

The Boston State Hospital Case: Its Impact on the Handling of Future Mental Health Litigation

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On October 29, 1979, a Federal District Court in the Boston State Hospital case¹ issued an order prohibiting the forcible medication of an institutionalized mental patient without the consent of a guardian except in situations creating a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution. Recently, a number of articles have discussed the logic or illogic of the trial court's order and opinion and the potential impact of the court's ruling on patient care at mental hospitals.^{2,3,4,5}

Hopefully, the impact of the Boston State Hospital case will not be limited to its effects on patient care, for the trial of the case itself posed significant problems likely to reoccur in future mental health litigation. This article will discuss three of the major problems encountered in defending the Boston State Hospital case, and lessons for both lawyers and psychiatrists to help alleviate these problems in the future.

Preventing Harm Caused to Patients by Litigation

The Boston State Hospital case made it clear that suing your psychiatrist can be bad for your health. The named plaintiffs in the case all saw their therapeutic alliance deteriorate with the doctors and staff they were suing, while one plaintiff regressed to an infantile state apparently from guilt he felt from suing his doctor.⁶ Court appearances were almost always preceded and accompanied by increased patient anxiety.⁶

Arguably, the deterioration in patient health caused by litigation can outweigh any benefits being sought by the patient in the litigation. Thus, the Boston State Hospital experience has shown that the defense counsel faces a dilemma from the moment he begins to handle mental health litigation. On the one hand, everyone has the right to his or her day in court. On the other hand, unquestioning acceptance of this right can act to the patient's detriment. The defense counsel must decide at the very beginning of a case whether his own duty to the public interest requires his taking the rather drastic step of seeking to cut off a case involving patients at public hospitals even before the substantive issues

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of the case are heard.

To fully understand the attorney's exact options in meeting this dilemma, it must be understood how litigation can be brought in the first instance, when the fact of litigation itself is apparently not in the plaintiff's best interests. The Boston State Hospital case offers a good example of how this situation can arise and is likely to arise again.

The Boston State case was brought by attorneys in the Greater Boston Legal Services Program. The case was brought against twenty-four doctors at two units of the hospital, where, ironically, because of the progressive, libertarian thinking of the units' directors, the legal service program had been invited into the hospital to protect patients' legal rights.

The suit was apparently brought because of the ideals and beliefs of the plaintiffs' attorneys, and not because of any damages suffered by the plaintiffs at the hands of the defendants. Gary Bellow and Jeanne Kettleson, directors of legal services programs affiliated with Harvard Law School, have written that legal services and public interest attorneys, unlike private attorneys, frequently decide on their own, in advance of knowing of specific events, what issues they will litigate.⁷

The Boston State case was apparently brought because the plaintiffs' attorneys believed that the Constitution gave patients a right to refuse forcible medication and a right not to be secluded if any less restrictive alternative were conceivable. According to plaintiffs' counsel, the case sought damages against the doctors because of the attorneys' belief that the only way to get doctors to change inadequate institutional care was to make them personally liable for not bringing about institutional change.

Although the damages being sought against the doctors created much of the tension which furthered patient deterioration, damages, and the consequence of seeking them, appeared to be almost an afterthought to plaintiffs' attorneys. In plaintiffs' opening statement at trial, at which time counsel set forth the evidence they intended to present, counsel made no mention of any alleged damages suffered by any plaintiff. It was only as the trial progressed, as plaintiffs' counsel must have become aware that they could not succeed absent proof of damages, that plaintiffs began to develop damage theories, ranging from claims that one period of seclusion three years earlier caused one plaintiff to give up his ambitions, to a claim that a retarded patient, whose IQ increased by 16 points and educational accomplishments improved by two grades during her hospitalization, had the rate of her educational development slowed because of the use of seclusion and forced medication.

That the lawsuit was precipitated by plaintiffs' attorneys' beliefs and not specific events is further evidenced by the number of doctors sued in the case. Plaintiffs originally sued twenty-four doctors. Four of these doctors were never served a summons and complaint, hardly consistent with a belief that doctors committed wrongful acts needing to be

redressed. The cases against five of these doctors were voluntarily dismissed, but only because defense counsel showed either in formally or in motions for summary judgment that these doctors had absolutely no, or only the most minimal, contact with the plaintiffs who were suing them. The only apparent common characteristic of the defendants, all sued for malpractice, is that they were unfortunately for them, all working on the wrong wards of the wrong hospital at the wrong time, and all signed or supervised someone who signed a seclusion or medication order for the named plaintiffs. It is not unreasonable to suggest that the fourteen doctors, who had to defend the case and with whom plaintiffs' therapeutic alliance deteriorated, could have been fourteen different doctors if the suit had been brought two years earlier or two years later.

Because the Boston State case appears to have been generated by attorneys' beliefs and principles rather than from an initial request by a patient seeking redress for specific events, the likelihood of a conflict existing between the patients' and the counsels' interests is far greater than in normal private litigation. Such conflicts manifested themselves in the Boston State case when three plaintiffs testified in depositions that they believed they had received good care from the defendants, and when one plaintiff testified that she wanted to drop the suit. Despite this testimony, the court refused to dismiss the cases and plaintiffs' counsel continued with the suits.

Mental health litigation, frequently brought by public interest attorneys on behalf of indigent patients of limited competence, are inherently prone to being directed by counsel without real consultation with the plaintiffs and without study of the consequences of the litigation on the plaintiffs' health. Defense counsel must take on the burden, at least in cases apparently not precipitated by specific events, of trying to assure that the litigation itself is not harmful to the patient.

Avenues of redress available to defense counsel are few. While the layman or psychiatrist might suggest that redress be sought against plaintiffs' counsel for soliciting the litigation, solicitation by public interest law firms has been upheld as constitutionally protected. In the case of *In re Primus*, the United States Supreme Court upheld the conduct of an ACLU lawyer who first advised a gathering of women, who had been sterilized as a condition of receiving public assistance, of their legal rights and then offered one of the women free legal assistance. The Supreme Court upheld the lawyer's actions noting that for the ACLU litigation is a form of constitutionally protected political expression and not merely a technique of resolving private differences. The Supreme Court did not accept Justice Rehnquist's arguments, made in dissent, that "a lawyer's desire to resolve 'substantial civil liberties questions' may occasionally take precedence over the duty to advance the interests of his clients" and that "[i]t is even more reasonable to fear that a lawyer in such circumstances will be inclined to pursue both

culpable and blameless defendants to the last ditch in order to achieve his ideological goals.”⁸

The only practical course for defense counsel is to seek appointment of a guardian *ad litem*, who is a guardian appointed only for purposes of litigation involving the ward. At first glance, seeking a guardian *ad litem* for the plaintiff may seem inconsistent with the position taken by the defense in the Boston State case that doctors should not need to seek appointment of a guardian before they can forcibly medicate patients. In fact, seeking a guardian once litigation has already commenced is inherently different from seeking a guardian to approve treatment decisions, as it does not bring the legal system and its inherent delays and obstacles into a situation in which it is not already involved.

Not only must defense counsel seek the appointment of a guardian *ad litem* when they suspect that counsel and not the patients are the motivating force behind new litigation, but defense counsel must also seek carefully to define the role to be played by the guardian. In the Boston State case, a guardian *ad litem* was appointed for one of the patients. However, the individual acting as guardian had no clear idea of what functions he was to perform and he quickly faded into the background. The guardian should be required to file a specific report on a date certain discussing the potential effects of the litigation on the patient's health and treatment and the likelihood of the patient's succeeding in the legal action. The guardian should reach a conclusion whether litigation is in the patient's best interest. The litigation should be suspended pending the guardian's report. Finally, the guardian should be given authority, subject to review of the court, to dismiss voluntarily the litigation.

Preventing Disclosure of Patient Records

Defense counsel in future mental health litigation must also seek to prevent the massive disclosure of patient records revealed in the Boston State case. The Boston State case was brought as a class action, *i.e.*, it was brought by seven named patients on behalf of all patients at the hospital. Plaintiffs' counsel took the position that as they nominally represented all patients as members of the class, they should be allowed to review the records of all patients.

Defense counsel vigorously objected to such massive discovery and plaintiffs' counsel reduced their demands to the records of 89 patients. Over defendants' objections, plaintiffs' counsel were permitted to review and introduce the records of the 89 patients.

In future mental health litigation, defense counsel must continue to object to disclosure of the records of all members of the plaintiff class. In forty-three states psychiatric records enjoy some degree of statutory privilege. Under federal law, patients' records arguably enjoy either a constitutional or a common law privilege. Even if psychiatric records are not privileged, a federal court, in its discretion, may deny discovery

whenever interests in confidentiality outweigh a litigant's need for the information sought.⁹

Discovery in mental health class actions must be treated differently than discovery in other class actions. Historically, plaintiffs' counsel have been entitled to review the records of all class clients as the presumption exists, unless a person "opts-out" of a class, that the absent class member acquiesces in the actions of the named plaintiffs. This presumption is particularly valid in the typical class action involving many small claimants all allegedly wronged in the same manner, who are unlikely to oppose the recovery of any money damages on their behalf without the burden of having to pay for their own attorney. On the other hand, an institutionalized mental patient whose psychiatric records are disclosed in class action litigation does not gain a benefit analogous to that enjoyed by a small claimant. The patient who fails to opt-out is drawn directly into the litigation, as his records are made public and his treatment and illness are debated in open court. Moreover, the inference that a mental patient who fails actively to oppose disclosure of his psychiatric records thereby indicates his willingness to permit their disclosure is clearly erroneous. Institutionalized mental patients are typically passive and ambivalent and frequently too out of touch with reality to take the affirmative steps necessary to protect their records.

Defense counsel should seek to limit discovery of patient records to information which goes to the heart of the lawsuit and which is not available from alternative sources. Even if this threshold test is met, absent the obtaining of written consent from a patient to see his records, patients' records should remain confidential.

Preventing Self-Imposed Problems From the Psychiatric Community: Preventative Legal Medicine

A final set of problems in the Boston State case were self-imposed by the psychiatric community and are clearly preventable in the future. Psychiatrists, as a group, are trained to work with differences between individuals by seeking to form and maintain alliances, by achieving a common ground of consensus, and by eventually establishing compromises.¹⁰ The legal system, on the other hand, while at times encouraging compromise and settlement, is nevertheless founded on an adversarial structure which at times precludes give-and-take and compromise. The inability or unwillingness of the psychiatric community to take an adversarial posture to defend their prerogatives, at times burdened the defense of the Boston State case.

For example, the Massachusetts Psychiatric Society, over the strenuous objection of defense counsel, insisted on filing an *amicus* brief with the trial court requesting the court to establish an administrative board of one attorney and two psychiatrists to review right-to-refuse treatment cases. The Massachusetts Psychiatric Society further suggested that a civil rights officer be appointed to monitor hospital operations and

report to the review board.

Defense counsel had argued against such a proposal by noting that encouragement of judicial legislation inevitably opens a Pandora's box. While consent decrees have their time and place, such as in the cases challenging the abominable conditions in the schools for the retarded in Massachusetts, inviting judicial legislation and constant monitoring of the mental health system creates loss of control over decisions better handled by anyone other than a court. In the Massachusetts retardation cases the regular reporting to the court of such minutiae as the type of shower heads to be installed or whether windows should remain open or shut should give pause to the encouragement of judicial legislation in any case in which the defendant's actions are clearly defensible, as they were in the Boston State case.

This same desire toward reconciliation was also seen on the personal level when one of the leading members of the Massachusetts Psychiatric Society refused to testify on behalf of the defense at trial, noting that he had sympathy for both sides' arguments. Interestingly, this same person was also one of the first individuals to call the Department of Mental Health after the court's order in the Boston State case, asking if there was any way to keep the order from applying to his and other hospitals than Boston State.

Pronouncements made in the spirit of libertarianism and compromise by psychiatric groups also caused considerable difficulties in defending the case. In 1975, the APA's Task Force on the Right to Treatment stated that, except in emergencies, physicians should seek guardians before they override a patient's refusal of treatment. In 1977, after the devastating effects of the temporary restraining order at Boston State Hospital were already a matter of public record, and after Olin and Olin had already published their study showing that informed consent at mental hospitals was clearly an impossibility absent obtaining guardians for 90% of the patients,¹¹ the same APA Task Force declared that mental patients' informed consent to treatment is required except for emergency situations. Not to be outdone, the Massachusetts Department of Mental Health had declared in a civil rights poster placed on the walls of each state hospital, that patients have the right to refuse treatment at any point. Not surprisingly, the court in the Boston State case quoted the APA and the Department of Mental Health liberally in its opinion.

The American College of Neuropsychopharmacology (ACNP), undeterred by the lower court's use of conciliatory psychiatric community statements, asked the appeals court hearing the Boston State case to accept a brief filed by the ACNP in an untimely manner. The reasons offered for accepting the brief at this time were that the ACNP supports both sides of the litigation, as it supports the concept of a right to refuse treatment and wants to call to the court's attention six alternative mechanisms for implementing such a right. The APA's present posture of total support of the defendants in the Boston State

case as well as its argument by *amicus* brief against the judicial legislation ordered by the Federal Court in the New Jersey case of *Rennie v. Klein* acts as a welcome comparison to the continued posture of the ACNP.

Many a psychiatrist has argued that lawyers and courts should stay out of the profession of medicine. Similarly, psychiatrists would do well to stay out of the profession of law. The psychiatric community's penchant for making conciliatory statements regarding abstract principles clearly backfired when applied to legal scrutiny involving very specific patient problems presented in the Boston State case. While psychiatrists must offer their expertise to assure proper defense of mental health litigation, the psychiatric community must remember both that it is the lawyer who is trained to make legal decisions and that at times it is best to fight for the right to continue what you are doing.

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