In the ORIGINAL

Supreme Court of the United States

MARK J. MILLS ET AL.,	)	
	)	
Petitioners	)	
	)	
v.	)	NO. 80-1417
	)	
RUBIE ROGERS ET AL	)	

Washington, D. C.

January 13, 1982

Pages 1 thru 74

ALDERSON REPORTING

400 Virginia Avenue, S.W., Washington, D. C. 20024

Telephone: (202) 554-2345

IN THE SUPREME COURT OF THE UNITED STATES

- -x

MARK J. MILLS ET AL.,

Petitioners

v. : No. 80-1417

RUBIE ROGERS ET AL.

- -x

Washington, D. C.

Wednesday, January 13, 1982

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 1:08 o'clock p.m.

APPEARANCES:

STEPHEN SCHULTZ, ESQ., Special Assistant Attorney General of Massachusetts, Boston, Massachusetts; on behalf of the Petitioners.

RICHARD WAYNE COLE, ESQ., Roxbury, Massachusetts; on behalf of the Respondents.

ALDERSON REPORTING COMPANY, INC,

400 VIRGINIA AVE., S.W., WASHINGTON, D.C. 20024 (202) 554-2345

C O N T E N T S

P R O C E E D I N G S

CHIEF JUSTICE BURGER: We will hear arguments next in Mills against Rogers.

Mr. Schultz, I think you may proceed when you are ready.

ORAL ARGUMENT OF STEPHEN SCHULTZ, ESQ.,

ON BEHALF OF THE PETITIONERS

MR. SCHULTZ: Mr. Chief Justice, and may it please the Court, in argument today I would like to focus on what the defendants believe to be the two fundamental reasons that there is no constitutional right to refuse treatment.

First would be that allowing one patient to refuse treatment is necessarily going to negatively impair the state's ability to perform its legitimate objective of maintaining order in its hospitals, and second of all, of treating those patients who are not themselves refusing treatment. In other words, what I am saying is that to allow one patient to refuse treatment, there will necessarily be an increase of violence in our institutions.

The First Circuit talks about allowing forced medication for emergency situations, but they simply do not focus on the fact of the unpredictability of violence in mentally ill patients, the impulsivity of violent acts, the fact that mental patients are acting upon irrational thoughts, and that this simply cannot always be predicted.

The second --

QUESTION: Well, they did give you a broader mandate than Judge Toro had done, didn't they?

MR. SCHULTZ: There is no doubt that the First Circuit opinion in our mind is less wrong than the district court opinion. I could say that maybe less people will be hurt under the First Circuit opinion than would be hurt under the district court opinion. I hardly feel that justifies the opinion.

The second point that I want to make as to this first fundamental reason is that if you allow one patient to remain in your hospital in a deteriorated state, this is going to affect the health of other patients, whether or not there is violence. A hospital is a milieu setting, and if you have patients who are deteriorated, this will set off the illnesses of other patients, and I will talk about this more later.

The second major point that I want to discuss in argument today which we believe to be a second fundamental reason is that we suggest that the original decision to commit an individual against his will for treatment purposes when it is known at the time that the patient is committed that antipsychotic medications are a necessary part of the treatment of the vast majority of the seriously mentally ill acts as a sufficient predicate for the later administration

of this medication against the patient's will after the commitment.

In other words, let me just reword what we consider this basic argument to be all about. There is no determination of incompetency at the time that a patient is committed, yet the state is empowered, despite this lack of a finding of incompetency, is empowered to commit an individual against his will for treatment. We suggest similarly without any finding of incompetency the state should be empowered to carry out that treatment against the patient's will which was ordered at the time of commitment.

In order to fully understand these two fundamental arguments that we believe necessitate there being a finding of no right to refuse treatment, I think it is first necessary to focus very, very briefly on what exactly is the role of antipsychotic medications in our state hospitals. The record in this case is clear that antipsychotic medications are a necessary part of the treatment for the vast majority of seriously mentally ill patients.

QUESTION: Do those drugs have a component of tranquilizer in them?

MR. SCHULTZ: They do, but they are not very good tranquilizers. You shouldn't use them and it wouldn't be proper practice to use them as a tranquilizer. They are a poor tranquilizer, and to the extent that they do

tranquilize, the sedative effects wear off in two or three weeks. If you want to tranquilize, there are other drugs which are tranquilizers.

We are talking about a specific group of patients, and it must be recognized, and that group of patients are patients who are so seriously mentally ill that they could be committed, plus it is acceptable medical practice to use antipsychotic medications for those patients.

QUESTION: Mr. Schultz, do you disagree with the district court's findings about the drugs themselves, that they are mind-altering and they have significant side effects and so forth?

MR. SCHULTZ: I certainly disagree with the finding that they are mind-altering. What they do is restore a chemical imbalance in the brain to the original balance. It is the psychosis that is mind-altering, as I think a very cogent article points out. The non-conformist treated of his illness, the psychotic non-conformist will remain a non-conformist. A conformist treated of his illness will remain a conformist. They don't alter the mind. The psychosis alters the mind.

As for the effects, the side effects, there are side effects, but simply put, the state's position, and I think the First Circuit so found, is that the dangers of psychosis untreated are far greater than the dangers of any

of these side effects.

The one other point that I can point out about the side effects is that there has sort of been a pendulum in the knowledge of these side effects. At first there wasn't much knowledge of them. Then everybody thought everything was a side effect, and now they are finding that the side effects are more limited than they thought, and are certainly more treatable.

Let me turn back to the question of what these medications are all about. A point which the defendants want to emphasize is not only is the record clear that these medications are effective when taken voluntarily; the record is also overwhelming that these medications are effective when forcibly administered, the district court's finding notwithstanding.

There is no way -- To argue that these drugs are not administered -- are not effective when administered forcibly simply ignores the tens of case histories in this case of patients who refused antipsychotic medication and deteriorated, and then against their will were forcibly medicated and improved, and there is simply no explanation for that other than the fact that these are chemicals, and they make the brain -- they restore an imbalance, and this balance is restored whether or not a person voluntarily takes these medications or whether a person is forced to

take these medications.

Let me turn to what the Commonwealth feels is another very important point in this case, and that is the recognition that we are talking about seriously mentally ill individuals, as the patients who have been given the right to refuse medication, and specifically, what do we know about the serious mental illness which is sufficient to commit an individual?

We know that an acutely psychotic patient is terrorized, in a state of panic, unbearable agony, pain, and distress. That is undisputed in the record. We know that schizophrenic patients, which are the majority of patients for whom it would be a proper practice to give antipsychotic medications, don't think rationally, that they think on their own autistic terms.

We know that a classic symptom of mental illness which leads these patients to being committed is ambivalence, including ambivalence to treatment. We know that -- it is undisputed in the record that many, many patients who were forcibly medicated in the past, after they were forcibly medicated, thanked the doctors for forcibly medicating them when they weren't speaking their own true mind.

Now, despite --

QUESTION: Could I ask you one question --

MR. SCHULTZ: Certainly.

QUESTION: -- about the basic facts that I just didn't recall as you are developing your argument. The institution houses both voluntarily committed and involuntarily committed persons. Is that correct?

MR. SCHULTZ: That's correct.

QUESTION: What is the rough proportion of the two?

MR. SCHULTZ: I believe it is 90 percent voluntary and around 10 percent involuntary. The reason for that is that in Massachusetts the laws changed in 1970 requiring you to, even if you could commit somebody, ask them if you wanted them to come in voluntarily, because they felt there would be a benefit to patients being voluntary patients. There is not necessarily much of a difference in the illnesses between the two.

QUESTION: Do I correctly recall that those who are voluntarily committed do have a right to refuse this treatment?

MR. SCHULTZ: Or leave the hospital, or face a petition for their commitment.

QUESTION: But as a matter of fact, is something comparable to the district court or the court of appeals procedure being followed with respect to the 90 percent who are voluntarily committed?

MR. SCHULTZ: Yes, except that many of them -- it

used to be felt that you could ask them to leave the hospital and if you didn't you could forcibly medicate them. Now what is happening is, after this opinion, if you feel they have to be forcibly medicated, they are making them involuntary patients. So when the patient refuses medication now, there could well be a shift in this percentage, given if the kind of opinions that the First Circuit and the district court issued would have become the law.

I simply don't know the statistics as to whether or not there has been a change over the last several years.

QUESTION: In any event, basically what is at issue here is whether you must follow with respect to the 10 plus percent, because presumably the number would grow by reason of the circumstances you describe, whether you must follow the same procedure with respect to them that you follow with the other patients in the hospital.

MR. SCHULTZ: I am afraid I don't understand your question.

QUESTION: Well, the court has ordered you to follow certain procedures before you involuntarily administer these drugs to the 10 percent who have been involuntarily committed.

MR. SCHULTZ: That's correct.

QUESTION: And as I understand it, you are applying

those procedures, or substantially those procedures, as to the 90 percent of the people in the hospital. So the question is whether the 10 percent must be treated like the rest of the patients.

MR. SCHULTZ: Well, what they are doing with the 90 percent is saying, you have a choice of leaving, if you want, and if you don't, we are going to make you an involuntary patient.

QUESTION: Well, I know, but if they don't leave.

QUESTION: If you could. If you could. You may not be able to.

MR. SCHULTZ: That is correct. That is correct.

QUESTION: Mr. Schultz, I would like to pursue something that may be somewhat similar to Justice Stevens' question. As I understand it, the court of appeals required that an individualized estimation be made by the physicians in attendance of the possibility and type of violence in which the patient might engage, and the likely effects of the particular drugs on the patient, and an appraisal of the alternative means of treatment, and then if the physicians determine, having applied that standard, that the drug should be given, it may be given involuntarily.

Now, I think that is what the court of appeals has said. I also believe that that is the procedure that you have outlined in your brief that you assert the state

follows anyway. Is that right?

MR. SCHULTZ: No, that is not right, because what they -- first, what the court of appeals has done is, they set up two procedures for what they call dangerous patients and non-dangerous patients. What happened before the temporary restraining order, there was no decision about dangerousness. It was recognized that this was not something which was predictable necessarily for these patients. It was decided whether or not the medication was medically necessary on an individual basis, but there was never a decision made on, do I believe that because the possibility of dangerous outweighs the individual's private rights, which is what the individual decision has to be according to the First Circuit, that decision wasn't made.

Yes, it was an individual determination, but the questions that were asked were quite different.

I want to go back to the point of who these patients are, because I want to talk briefly, because the state, I think, has been misconstrued on this point in both courts below, on who is this competent mentally ill patient that is talked about by the two courts below.

The district court found that a majority of the committed patients are capable of appreciating the benefits, the risks, the side effects of these medications. The Commonwealth suggests simply there is absolutely no basis in

the record for that finding, but putting that aside, the major problem with both the district court opinion and the First Circuit opinion in this respect is that nobody discusses what they mean by such terms as appreciate, benefits, competent, or capability.

And it is quite one thing to say that a patient is able to understand that there may be risks to medication and to understand that he has been told he will get better if he is given the medication, and it is quite another thing to say that a seriously mentally ill patient can appreciate the benefits of being well when by definition part of his illness is that he doesn't understand that what he is is not well, and let me make the Commonwealth's position clear here.

We are not stating that a petition of commitment is the same as a legal finding of incompetency. We recognize that people may be delusional in some aspects, but clearheaded in other aspects of their life.

QUESTION: What does Massachusetts require to be found in the case of a commitment?

MR. SCHULTZ: At a commitment there must be a finding of mental illness, there must be a finding of a serious risk of harm to an individual by reason of mental illness. Serious risk of harm is defined as three types of patients, danger to others, danger to yourself, or incapability of taking care of yourself.

Let's look at those three kinds of patient. You talk about the kind of patient who is a serious risk to himself. This patient by definition, if he is going to be committed, is seriously depressed, his affect is impaired, he feels that there is really -- he doesn't understand that there is a better world. He feels usually that the only way out is by killing himself. Now, certainly, this patient is not going to be able to understand the benefits of what it means to be well, because in his world the whole world is bleak.

Look at the second kind of patient. The second kind of patient is a patient who is a danger to others. This person by definition has basically -- has a distorted view of interpersonal relations with somebody. Classically, he is either in a state of rage or he is in a state of panic, a rage at somebody or a panic that somebody else is going to hurt him. Yes, the rage and the panic may wax and wane on a given day or in a given period, but the basic underlying problem of his illness is that he doesn't understand that his rage or panic is unreasonable, and there is no way that patient can weigh the benefit of what the medication is going to be --

QUESTION: Well, counsel, under the court of appeals opinion, if the physician determines that there is this element of violence which is a possibility, and as you

have indicated, to commit the person in the first place the court had to decide that violence was a substantial possibility, I don't understand why the court of appeals requirement adds anything in addition to what the doctors would be looking at anyway.

MR. SCHULTZ: What the court of appeals does is require -- they say that the fact of violence at the time of commitment is not enough to later forcibly medicate the person in the hospital. They say that dangerous on the outside may not mean dangerousness on the inside. And they set up this arbitrary distinction of, you can forcibly medicate some people if you think they are violent, and forcibly medicate other people if what you want is treatment.

What the Commonwealth says is, everybody is committed for treatment. It is simply not accurate to say that there is anybody in Massachusetts hospitals because they are dangerous. That is not why they are there. They are there because they are dangerous by reason of mental illness.

QUESTION: Well, here, the court of appeals gave alternative standards. It said that the petitioner -- the hospital may forcibly administer drugs without a finding of incompetence if it is reasonably believed to be necessary to prevent further deterioration in the patient's mental health or the other standard that I have been talking to you about.

MR. SCHULTZ: That's right.

QUESTION: Now, isn't that enough to encompass the patient's needs and the hospital's needs as well?

MR. SCHULTZ: No, absolutely not. Under the first standard -- it is more than that. They require that they go to a court to get a finding of incompetence, and the question is, why --

QUESTION: In addition to the initial finding on commitment.

MR. SCHULTZ: That's right. This is the First Circuit and the district court. They say the mere fact that you have to treat the patient, that in your mind treatment may be necessary, unless you can find these exceptions that you gave, you are going to have to go to a court for a finding of competence, and --

QUESTION: But I thought one of the exceptions that the court of appeals found and modified the district court was that the patient could be forcibly medicated without a finding of incompetence when it is reasonably believed to be necessary to prevent further deterioration of the patient's mental health.

QUESTION: Well, what they say is for the significant deterioration, and you run into two situations. First of all, what does significant mean? You take the Rennie versus Klein case. I will use that as an example of

the facts. This is an individual who slowly, when the district court told him he couldn't be forcibly medicated, he slowly deteriorated. Where was the significant deterioration? It was on a daily basis, until his life was endangered. Because of the district court opinion that you had to have a determination of incompetency, Mr. Rennie's life was unnecessarily endangered. So why not focus on significant?

Second of all, you have the problem of, we are talking about a milieu setting. What about the patient who is seriously ill, who is suffering, who is in agony and distress, but isn't deteriorating? He is already so deteriorated. What about that particular patient? I think it is important to maybe look again at some of the examples. Maybe I can help answer your question by looking at some specifics of what is in the record of this case.

I have an example of one of the plaintiffs in this case. Her name is Betty Bybel, and the testimony is that when Betty Bybel was deteriorated, not only could she become violent, but one thing she would do is sadistically taunt the other patients about their personal lives, causing a deterioration in their health. That wouldn't fall under any of these exceptions, yet under the First Circuit Betty Bybel is going to continue to cause the other patients to deteriorate.

The record is that when Betty Bybel would start yelling, everybody would start yelling. That is not covered under either of those exceptions. There is no significant deterioration in Betty Bybel. There is nothing about dangerousness, but the hospital is going wacky, and going -- the hospital is going up at that time, because of the effect in the milieu, which is not discussed in either of the opinions.

You have an example of another patient, James Colleran. He would sadistically taunt female patients sexually. All right. For the female patients, you might have the question of dangerousness, but what happens is that he set up some of the male patients who had their own sexual hangups, and couldn't stand James Colleran taunting the female patients, and the male patients' illnesses deteriorated, and there are just example upon example of example of these kinds of situations, and you must recognize that we are talking about a milieu here, we are talking about the state's ability to perform its legitimate objective of maintaining order in these hospitals, and neither opinion deals with this very fundamental reason that there should not be a right to refuse treatment.

QUESTION: Mr. Schultz, you say that treatment with antipsychotic drugs is the standard fare with maybe 90 percent or at least the great majority of your patients.

There is a group of patients that you don't use drugs on.

MR. SCHULTZ: That's correct.

QUESTION: So you must have some criteria, some criterion for separating out those you use them on and the ones you don't.

MR. SCHULTZ: Medical judgment.

QUESTION: Medical judgment. Well, if the courts had said to you, well, you have two groups, the ones you use them on and the ones you don't, if you decide that a certain person belongs in the group that you are going to give drugs to, you should go through a procedure to decide that.

Now, do you say that those -- nothing about the commitment helps you decide which group you give the drugs to and which you don't. They have all gone through this process of being involuntarily committed.

MR. SCHULTZ: What they were all involuntarily committed for was appropriate treatment, we would suggest. We would suggest --

QUESTION: I know, but there had to be some findings before there was an involuntary commitment, either danger to themselves, to others, or they couldn't take care of themselves. The reason you have committed them is for treatment maybe, but nevertheless you had to make those findings.

MR. SCHULTZ: Well, let me answer that in two ways,

if I can, and I think I can deal with the questions you are raising. This case is not a procedural case, is my first answer. This is not a case where you are simply talking about the First Circuit setting up additional procedural safeguards. The First Circuit is talking about changing the substance of law, of setting up a different class of patients within the hospital, a group which, procedures aside, is going to be called your mentally ill competent patient, who is allowed to stay in the hospital, as the defense puts it, demand hotel service instead of treatment, and refuse their medication.

They are talking about another group of patients that is going to be set up that just didn't exist before, which is a group called incompetent patients but for whom there is going to be a substituted judgment that if they were competent they should be allowed to refuse, and those patients are going -- somebody else is going to be allowed to say, they should be allowed to refuse their medication. It has nothing to do with setting up -- this is not the procedural question.

The First Circuit opinion doesn't even mention procedural due process. This isn't an opinion which talks about the state's rights and the individual rights and the need to have some type of mechanism which will lead to an accurate assessment, which we would suggest in our brief the

hospitals do have, which is the second half. We believe the type of review that takes place at these hospitals is constitutionally adequate, but what I want --

QUESTION: Could you be specific on what type of review the hospitals do employ? Could you describe --

MR. SCHULTZ: At these hospitals, there are rounds every day in which medications are discussed, at which a doctor must be present.

QUESTION: Is it discussed with the patient?

MR. SCHULTZ: At team meetings twice a week, it is discussed with the patient. At one of the units at the team meetings, the medical supervisor attended the team meetings.

QUESTION: Are the patients' desires concerning medication considered then?

MR. SCHULTZ: The record shows that they are. That that was always a factor. That they would listen to the reasons that the patients gave as one factor they would take into account.

QUESTION: And do the physicians consider the dangerousness of the patient or the propensity for violence?

MR. SCHULTZ: Before, not -- not really. I mean, dangerousness is part and parcel of the mental illness. Yes, they considered it to the extent that because these people are mentally ill, because some of them certainly have a history of dangerousness, that these patients need

treatment, but I cannot honestly say that dangerousness was one of the factors that they took into account.

What they took into account was whether or not these particular patients needed the antipsychotic medication.

QUESTION: And they consider the alternative forms of treatment for medication?

MR. SCHULTZ: There is not an alternative form of treatment for most of these patients. I mean, I cannot honestly tell you that they went through -- we have proposed remedies in this case, where the other side suggests under the doctrine of least restrictive alternative there are 12 other alternatives that must always be considered, one of them being seclusion, which they suggest is less restrictive than forcible medication. The doctors did not do that.

Would the doctors prescribe antipsychotic medication if they didn't believe that was the best treatment? No. And to that extent, it is a consideration of the alternatives, but it was not a matter that they said to themselves, which is the least restrictive form of treatment that could be given. Instead, what they would say to themselves is, what is the best form of treatment that they could be given.

Let me go back on --

QUESTION: When you say they consider in these

rounds or in these meetings whether the patient needed the medication, what do you mean by need?

MR. SCHULTZ: Well, it would be a consideration of, one, what are the side effects this patient is having, are the side effects so serious that we should -- first of all, one of the units had specific meetings simply where the patients could raise complaints about the medication. Now it is the full purpose of the meeting every week. So obviously in that situation they consider what the patient complained about.

QUESTION: What do you mean, that they need the medication? Need it for what? Need it for treatment?

MR. SCHULTZ: Need it for treatment, and does the need outweigh whatever side effects this particular patient might be experiencing at this time. Is the patient's health changed sufficiently? It may be one can start other therapies in addition to medication. These were teaching hospitals, both of these hospitals that we have here. So there were residency programs. The residents, as in any teaching facility, would regularly be meeting with their supervisors. They would be regularly meeting with the patients. And these are hospitals that had a lot of feedback, that had a lot of periodic review of the various medications.

One other point that I want to emphasize that I

think both courts below simply have misinterpreted what parens patriae power and what police powers are all about. Police power is talked about in terms of a policeman's ability to prevent dangerousness, and the defendant suggests that simply is not what the police power is. The police power, according to past cases in this Court, is the ability to protect the general welfare, including to protect the public health of its citizens.

The Commonwealth would suggest that this ability to protect the public health is clearly implicated when you are talking about the need to treat patients against their will who have already been committed against their will for treatment purposes. As to the parens patriae power, I simply want to say that this notion of competency seems to have been invented by the First Circuit to justify its opinion. You will find nothing in the opinions of this Court that ties this variable competency that can change in one day, where one day you are competent and one day you are not competent, to the parens patriae power. The state is the sovereign, as a sovereign is the guardian over all idiots and lunatic, according to the opinions of this Court.

This Court has never mentioned incompetency. This notion of incompetency, the Commonwealth would suggest, is one that has been brought in from the rear to justify the opinion. It simply is not necessary. The parens patriae

powers and the police powers are more than adequate to justify the actions taken by the doctors in this case.

Thank you very much.

QUESTION: Mr. Schultz, does the record show anything about the adequacy of staffing in these hospitals? We hear a lot of complaints over the country about understaffing, insufficient number of psychiatrists and other attendants. Does the record show anything here?

MR. SCHULTZ: It shows that they were half of what you might find in a private hospital, where they were compared to McLean Hospital in Boston for the comparison in staffing. They were far above the minimum standards that were set out in such cases as Wyatt.

QUESTION: I gather from your remarks, these frequent sessions and the like, that there was no problem with staffing.

MR. SCHULTZ: The staffing could have been better, but it is not a question of there were not doctors, there were not good registered nurses, there were not residents. I mean, that kind of staffing was there.

QUESTION: Before you sit down, let me put one at you that we have got you stopped. I get a feeling reading this record, the massive record, this case went on how many weeks?

MR. SCHULTZ: It was a year and a half of trial and

74 -- I guess 72 trial days and two days of closing argument.

QUESTION: I get a feeling, and I wonder what your reaction is, whether I am being led astray, that the judges, as we judges tend to do, were reading this testimony in this record as though mental illness, psychiatric problems, are like physical illness, that you can take someone's temperature or pulse or blood test and then you know something about what is going on inside that person. Is that a strange reaction that I get, or would you --

MR. SCHULTZ: No, I think that is certainly there, and I think that goes to this problem of the inability to predict the violence of some patients, the unawareness that people who do not think rationally are going to act impulsively on those irrational thoughts. There is simply no recognition by either judge of those particular problems.

QUESTION: A diabetic patient, for example, if he is getting near diabetic coma, they can find that out by a blood test, can't they? But you are saying that you can't do that with the psychotic or the schizophrenic.

MR. SCHULTZ: I don't want to overstate it. There are certainly many patients you cannot do that for. There are some patients that might have a clear history that if they do something, they do something first. Then you know that something else almost always follows. Then you have a history showing you for those psychotic patients that when

they start winding up you have got to look out, the next thing they are going to do is punch somebody. But if you don't have that kind of history, certainly you have that problem.

QUESTION: Mr. Schultz, I take it there is a regular procedure at these hospitals for periodically determining if the grounds for commitment still exist.

MR. SCHULTZ: That is correct.

QUESTION: So that presumably in between -- just take a particular patient, Mr. A. In between the times that his case is reviewed for that purpose and the next time it is reviewed for that purpose, presumably he still fits the definition of a proper committee, that he is either dangerous to himself or to others or can't take care of himself.

MR. SCHULTZ: That's correct. There is an affirmative obligation on the superintendent to release a patient who is no longer mentally ill or felt no longer mentally ill and dangerous. In addition to that, there is a six-month periodic review and then another six-month periodic review at the beginning, then they are yearly after the first six months, and in addition, there is what is known as a Section 9 petition, where any time the patient himself wants to petition the court, he can do so.

QUESTION: So we are talking about -- the court of

appeals is talking about saying you must determine -- you must get the consent of someone who right now is dangerous to himself or to others or can't take care of himself.

MR. SCHULTZ: That is correct. I mean, what they say, without, we suggest, any real support, is that once you are in the institution, they say the finding is dangerousness on the outside, not necessarily what is on the inside. We say the finding is dangerous because of mental illness, and that they are just missing the point of what the mental illness does to the individual.

QUESTION: Well, if they don't qualify any longer for commitment, they should be turned loose.

MR. SCHULTZ: That's correct.

QUESTION: Mr. Schultz, the opinion in this case is based, of course, in part on the fact that in Massachusetts someone can be an involuntarily committed patient and under Massachusetts law is still competent legally to make a variety of decisions. Is that not true?

MR. SCHULTZ: All Massachusetts law says is that you are competent to do some very specific things, write a will, manage your affairs.

QUESTION: Dispose of property.

MR. SCHULTZ: That's right. It says nothing about that you are competent to make treatment decisions. That is a gloss that the First Circuit and the district court

opinion have put on the Massachusetts law.

QUESTION: Can they vote in Massachusetts?

MR. SCHULTZ: Yes, they can. But again, this goes to -- we accept that somebody may be delusional in some areas and not delusional in other areas.

QUESTION: Well, part of the decision here may be affected, may it not, by this provision of Massachusetts law providing that they continue to be legally competent, right?

MR. SCHULTZ: I don't think it should be. I don't think -- one, competency is relevant, as I have discussed, competency is a variable thing, so that you can be more competent one day than the next day, and really what is relevant is why you are committed. Beyond that, Massachusetts law, I think, is clear. It does not recognize a right to refuse treatment. It sets out in the law specifically that there is a right to refuse electric shock and lobotomy, and does not mention antipsychotic medication. I think under normal rules of statutory interpretation the right interpretation of Massachusetts law is that it does not recognize the right to refuse treatment with antipsychotic medication.

QUESTION: Mr. Schultz, may I ask you one other question? Apart from procedures that have been adopted in response to this litigation -- just assume we didn't have the case -- does the record tell us whether the hospital

draws any distinction in its day to day administration between voluntarily and involuntarily committed patients?

MR. SCHULTZ: They did not before this suit except to the extent that for the voluntary patient they would say, you can leave, but if they didn't, then they treated them like involuntary patients, without bothering to commit.

QUESTION: The voluntary patient always had the right to leave. Is that right?

MR. SCHULTZ: Yes, Your Honor.

QUESTION: I see. But other than that, in terms of medical decisions and the like, they are treated alike?

MR. SCHULTZ: That's correct.

QUESTION: Mr. Schultz, we have been taking your time that you wanted to reserve to reply, and perhaps the Court will give you additional time.

You have not responded to the motion of the other side that we dismiss this case in light of the court's decision in your state in Roe.

MR. SCHULTZ: Well, I have certainly responded by brief.

QUESTION: You did briefly, but that is a rather important issue, at least for me.

MR. SCHULTZ: Well, I can do no more than really repeat what I think are the basic points in our brief, so I will do that very briefly, if you would like. I think the

Roe decision, first of all, they went out of their way to say that they weren't deciding this case. On four different occasions they said, we are not --

QUESTION: Without going into that detail, let me ask you this.

MR. SCHULTZ: Okay.

QUESTION: Do you think the Roe decision changed the law of Massachusetts in any way?

MR. SCHULTZ: It is hard to say, because the Roe decision deals with a moot situation which is never going to come up again, and I really don't think the Roe decision is going to have any impact whatsoever in Massachusetts.

QUESTION: You think it is totally irrelevant to this case?

MR. SCHULTZ: Absolutely.

Thank you.

CHIEF JUSTICE BURGER: Your time for rebuttal will be reserved as you undertook to reserve it, which is five minutes.

Mr. Cole, you may proceed when you are ready.

ORAL ARGUMENT OF RICHARD WAYNE COLE, ESQ.,

ON BEHALF OF THE RESPONDENTS

MR. COLE: Thank you.

Mr. Chief Justice, and may it please the Court, I would like to try to clear up two comments that were made at

the end of the argument in terms of commitment. The Roe case specifically dealt with whether or not merely because someone is being committed for dangerous in the community, dangerousness in the community, whether it means that a person would be necessarily dangerous in the hospital, the Supreme Judicial Court said specifically it does not mean, and I will give an example of that.

Someone may be dangerous to their family because they are having problems with their family, and they are dangerous, and they are put in the hospital. Now, they cannot be discharged, because if they are again discharged into the community, they would be dangerous in the community, does not necessarily mean that they would be dangerous in the hospital.

In fact, the district court found as a matter of fact, based on the evidence presented by the defendants, that only 25 percent of the patients in the hospital are in fact potentially dangerous, and I will address that later.

Second of all, in terms of the practice dealing with voluntary patients, they were treated specifically like involuntary patients. What happened was that patients weren't told that they had a right to leave. They were told that if they refused their drugs, they would be forcibly medicated, and that if they tried to leave, they threatened them with commitment. So there wasn't such a thing that

-- they are called conditional voluntary patients, where the patient has to give three day notice to the hospital, and during that period of time the hospital has the right to petition, and the record was consistent in the patients who testified and staff who testified that patients were threatened that if they did refuse and they tried to leave, that they would attempt to commit them.

I would like now to go to certain brief points concerning this case.

QUESTION: Well, let me ask you one question about the record. Does the record indicate what happened in the event that there were commitment proceedings? Were the patients who refused treatment invariably committed?

MR. COLE: There was nothing in the record concerning that. Most patients, at least the testimony that we have from staff and patients was that the patient would not sign the voluntary -- or withdraw the voluntary under the threat of commitment. But there was no record concerning what was the rate of those individuals who refused and whether or not they would be committed.

First of all, I would like to make the point that respondent in this case had never sought to restrict the use of antipsychotic drugs on individuals who were able to weigh the risks and benefits of these drugs and who voluntarily agreed to take them.

QUESTION: You say they are able to weigh it.

MR. COLE: That is correct.

QUESTION: Who says they are able to weigh it?

MR. COLE: The district court found, based on the evidence that was presented below, that most patients in the hospital as a matter of fact were able to weigh the risks and benefits of the drugs, specifically and particularly those patients who had experienced antipsychotic drugs before. Now, 85 percent of the patient population were either patients who were chronic patients or patients who had been rehospitalized previously, and one can assume by both the evidence in the case and as petitioner says that almost all those patients had antipsychotic drug experience in the past.

Secondly, this is not a situation in which if patients are provided with the right to refuse antipsychotic drugs, that many patients will be without treatment. Now, the petitioners have here asked for de novo review of a number of facts found by the district court after a 72-day trial, a voluminous record with testimony which -- some of it was in dispute, but which the district court found -- but the district court found, and based on -- by statements made by the defendants themselves, that the vast majority of patients after the district court order accepted some form of antipsychotic drug, though not necessarily the drug or

dosage the doctors originally prescribed, as long as the doctors tried to use discourse to discuss with the patient the risks and benefits rather than the previous practice of using force on the patients.

Now, this was a different practice, and the defendants admitted, there are admissions in the record that the defendants' practice in the past was for patients, some patients who were able to make rational decisions, that they would ignore or disregard patients' complaints about the adverse side effects, and medicate them anyway because the doctors believed that it was in their best medical interest.

Secondly, the district court found that a number of effective alternatives are available to the hospital for those competent patients who refuse antipsychotic drugs.

QUESTION: What does the district court know about these things, any more than most judges know about the processes that go on in a medical hospital?

MR. COLE: Well, Your Honor, there was substantial testimony from a number of national experts on both sides concerning alternatives --

QUESTION: And this should be ultimately relegated to the decision of one district judge, or of a court of appeals, or, for that matter, this Court?

MR. COLE: Well, the fundamental question in this case is, we perceive as a fundamental historic right in our

society that an individual, a competent adult individual has a right to refuse treatment recommended to them by a doctor, even if they --

QUESTION: What percentage of these people are competent adult persons, of these inmates?

MR. COLE: Well, Your Honor, first of all, the Roe case, the Massachusetts Supreme Judicial Court, the highest state court, specifically said that patients are competent to make treatment decisions even though committed, so in their interpretation of state law --

QUESTION: All of them? All of them?

MR. COLE: No, Your Honor. We don't believe that all of them are, but as the Roe case said, and as the district court and the court of appeals said, that for those patients who are unable to weigh the risks and benefits, there is a state procedure present, and in fact, the petitioners followed that same state procedure for medical treatment for those same patients, the surgical treatment for those same patients, and for psychosurgery and electroshock.

That means that if -- that they either have to get the consent of those same patients who are in the hospital who they say they don't have to get for antipsychotic drug treatment, and if they believe they are incompetent, that they have to go to the probate court to get an adjudication

of legal incompetency before they can be forcibly treated for medical treatment, surgical treatment, electroshock and psychosurgery, and this treatment could be ongoing also.

For example, medical treatment could for the same patient be ongoing and involves drugs also, the drug, for example, dilantin, phenobarbital, dealing with seizures. They are ongoing. And they need the consent of the patient in those circumstances.

QUESTION: Mr. Cole, I understand your view that there is a great difference between being committed for statutory reasons and being mentally incompetent. Is it your view that the test of incompetence for things such as making wills and voting and entering into contracts should be precisely the same as the test for competence to make this medical decision?

MR. COLE: Your Honor, the answer is, each type of situation for competency to vote, for contracting, are all individual legal determinations that are made by courts of law in Massachusetts traditionally. In fact, dealing with --

QUESTION: But are there grades of incompetence in Massachusetts? You could be incompetent to vote, but not to enter into a contract or not to make a will?

MR. COLE: There is a belief in -- there is law that in Massachusetts someone can be specifically incompetent in one area and not legally incompetent in

another area. But in terms of medical treatment, the same procedure follows the state case that we cited in court dealing with Lane versus Candura, where a doctor believed that a patient who was going to -- refused surgery, and the doctor believed the patient was incompetent, and they went to court, and the court says, even though the doctor believed that the decision by the patient was unwise and foolish, and maybe even incompetent, that in fact she was still legally competent under Massachusetts law. And the Roe --

QUESTION: Under Massachusetts law, is the test of competence merely one of the intellectual ability to know what is best for oneself, or does it also require something to do with the kind of self-discipline that might be necessary to make the decision?

MR. COLE: I think the Massachusetts law, though, it is not clear, is that if a person understands and is able to weigh the benefits and risks of the type of treatment, even though --

QUESTION: Some people weigh the benefits and risks of stopping smoking, but then they go ahead and smoke.

MR. COLE: Our society believes that an individual has a fundamental liberty interest in making certain decisions except for in certain extraordinary situations.

QUESTION: The test is really an intellectual test.

MR. COLE: That is correct.

QUESTION: Could I ask you, say here is a particular person who is involuntarily committed, and there has been the proper finding that he is either dangerous to himself or to others or he can't take care of himself by reason of mental illness, and so he is committed, and the judge has found that he is in that condition.

MR. COLE: The finding is only that the person is mentally ill and dangerous if the person remains in the community, but there is not a finding that the person is mentally ill and dangerous in general. That means it will follow the person.

QUESTION: What if it is found that he cannot take care of himself by reason of some mental illness?

MR. COLE: That is the third category.

QUESTION: Yes.

MR. COLE: That is the inability to care for themselves in terms of the basic necessities of life.

QUESTION: That is the same, in or out.

MR. COLE: Excuse me?

QUESTION: That is the same, inside or outside.

MR. COLE: That's correct. That's correct.

QUESTION: And if you are dangerous to yourself, I suppose it is the same inside or outside.

MR. COLE: That is not necessarily so.

QUESTION: Nevertheless, the day after he is committed, and he goes into the institution, the doctor says, I want to treat him, I want to give him an antipsychotic drug. Now, you say at that point the doctor must go through some -- he must decide whether the person is competent or not.

MR. COLE: That is correct in terms of the use of drugs for treatment for parens patriae circumstances.

QUESTION: Well, now, if the doctor decides in his own mind that -- he says, this person right this very minute is either -- is dangerous to himself or to others or he can't take care of himself by reason of mental illness. Now, suppose he says, of those three, this person is dangerous to others, right now. Now, does he -- is that mutually exclusive to being competent to decide whether to take a drug?

MR. COLE: No, it is not.

QUESTION: That is what I have very great difficulty understanding. He might be very competent, but can you be competent to refuse treatment that the doctor wants to administer to keep you from hurting others?

MR. COLE: Okay. In that situation, the court of appeals directly addresses that circumstance. In a situation where a person -- and the respondents have always conceded this -- that even if a person is competent in a

situation where there is a threat to the institution, that there are institutional needs that have to be taken into consideration, and in that circumstance the individual's fundamental liberty interest can be overridden.

QUESTION: Well, any time then -- the court of appeals judgment will be no barrier to any doctor who says, this person is dangerous to others, or this person is dangerous to himself, or he can't take care of himself by reason of mental illness right this very minute? Then competency is beside the point?

MR. COLE: Under the -- what the court of appeals is saying is that because a patient is not necessarily dangerous in the institution, in fact, in terms of violence, there are only, according to the petitioner's testimony, approximately 25 percent had the potential for violence, that all the doctor has to do is, if the doctor makes an individualized assessment -- that is all we are asking -- that that particular patient creates a danger to self or others at that time, then the state has a legitimate interest in overriding the competent individual's right to refuse.

And so that is correct. The fact is, if that was the issue, and all they had to do was that, the petitioner wouldn't be here today.

QUESTION: You wouldn't either.

MR. COLE: We wouldn't either, because that would end the --

QUESTION: You wouldn't have brought the suit if that was all that was involved.

MR. COLE: That's right. The fact is there are a large percentage of patients who do not fit into that category.

QUESTION: Who if they were out might be commitable, but if they are in, they are not necessarily dangerous to anybody or themselves.

MR. COLE: That's correct. An example, as I said, was an individual who may have shown violence to his family, and has a pathology with his family, but you separate them from the family, and they are in the environment of the hospital, they are not dangerous to anyone else, their danger was specific. They were dangerous to the family themselves. And they can't discharge them because that danger continues if they are released, and society has decided -- I mean, the patient didn't ask to be there in the first place. Society has decided that they have an interest, a police power interest in taking that individual off the street.

QUESTION: Tell me what you object to in the medical decision. I don't suppose the doctors involved are just interested in giving medication willy-nilly. There is

a range of reasons that they use, I suppose. What reasons do you particularly object to?

MR. COLE: Well, if I can first begin to answer by saying that the first thing we take is that these drugs are extremely dangerous drugs.

QUESTION: I understand that.

MR. COLE: These are not relatively risk-free drugs. And what we are saying is, in an individual who is not dangerous, that means, the doctor does not believe there is a potential for harm in the institution, number one, and who is not causing the kind of security problems which belong to the police power --

QUESTION: So why is he giving it?

MR. COLE: Then he is only giving it in order to what they believe to benefit the individual, to have them improve their health in the institution, and it is our view that the state --

QUESTION: And you suggest that even if those are the reasons, and valid ones, nevertheless the patient should be, if he is competent, should be able to say, sorry, I don't care to take it?

MR. COLE: That's right. That is particularly important in this case, because we are not talking about relatively risk-free drugs. We are talking about a drug which the district court found that 30 to 50 percent of the

patients are getting a syndrome called tardive dyskinesia, which is the deforming, often irreversible and untreatable symptom that causes patients to have facial contortions and grimaces, to have lip-smacking and tongue protrusions that can't be controlled by the patient, that when this syndrome gets fully manifested patients find that they cannot speak, that -- and speech becomes incomprehensible, swallowing and breathing are impaired as well as all motor activity.

Now, if this was only 1 or 2 or 3 percent of the patient population involved --

QUESTION: So the patient, if he is competent, should say, well, I would rather be the way I am than be that other way.

MR. COLE: That's correct, and we are saying that -- we are not saying this for all treatment. We are saying that there are particular types of treatment, such as psychosurgery, electroshock, that raise such fundamental interests in terms of what these drugs can do. The petitioners say these drugs don't affect the mind. Well, the district court found -- there was substantial evidence in this case -- that these drugs can blunt the consciousness, impair cognition, learning ability, problem-solving ability.

MR. COLE: Mr. Cole, none of the plaintiffs in this case suffered any of these effects, did they?

MR. COLE: That is not correct, Your Honor. There were admissions given -- the distinction that is being drawn is between the main plaintiffs and the class of patients, where there was substantial evidence dealing with both, and there was admissions concerning the effects of these drugs, and doctors admitted that some patients had from these drugs in the class, had clouded consciousness.

QUESTION: Not 25 to 50 percent of the class. You didn't mean to say that, did you?

MR. COLE: No, in terms of tardive dyskinesia, which is the side effect, the only -- they agree that many patients had tardive dyskinesia in admissions. The only specific evidence they had --

QUESTION: What do you mean by many?

MR. COLE: There was no -- in the --

QUESTION: Because I got the impression from the district court's finding that this is a very serious possible side effect, but the actual litigants, at least the named plaintiffs, you are right, had not suffered that.

MR. COLE: We only raised it for one named plaintiff, Your Honor.

QUESTION: That it is a danger, but one that didn't materialize very often within this class.

MR. COLE: On one ward, the testimony they had in specifics of one ward in the hospital during one period

where a defense witness, a doctor who worked there, testified that 10 to 15 patients out of 70 to 75 patients on that ward had clear cases of tardive dyskinesia. That is a 20 percent rate of patients who have tardive dyskinesia, clear cases. We are not talking about subtle signs of tardive dyskinesia. The testimony was clear cases of tardive dyskinesia. So that there was evidence for the district court. The district court also used the medical literature and the expert testimony, and there was a lot of national experts who testified about what is the general rate of patients who are getting this deforming, disabling syndrome, and --

QUESTION: Would it not be correct that when a patient gets that -- is in that unfortunate group, that somebody has made a medical misjudgment?

MR. COLE: No, Your Honor. Any patient who gets antipsychotic drugs is at risk. The problem with these -- I mean, one of the problems is, not only do the drugs cause tardive dyskinesia, but they can also mask the development of the syndrome, that means, the manifestations of the syndrome, initially, so often by the time the doctor finds out, even using the best medical standards, by the time the doctor finds out that the patient has the syndrome, it is often irreversible, often untreatable. Not always, but often.

So, we are not talking about if there is bad practices.

QUESTION: The difficulty with your argument that I see, at least, is that the more difficult it is to accurately appraise the risk, it seems to me the less wisdom there is in saying that the layman should make the medical judgment.

MR. COLE: What we are saying is, is that the patient is the one who has to assume the risk of this irreversible side effect, and a competent individual should, just like other competent adults in our society --

QUESTION: But even a competent doctor apparently can't appraise it accurately.

MR. COLE: Well, the question is not whether -- one can competently say that 20 to 50 percent of patients over the long term who are taking these drugs are getting tardive dyskinesia. That is a risk that one can understand. One can't selectively say that this particular patient is going to get it. Just like when someone has an operation and the doctor says there is a one in 100 chance of death, they don't know if specifically that one person is going to be the person who is going to die. Of course, that person wouldn't take the therapy.

QUESTION: Well, and of course this doesn't show up until there has been medication over a prolonged period of

time, as I recall.

MR. COLE: Well, the record reflects that within three months of antipsychotic drug treatment, there have been reports that patients have had tardive dyskinesia. Within a year of antipsychotic drug treatment, the patient is at high risk. Now, you have to remember that a number of these patients have been on antipsychotics in the past. We are not talking about one year straight. We are talking about one year. Eighty-five percent of the patient population are either chronic patients or patients who are being readmitted to the hospital who have had prior hospitalizations, and therefore have taken antipsychotic drugs, so the risk is great for that 85 percent immediately if they have had any history of antipsychotic drugs.

QUESTION: But you would apply the same procedures Justice White asked you about where the man is dangerous to himself and so forth, you would apply the same procedure whether the patient has ever had the drug before or whether he has been using it for ten years.

MR. COLE: That's correct, because that is not the only side effect that a patient experiences.

QUESTION: No, but this is the more serious one, as I understand.

MR. COLE: Well, it is the one that in terms of permanent effect is there, but there are a number of other

-- a patient can experience a number of side effects that last the course of being on antipsychotic drug treatment, very painful syndromes, disabling, not only of the body but also of the mind. And what we are saying is that the tradition in our society has been a competent individual has the right, even if we believe it is wrong, to refuse treatment as long as -- and in this situation we are talking about extremely dangerous treatment, and we believe that there is a liberty interest involved, and the court of appeals attempted to weigh the strong patient's interest and the institutional interest, and we feel that the weighing was responsible, giving due deference to the state and the institutional needs, but at the same time recognizing the dangers of these drugs and the important patient's interest in being able to refuse, especially considering that we are really talking about and focusing on patients who the Supreme Judicial Court of Massachusetts says are competent to make these rational treatment decisions.

QUESTION: Well, Mr. Cole, suppose the doctor says, well, the reason I am interested in giving these drugs is, I think I can maybe restore you to the community, maybe even cure you, or at least get you stable enough that I can turn you loose, and the state has a major interest in doing that, no matter what you think. Now, is that an improper consideration?

MR. COLE: No. We recognize that it is a legitimate state interest. The question is whether or not that interest when it is the state that initially had decided on putting him into the hospital in the first place. And that interest, for example, is under the police power to protect society in general. And we are saying, does that interest standing alone for competent individuals dealing with these dangerous drugs outweigh the patient's interest.

QUESTION: Well, at least it is a consideration that the state has a legitimate interest in trying to remove these people from the institution if they can by curing them.

MR. COLE: Your Honor, the evidence demonstrated that the vast majority of patients did not refuse antipsychotic drugs over the long term when the doctors responded to the patients' complaints about adverse side effects, maybe changed the drug or the dosage.

QUESTION: Is anyone in this whole universe of patients ever released because they have gotten better or not?

MR. COLE: I assume that there have been patients who have been released because they have gotten better.

QUESTION: But not many?

MR. COLE: No, I think there was -- we don't dispute the fact that these drugs have some efficacy. We

challenge the --

QUESTION: Enough that some people are released.

MR. COLE: Enough that some people are released. That is correct. But the question is, the state has decided to commit the individuals, and has the interest -- and their interest has been satisfied by committing them. In a committing hearing --

QUESTION: Well, but their interest isn't satisfied. Their interest is, they don't want to keep the people there. That is a great expense to the taxpayer. They want to get them out if they can. What is wrong with that as an interest?

MR. COLE: As I said, we concede that that is a legitimate state interest, and the district court and the court of appeals reviewed that. The evidence doesn't bear out that --

QUESTION: You say the person should be able to say, sorry, no, I would rather stay here, and live on you for --

MR. COLE: Well, the thing is, the misperception about that is that the state has decided to put the person in the hospital, especially under the police power, that has nothing to do --

QUESTION: Well, they have decided to get him in to treat him, that he is dangerous, they want to treat him, and

perhaps he will no longer be dangerous.

MR. COLE: There is no finding nor necessary finding in a commitment court to find whether or not a patient has -- whether or not treatment is available, whether or not treatment will be effective. If you take a look at --

QUESTION: Well, I understand that.

MR. COLE: So patients who cannot be treated at all, the state still commits.

QUESTION: Would you agree that the state, if it came -- if push came to shove in a situation like this, would be free to release the person --

MR. COLE: If the person --

QUESTION: -- if they felt the person were so disruptive and still refused to submit to what the doctors thought was proper medication?

MR. COLE: If the doctors in their medical judgment believed that that person is no longer dangerous in the community, they can --

QUESTION: No. If he is just such a disruptive force in the hospital that although all the reasons for commitment were still there, his right to refuse treatment is producing such a disruptive effect that the state says, we would rather have one guy like this on the outside rather than have him on the inside, so to speak.

MR. COLE: The response is, they can't release them, but on the other hand, the police --

QUESTION: Why can't they?

QUESTION: Why can't they?

MR. COLE: Well, they would probably have to go to the committing court to ask for permission, but let me --

QUESTION: Well, what if the committing court gave them permission? Is there any constitutional argument against their doing it?

MR. COLE: No, absolutely not. Let me just mention that the individual who is wreaking havoc on the institution, the police power standing of the First Circuit takes care of that individual. If the risk of institutional security, if the doctor believes that it is affecting other patients, significantly deteriorating other patients, then the hospital can do that if there are no other alternatives. They can --

QUESTION: And restrain him

MR. COLE: Well, they can use medication to deal with that situation. That is correct, Your Honor.

QUESTION: Doesn't the doctor run some risk of being second-guessed in a 1983 action?

MR. COLE: If the doctor in good faith and honestly complies with the standard, they can make a mistake and still not be held liable. In the situation of this case --

QUESTION: They are still subject to a jury trial.

QUESTION: They may have to litigate forever.

MR. COLE: Well, Your Honor, that is a risk. However, an example of this situation was in our case, where the court, district court found the defendants violated the state seclusion statute, and knew or should have known that they violated it, but they were not held liable because the court said they couldn't have anticipated that they violated the statute, and even though they made a mistake, the court found that they were not liable.

So, we are not talking about a situation -- whatever standard we are going to use, whether or not -- if we are going to use a standard of that doctors can only treat when they think it is necessary, the doctors can be sued by patients if the patient believes it is not necessary. That is always the risk. Whatever the standard, as long as they act in good faith, even if they are mistaken, they can't be held liable.

Now, Massachusetts, dealing with malpractice, has a malpractice tribunal to deal with frivolous complaints and to screen them out, but --

QUESTION: Mr. Cole, can I ask you a question about the -- of course, this is a constitutional case. We are trying to decide what the Constitution requires Massachusetts to do, and if I understand you correctly, if

Massachusetts passed a statute and said that a commitment of this kind, even if accompanied by a finding that this kind of treatment may be in the best interest of the patient, and the finding specifically authorized the doctor to administer this treatment whenever it was found to be, after a full hearing and all the rest, in the best interest of the patient, he still couldn't -- that would be unconstitutional.

MR. COLE: Our belief is that that would be unconstitutional.

QUESTION: Because your standard is that as long as the individual is mentally competent to make the decision, he has a constitutional right to refuse, notwithstanding medical judgment that it would be in his best interest otherwise.

MR. COLE: Except in circumstances where the institutional security or --

QUESTION: I understand that. I am talking about the non-violent, the non-violent person but does have an illness of some kind that there is a reasonable difference of opinion on whether he could be cured, and a medical judgment, the state could not provide that the medical judgment would ever prevail over his will if he is intelligent enough to weigh the --

MR. COLE: That's correct. In fact, that is the procedure that the defendants -- the petitioners use in a

situation --

QUESTION: I just wanted to make it clear.

MR. COLE: -- in situations of electroshock and psychosurgery.

QUESTION: Mr. Cole, you have been talking about the right of patients in Massachusetts to refuse treatment. Does that right extend in your state to the right to die?

MR. COLE: You are asking whether or not the patients in the hospital --

QUESTION: Suppose a patient is in a condition that is terminal. The doctor so advises him, and says, we can keep you alive for another year or two or three by these treatments, and the patient says no, the illness is terminal, I have a right under Massachusetts law to refuse treatment. Is that the law of Massachusetts?

MR. COLE: Yes, that is the law of Massachusetts. The Secowitz case, which dealt with an institutionalized mentally retardive individual, was specifically that case.

QUESTION: The right to refuse treatment in Massachusetts includes the right to die?

MR. COLE: Well, it includes that the state does not have to use extraordinary -- in that case, it was a situation where whether or not the patient could refuse treatment that may extend their life a year, maybe two years, that they had a right to refuse that kind of

treatment.

QUESTION: Mr. Cole, would you clarify for me your position as to the constitutional right that may exist for the patient who is committed and who is incompetent by court finding?

MR. COLE: Our view is that this Court need not reach the constitutional issue because there is a state procedure that is available and the Supreme Judicial Court of Massachusetts in Roe says that that is the procedure to follow in that situation. Our view is that this Court should apply the state procedure dealing with that.

In terms of what we believe is constitutionally due, our view is that competency is a legal determination. It has been in every context in our society, including medical care. It has been in Massachusetts, certainly, both in the Secowitz case, Lane versus Candura, and the other cases we have cited, has always been a legal determination. Number one, we believe that even if state law didn't apply and require a competency proceeding, that constitutionally an individual would be required to have it, and once again, it emphasized the defendants follow that procedure for medical, surgical treatment, electroshock, and psychosurgery.

QUESTION: Do you know how many states have commitment laws that incorporate a finding of incompetence?

MR. COLE: I don't believe --

QUESTION: Or have the effect of incompetence by virtue of the commitment?

MR. COLE: I believe the American Psychiatric Association tries to indicate -- indicates in its brief that there are certain states -- I don't think there are a lot of states that have that finding, and they recognize that Massachusetts is not one of those states that actually have that finding in their brief.

QUESTION: What happens, laying aside for a moment the mental illness problem, what happens if a patient develops an attack which the hospital physician diagnoses as possible ruptured appendix that should be operated on immediately. Do they have to get the consent of the patient?

MR. COLE: No, Your Honor. That is an emergency situation, and the Attorney General of Massachusetts wrote an advisory opinion to the Department of Mental Health and said that surgery of individuals who are committed, that except for cases of an emergency, that you must get the consent of the individual in order to treat, so that would be just like we are saying, that there are emergency exceptions to the rule, but that the general rule is that when there is not that kind of an emergency, that the competent individual --

QUESTION: Well, competent. You have used that phrase so much, but how many of the people in this 10

percent are competent in the sense that they are capable of making the day to day decisions of life that presumably the rest of us outside are capable of making?

MR. COLE: The district court didn't give a number. What the district court said was that most patients who are involuntarily committed are competent to make that -- to weigh the risks and benefits.

QUESTION: Was there any expert testimony as to the percentage of serious schizophrenic patients who ever get well?

MR. COLE: I don't believe there was -- there was medical articles dealing with comparing patients who were on antipsychotic drugs versus not using antipsychotic drugs. But there wasn't any percentage of the number of patients --

QUESTION: Wouldn't it be very important for any -- if judges are going to get into this business, wouldn't it be important to know whether certain categories of mental illness are treatable and have any possibility of recovery and some are not? That is certainly known, isn't it?

MR. COLE: That's correct. There was testimony concerning the rate of improvement with antipsychotic drugs and without, dealing generally, not dealing with the particular wards here, in general, and it was -- for example, the chief of pharmacology of the Department of Mental Health testified that at most, 50 percent of

schizophrenic patients benefit from antipsychotic drugs, benefit, improve at all.

QUESTION: That is different from being cured.

MR. COLE: Improve at all. And in our brief we indicate what the different kinds of -- what improvement means, and that improving could be limited to the extent that someone may at that point be able to cloth himself. That is considered improvement, but as this doctor said, who was the chief psychopharmacologist, that approximately 50 percent of patients with schizophrenia improve at all on antipsychotic drugs.

QUESTION: Was there any expert testimony that pointed out that a great many patients who show improvement, not a cure, but an improvement in the protected environment of a hospital nevertheless are not subject to release because if they are out of that protected environment, with all the stresses of outside life, they would regress? Was there any testimony along that line?

MR. COLE: There was testimony concerning that, Your Honor, that even though someone may improve, it doesn't mean that they would be released necessarily. Improve in the limited sense that they would be released. Approximately 50 percent of the patients in this hospital were long-term patients, were long-term chronic patients. That was testified by one of the -- Dr. Gill, I believe,

that approximately 50 percent were long-term patients.

QUESTION: Mr. Cole, may I ask just one other question about your constitutional theory? I take it your claim of a constitutional liberty interest here is limited to the case in which there is this kind of very serious permanent damage? But you make the same claims, to the patient, assuming a competent and non-dangerous person, to refuse less severe treatment, such as flu shots or an exercise program or something he just didn't want to do. You wouldn't contend he had a --

MR. COLE: No. I think there is a distinction.

QUESTION: But a non-committed person would have a right to refuse those things, I suppose.

MR. COLE: Well, I think we are talking about a balancing test that this Court has used with institutions, and what we are saying is that situations which deal with conditions of confinement, that there is a different test than dealing with fundamental intrusions.

QUESTION: Used as non-punishment.

MR. COLE: Used as non-punishment, but that involve fundamental liberty interests. What we are saying is that it is --

QUESTION: For it to be a constitutional violation, are you taking the view that it has to be viewed as a form of punishment?

MR. COLE: No. Absolutely not, Your Honor.

QUESTION: What is the difference between what you object to and a man refusing flu shots?

MR. COLE: It is the significance of the intrusion. I am not saying that with a flu shot -- the fact is, the petitioners say that someone with a flu shot has the right to refuse in the hospital, so they do have.

QUESTION: Well, I am asking, is that what you are asking us to hold. Say he doesn't want to go on an exercise program, he is overweight or something.

MR. COLE: I think that would be termed a condition of confinement, where as long as there was a rational reason for the state to do that, that -- what I am trying to distinguish between those -- there is a balancing test in an institutional setting, and that when a treatment crosses the line, electroshock, psychosurgery, maybe antipsychotic drugs, cross that line --

QUESTION: Crosses what line?

MR. COLE: Crosses a line in terms of raising a fundamental liberty, a fundamental liberty interest. And our view is that wherever the line is going to be drawn in the future --

QUESTION: Well, I think it is a fundamental liberty interest if I don't want flu shots.

MR. COLE: The question is, it is a fundamental

liberty. The question is, does the state have the ability to override that in an institutional setting. That -- the analysis is, our view is that in a situation where it is so intrusive that the state in many situations doesn't have the legitimate interest to overcome that general right, we are saying there are certain other situations where the state may have that interest, but that is not as significant an intrusion as we have with antipsychotic drugs.

QUESTION: Mr. Cole, just give me in a word what you think the decision -- what is the name of the decision?

MR. COLE: In the matter of Guardianship of Richard Roe III.

QUESTION: In a word, what is the impact, if any, of that case on this one?

MR. COLE: Our view is that it disposes of this case under state law.

QUESTION: Because?

MR. COLE: Because the court attempted to analyze -- it is hard to say briefly. Under parens patriae the court said that the state does not have a parens patriae justification for forcibly drugging --

QUESTION: Just competent persons?

MR. COLE: That is correct.

QUESTION: It is a competent person, so that if a person is competent, the state foreswears any parens patriae

interest in treating him?

MR. COLE: That is correct.

QUESTION: Over his objection.

MR. COLE: Without an incompetency determination. Second of all, dealing with --

QUESTION: So that means that under state law necessarily you are going to have to sort out the competent from the incompetent.

MR. COLE: That's correct.

QUESTION: And that is exactly what you want done.

MR. COLE: That's correct.

QUESTION: And also if he is competent, that case provides exactly what you want done.

MR. COLE: That is correct. And secondly, in terms of the police power, what the Supreme Judicial Court said is, when drugs are used to protect safety, they are being used as a chemical restraint. The Massachusetts legislature and the Department of Mental Health have their regulations dealing with drugs when they are using restraints, when they are used for restraints.

QUESTION: Well, do you think we should -- did you move --

MR. COLE: Yes, we did. We filed a motion to --

QUESTION: To what, remand?

MR. COLE: To either --

QUESTION: Dismiss as moot?

MR. COLE: To either dismiss it or certify the questions to the Supreme Judicial Court --

QUESTION: What about -- perhaps the court of appeals ought to decide whether this case is mooted out by the decision of the Massachusetts court.

QUESTION: If you are right, we should vacate the judgment of the district court. You don't need it.

MR. COLE: Exactly.

QUESTION: Your judgment should be vacated.

MR. COLE: Well, before we do that --

(General laughter.)

MR. COLE: Before we do that, I would say that I think it is important that patients --

QUESTION: Well, if you mean what you say, that is exactly what we should do. That would be our normal practice, is to vacate the judgment and order the dismissal of the case.

MR. COLE: Well, I think that there is sufficient uncertainty about the police power situation, and the problem is, the case said, it was talking about institutionalized. It talked specifically about the Rogers case for institutionalized.

QUESTION: Well, perhaps we should vacate the judgment in the court of appeals and send it back to the

court of appeals to decide whether there is anything left of the case or not.

MR. COLE: Our view is that it would be appropriate to certify certain questions to the Supreme Judicial Court.

QUESTION: Should we do that or should the court of appeals do that?

MR. COLE: Well, we feel as a matter of judicial economy, this case has been going on for seven years.

QUESTION: I mean certification. We may, of course, under Blotty, we may certify.

MR. COLE: That's right. The Court has in the past. We --

QUESTION: Why should we? Why shouldn't we leave that to the court of appeals? You say there is some uncertainty about the police power aspect.

MR. COLE: That's correct. Because we believe that as a matter of judicial economy, it would be faster, so we don't have to come back up if in fact there is any issue left open.

QUESTION: Well, except that perhaps the court of appeals could do a better job of it than we can.

MR. COLE: And you won't have to travel this far.

(General laughter.)

QUESTION: Certainly the Roe case is factually distinguishable from this in the sense that it involved

non-institutionalized patients. Am I not correct?

MR. COLE: That's correct, though it did discuss the rights of institutionalized in the context of that decision, and that is the confusion that is part of the case, and while -- we felt that it could be certified questions to the Judicial Supreme Court and get clarity about which way -- whether or not those -- the state law applies.

QUESTION: Do I correctly get from your position that if judges are going to be running your institution, you would rather have Massachusetts judges doing it? Is that right?

(General laughter.)

MR. COLE: We believe that Massachusetts has a system to deal with this situation after Roe. Now, prior to Roe there wasn't any clarity about what the rights were, and the fact is that both parties here intervened in Roe and were a party in Roe.

QUESTION: What was your motion filed here?

MR. COLE: A motion to either dismiss or to certify questions to the Supreme Judicial Court to clarify these issues.

QUESTION: So if we granted your motion to dismiss, it would be on the grounds of mootness, wouldn't it?

MR. COLE: That's correct.

QUESTION: So you don't want us to grant your motion.

MR. COLE: No, we believe that you could -- we still hold to that. My understanding is that it has been denied.

QUESTION: That it is moot?

QUESTION: Do you think the case is moot?

MR. COLE: Well, as I said, I --

QUESTION: Because then that is the end of the lawsuit. That satisfies everything.

MR. COLE: We would -- what we would ask for is this Court to certify --

QUESTION: Do you think the case is moot?

MR. COLE: I --

QUESTION: Your motion was to dismiss as moot.

MR. COLE: I suppose -- That is correct, Your Honor, but I would say that what we are interested in is more certification.

QUESTION: Do you think it is moot?

MR. COLE: I would say that it is too confusing to know whether or not it is moot at this time. Seriously, it is based on the Supreme Judicial Court opinion. What we would have to do then --

QUESTION: You don't know whether it is moot.

MR. COLE: We don't know. That is correct.

QUESTION: So you withdraw your motion?

MR. COLE: We withdraw that part of the motion, Your Honor, I suppose, and ask that the questions be certified.

Thank you.

CHIEF JUSTICE BURGER: Mr. Schultz, you have five minutes remaining.

ORAL ARGUMENT OF STEPHEN SCHULTZ, ESQ.,

ON BEHALF OF THE PETITIONERS - REBUTTAL

MR. SCHULTZ: I would like to briefly discuss the significance of the Roe case, because there simply is none, and I just want to make it clear that this case should not be vacated and should not be certified. In Roe, the court --

QUESTION: Should it be affirmed?

MR. SCHULTZ: Excuse me? No, it should not be affirmed either, in our view.

(General laughter.)

MR. SCHULTZ: I started today by saying there were two fundamental issues in this case. The first issue is, what does it mean when you are committed for treatment. Does that necessarily act as a sufficient predicate for the later treatment against a person's will. I said the second fundamental issue in this case is, what is the effect on the hospital of allowing some patients to remain in the hospital

refusing treatment?

Well, Roe simply didn't say, we are not discussing institutionalized patients. They specifically said one thing we are not going to discuss is what is the effect and what does it mean that you have already had a commitment hearing, and what does that allow the state to do? That was my first fundamental issue that they say in a footnote, we are not discussing.

The second fundamental issue is, they say the one thing we are not going to discuss is, what is the effect on the institution if you allow people to refuse treatment?

Certification makes absolutely no sense for answering these kinds of questions. There is no way --

QUESTION: Well, is it possible -- I am sorry. Is it possible that although they haven't squarely decided it, that Massachusetts law might require the very procedures that the court of appeals has ordered? Do we know that Massachusetts law does not require these procedures?

MR. SCHULTZ: Massachusetts law is constitutional law, is all I can tell you. The Roe decision --

QUESTION: Did Roe rest on the United States Constitution at all?

MR. SCHULTZ: Excuse me?

QUESTION: Did the Roe decision rest on --

MR. SCHULTZ: Roe turns on the United States

Constitution.

QUESTION: Did it rest on it?

MR. SCHULTZ: Excuse me?

QUESTION: Did the Supreme Judicial Court rest the decision on it?

MR. SCHULTZ: In our opinion, yes. They say --

QUESTION: On what provision of the federal Constitution?

MR. SCHULTZ: On the -- I believe they hit the right to privacy, and I don't know if they tied it to the Ninth or the Fourteenth Amendment. In Roe, they said there are three factors that they are deciding that case on. They said, on the Constitution, on the power over guardians. Now, certainly that is not relevant in this case, because we are discussing whether or not a guardian has to be appointed in the first place. And then they said, on the common law, and quoted one New York case for the common law talking about what are basic liberty interests, which is the exact same question you would ask as to what constitutionally under the Fourteenth Amendment is a basic liberty interest.

Roe is a constitutional case. Roe doesn't decide on any statutes or on any Massachusetts regulations. It is a constitutional case which is reviewable by this Court, which didn't have the record that this Court has to decide what is the effect on an institution of allowing patients to

refuse treatment.

If one were to certify, one would have to send down the entire 74-day record, and have the SJC look at that record to decide what the effect on institutions would be.

QUESTION: Didn't Roe expressly disavow any intent to decide an involuntarily committed patient's right to refuse medication?

MR. SCHULTZ: Absolutely. They say it four times, and why -- the other side is saying it is definitive, but if a court ever went -- they are right, we intervened in Roe, and what did the Commonwealth do when they intervened in Roe? We said, don't interfere with this case. This case -- Roe does not involve institutionalized patients, and I wrote half of my brief saying don't interfere with this case. And they bought it. Four times in their opinions, they say, we are not interfering with the Rogers case. And I just don't know how it could be any clearer under the circumstances.

I briefly want to mention just, I think, a very basic issue that Justice O'Connor raised, and that is, how many states determine incompetency at the time of commitment? According to the psychiatric brief, they state one, and I will take it as true. Utah. And what the Commonwealth asks is, if you have to determine competency to treat a person against his will, why can you commit that person against his will for treatment without that same

determination of incompetency? And what is really being challenged in this case is the commitments in those 49 states, because those people were not committed for dangerousness. You can't commit anybody because he is dangerous. That is preventive detention.

They were committed because they were dangerous by reason of mental illness, which the mental illness means they are either subject to care or treatment. We don't necessarily say everybody is treatable, but we are saying that to the extent that they are treatable, that that is why they were committed. Dangerous by reason of mental illness. Not dangerousness. It doesn't make sense to talk about police power commitments, to say that the state's interest is satisfied when they are taken off the street. The state's interest is not taking people off the street. The state cannot go around saying, you are dangerous, you are dangerous, you are dangerous, you should go off the street.

They have to show beyond a reasonable doubt in Massachusetts that they are dangerous by reason of mental illness, or that they are incapable of taking care of themselves by reason of mental illness. The state can't send somebody to a mental hospital simply because they are incapable of taking care of themselves. I think the parens patriae power might let them send them some place else, but

why are they sent to a mental hospital? Because they are mentally ill, and we suggest that this is a fundamental question which has been overlooked by both lower courts.

Thank you very much.

CHIEF JUSTICE BURGER: Thank you, gentlemen. The case is submitted.

(Whereupon, at 2:30 o'clock p.m., the case in the above-entitled matter was submitted.)

CERTIFICATION

Alderson Reporting Company, Inc. hereby certifies that the attached pages represent an accurate transcription of electronic sound recording of the oral argument before the Supreme Court of the United States in the matter of:

MARK J. MILLS ET AL., v. RUBIE ROGERS ET AL NO. 80-1417

---

and that these pages constitute the original transcript of the proceedings for the records of the Court.

BY Sharon Piper Connelly