Szaszian classic of the antipsychiatric legal literature.[39] That article occupies an ambiguous position in the literature on the right to refuse treatment. Much favored by patient advocates, it is generally avoided by legal scholars.[40,41] Clinicians, too, find Plotkin's writing on medical topics inaccurate and often hostile, as it emphasizes the use of drugs for "disciplinary purposes"[39] and disregards their therapeutic effect. Given its one-sided survey of clinical information, the Court should have attempted to balance its selection of data with more reputable medical sources. Its failure to do so results in a significantly distorted presentation of the clinical facts of antipsychotic medication and undermines the conclusions drawn from that basis.

In view of the Court's erroneous picture of antipsychotic medication, it is not surprising that the consequences of the Court's decision are clinically objectionable. At least in part because of its distorted view, the Court determined that any question of forcible medication for incompetent outpatients must be resolved in the courtroom. In so doing, it preempted the authority of the guardian in treatment decisions; it is unclear whether guardians retain any significant responsibility at all. Bringing the treatment determination into the court is an unrealistic solution, for the total number of persons affected statewide is quite large.[42] Such a procedure will crowd court dockets and will waste time for all parties involved. As the Supreme Court observed in *Parham v. J.R.*:

> One factor that must be considered is the utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them.[43]

The slowness of courtroom hearings also has strongly negative consequences for patient care. The *Roe* procedure leaves many patients untreated while they await judicial decisions. In most cases, antipsychotic medication must be taken continuously for some time to be effective. But now, if a patient disputes his or her medication, treatment will stop, and no swift resolution of the problem will be available.

We believe that expeditious substitute decision making is essential for treatment decisions involving incompetent wards. When a guardian serves this role, he or she is (optimally) familiar with the patient and understands treatment preferences. Reliance on the guardian at least would be consistent given the Court's commendation of the substituted judgment standard for treatment decisions. If the treatment determination is intended to reflect what the patient would have wanted were he or she competent, then the guardian may be the best conveyor of this information.

The Court contends that its decisions are superior for their objectivity and clarity. This impartiality ought to be questioned, however, in light of the

Court's unobjective selection of data sources for its opinion. In fact, it is likely that the proposed judicial hearings would become merely cursory reviews of each case, as a matter of necessity and expediency. In that circumstance, guardians would be preferable to courts, as they may devote more time to the treatment decision. As we have outlined, a quasi-judicial hearing in the treatment setting can provide the element of impartiality, if that issue is in question.

We would offer one final suggestion about the *Roe* decision to avoid future unsatisfactory decisions. The psychiatric profession lost an important opportunity in the 1960s when the writings of such "antipsychiatric" authors as Thomas Szasz were ignored rather than refuted.[44–50] As a result of this inattention, works by Szasz have become the only psychiatric "texts" in some law school curricula today.[51] In a parallel manner, many legal articles and judicial decisions may be incorporated into precedent without challenge from clinical sources. Recently, psychiatry has heeded Stone's advice by developing its own advocacy.[52] Still, advocates need clinical data with which to mount their challenges against ill-informed or inequitable decisions in the judicial arena. We would suggest that our colleagues collect and study empirical data on psychiatric-legal topics. The voice of well-supported medical fact must speak to be heard; only then can clinical misinformation be challenged.

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