

Legal Rights of Medical Patients in Massachusetts

Copyright 2012 by Ronald B. Standler

No copyright claimed for works of the U.S. Government.

No copyright claimed for quotations from any source, except for selection of such quotations.

Keywords

antipsychotic, electroconvulsive, informed consent, health, law, legal, lobotomy, Massachusetts, medical, medication, mental, patient, patient's, patients', refuse, right, rights, statutes, surgery, therapy, treatment

Table of Contents

Introduction	2
disclaimer	3
General Rights (Ch.111, §70E)	3
only hospitals and clinics	4
first bundle	5
female rape victim	7
second bundle	7
breast cancer	8
breast implant	8
maternity patient	8
victims of sexual assault	9
my comments	10
Rights for Specific Situations	13
records (Ch. 111, §70)	13
HIV test confidentiality (Ch.111, §70F)	14
in-vitro fertilization (Ch.111L, §4)	14
tuberculosis (Ch.111, §94C)	15
reporting some injuries (Ch.112)	17
STDs (§12)	17
reporting treatment of wounds, burns, overdose (§12A)	17
reporting treatment of victim of rape or sexual assault (§12A 1/2)	18
reporting communicable diseases	18
Mental Health	18

involuntary commitment (Ch.123, §5)	18
legal capacity of mental patients (Ch.123, §24)	19
consent to antipsychotic medication (Ch.123, §8B)	19
restraints (Ch. 123, §21)	22
mental health rights (Ch.123, §23)	23
defects in § 23	25
right to see psychotherapy record (Ch. 112, § 12CC)	27
duty to warn potential victims of mental patient (Ch.123, §36B)	28
Massachusetts Right-to-Refuse Medical Treatment	29
informed consent	30
nondisclosure	32
Massachusetts End-of-Life Cases	33
Conclusion	34

Introduction

In July 2012, I did a search of Massachusetts statutes for the right of mentally competent adult patients to refuse medical treatment. I was aghast to find a disorganized collection of statutes, parts of which were redundant, other parts of which are *inadequate* to protect patients. In addition to searching Massachusetts statutes and Massachusetts judicial opinions, I also made a quick search of medical literature and law review articles, to give some legislative history.

This essay includes quotations from statutes and citations to judicial opinions involving rights of *adult* medical patients in Massachusetts. The scope of this essay covers *neither* children, inmates of prisons, drug rehabilitation, sexual offenders, health insurance, *nor* retarded people.

This essay may be of interest to three different groups of people: (1) patients in Massachusetts who want to know their legal rights, (2) physicians and medical students in Massachusetts who want more detail about their legal obligations, and (3) legislators nationwide who look at Massachusetts as the first state to adopt patients' rights in a statute.

I emphasize that the statutes in this essay are *not* a complete list of the statutes regulating the practice of medicine in Massachusetts — this essay is *only* concerned with the legal rights of adult patients.

disclaimer

This essay presents general information about an interesting topic in law, but is *not* legal advice for your specific problem. See my disclaimer at <http://www.rbs2.com/disclaim.htm> . Using my essay as a source of free legal advice on your personal problem is *not* appropriate, for reasons given at <http://www.rbs2.com/advice.htm> .

The statutes quoted in this essay were current on 16-18 July 2012. The Massachusetts legislature can amend these statutes at any time, so readers should check the current version of the statute, instead of relying on what is quoted in this essay. Furthermore, I have omitted parts of statutes that are irrelevant to patients' rights. In this essay, my text is set in 12-point Times Roman font, while quotations from a statute are in an 11-point sans serif font.

I have used the following search queries in the Westlaw database for Massachusetts statutes:

```
("informed consent" right) /p (medical mental surg!) /p treatment
```

```
"informed consent" /p (medic! treatment surg!)
```

```
right /p (refus! reject! declin!) /p (medic! surg! mental)
```

I list the cases in chronological order in this essay, so the reader can easily follow the historical development of a national phenomenon. If I were writing a legal brief, then I would use the conventional citation order given in the *Bluebook*.

General Rights (Ch.111, §70E)

In 1979, Massachusetts passed a comprehensive “bill of rights” for medical patients in hospitals and clinics, which was the first statute of this type in the USA.

Massachusetts General Laws, Chapter 111, § 70E contains two bundles of patient's rights. This is a difficult statute to read and cite, because the individual paragraphs are *not* identified by letters or numbers, except for the first bundle or rights is (a) to (o), and the second bundle of rights is (a) to (h), plus three paragraphs. Further, the same right is not consistently labeled in the two bundles, e.g., informed consent is (l) in the first bundle and (a) in the second bundle. Style manuals for legal documents assign lower-case letters for the first-level subsection (typically a paragraph), which style has been violated by the authors of § 70E. I have inserted paragraph numbers in brackets at the beginning of each paragraph at the left margin.

only hospitals and clinics

- [¶1] As used in this section, “facility” shall mean
- any hospital, institution for the care of unwed mothers, clinic, infirmary maintained in a town, convalescent or nursing home, rest home, or charitable home for the aged, licensed or subject to licensing by the department [of Public Health];¹
 - any state hospital operated by the department;
 - any “facility” as defined in section three of chapter one hundred and eleven B;²
 - any private, county or municipal facility, department or ward which is licensed or subject to licensing by the department of mental health pursuant to section nineteen of chapter nineteen;³ or by the department of developmental services pursuant to section fifteen of chapter nineteen B;⁴
 - any “facility” as defined in section one of chapter one hundred and twenty-three;⁵
 - the Soldiers Home in Holyoke, the Soldiers' Home in Massachusetts; and

¹ Footnote by Standler. Bracketed material found in *Cohen v. Bolduc*, 760 N.E.2d 714, 720, n.22 (Mass. 2002).

² Footnote by Standler. Ch. 111B, §3 (current July 2012) “a convalescent or nursing home, rest home, infirmary maintained in a town, or a charitable home for the aged”.

³ Footnote by Standler. Ch. 19, §19 (current July 2012) “residential or day care services” that treat mental illness.

⁴ Footnote by Standler. Ch. 19B, §15 (current July 2012) “any private, county or municipal facility or department or ward of any such facility which offers to the public residential or day care services and is represented as providing [either care or] treatment of persons with an intellectual disability,”

⁵ Footnote by Standler. Ch. 123, §1 (current July 2012) “‘Facility’, a public or private facility for the care and treatment of mentally ill persons, except for the Bridgewater State Hospital.”

- any facility set forth in section one of chapter nineteen⁶ or section one of chapter nineteen B.⁷

Massachusetts General Laws, Chapter 111, § 70E (enacted 1979, current 15 July 2012) (formatting added by Standler).

Notice that § 70E does *not* apply to a physician's private office, where that physician is in solo practice or in a small group practice. The statute applies only to hospitals, clinics, convalescent or nursing homes, each of which is licensed by Massachusetts government.

The word "clinic" is *not* defined in this statute, but *may* refer to a medical office building in which the physicians are employees of the owner of the building (e.g., a health-maintenance organization, hospital, or university). See Massachusetts General Laws, Chapter 69, Appendix § 2-3(e) ("teaching hospital and associated clinics"); Chapter 112, § 9(3) ("... in a clinic which is affiliated with a hospital licensed by the department of public health").

first bundle

The first bundle says:

- [¶5] Every patient or resident of a facility [i.e., hospital, nursing home, clinic, etc.] shall have the right:
- (a) upon request, to obtain from the facility [i.e., hospital, nursing home, clinic, etc.] in charge of his care the name and specialty, if any, of the physician or other person responsible for his care or the coordination of his care;
 - (b) to confidentiality of all records and communications to the extent provided by law;
 - (c) to have all reasonable requests responded to promptly and adequately within the capacity of the facility;
 - (d) upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution insofar as said relationship relates to his care or treatment;

⁶ Footnote by Standler. Ch. 19, §1 (current July 2012) created department of mental health, "primary mission of the department shall be to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness".

⁷ Footnote by Standler. Ch. 19B, §1 (current July 2012) created department of developmental services, "The department shall have supervision and control of all public facilities for persons with an intellectual disability...."

- (e) to obtain from a person designated by the facility a copy of any rules or regulations of the facility which apply to his conduct as a patient or resident;
- (f) upon request, to receive from a person designated by the facility any information which the facility has available relative to financial assistance and free health care;
- (g) upon request, to inspect his medical records and to receive a copy thereof in accordance with section seventy, and the fee for said copy shall be determined by the rate of copying expenses, except that no fee shall be charged to any applicant, beneficiary or individual representing said applicant or beneficiary for furnishing a medical record if the record is requested for the purpose of supporting a claim or appeal under any provision of the Social Security Act or federal or state financial needs-based benefit program, and the facility shall furnish a medical record requested pursuant to a claim or appeal under any provision of the Social Security Act or any federal or state financial needs-based benefit program within thirty days of the request; provided, however, that any person for whom no fee shall be charged shall present reasonable documentation at the time of such records request that the purpose of said request is to support a claim or appeal under any provision of the Social Security Act or any federal or state financial needs-based benefit program;
- (h) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention;
- (i) to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;
- (j) to privacy during medical treatment or other rendering of care within the capacity of the facility;
- (k) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit;
- (l) to informed consent to the extent provided by law;
- (m) upon request to receive a copy of an itemized bill or other statement of charges submitted to any third party by the facility for care of the patient or resident and to have a copy of said itemized bill or statement sent to the attending physician of the patient or resident;

(n) if refused treatment because of economic status or the lack of a source of payment, to prompt and safe transfer to a facility which agrees to receive and treat such patient. Said facility refusing to treat such patient shall be responsible for: ascertaining that the patient may be safely transferred; contacting a facility willing to treat such patient; arranging the transportation; accompanying the patient with necessary and appropriate professional staff to assist in the safety and comfort of the transfer, assure that the receiving facility assumes the necessary care promptly, and provide pertinent medical information about the patient's condition; and maintaining records of the foregoing; and

(o) if the patient is a female rape victim of childbearing age, to receive medically and factually accurate written information prepared by the commissioner of public health about emergency contraception; to be promptly offered emergency contraception; and to be provided with emergency contraception upon request.

Massachusetts General Laws, Chapter 111, § 70E (enacted 1979, current 15 July 2012).

second bundle

The second bundle of rights says:

- [¶6] Every patient or resident of a facility [i.e., hospital, nursing home, clinic, etc.] shall be provided by the physician in the facility the right:
- (a) to informed consent to the extent provided by law;
 - (b) to privacy during medical treatment or other rendering of care within the capacity of the facility;
 - (c) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological or other medical care and attention;
 - (d) to refuse to serve as a research subject, and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;
 - (e) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of source of payment unless such delay can be imposed without material risk to his health;
 - (f) upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institutions insofar as said relationship relates to his care or treatment, and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities insofar as said ownership relates to the care or treatment of said patient or resident;

(g) upon request to receive an itemized bill including third party reimbursements paid toward said bill, regardless of the sources of payment;

(h) in the case of a patient suffering from any form of breast cancer, to complete information on all alternative treatments which are medically viable.

[¶7] Except in cases of emergency surgery, at least ten days before a physician operates on a patient to insert a breast implant, the physician shall inform the patient of the disadvantages and risks associated with breast implantation. The information shall include, but not be limited to, the standardized written summary provided by the department. The patient shall sign a statement provided by the department acknowledging the receipt of said standardized written summary. Nothing herein shall be construed as causing any liability of the department due to any action or omission by said department relative to the information provided pursuant to this paragraph. The department of public health shall:⁸

(1) develop a standardized written summary, as set forth in this paragraph in layman's language that discloses side effects, warnings, and cautions for a breast implantation operation within three months of the date of enactment of this act;

(2) update as necessary the standardized written summary;

(3) distribute the standardized written summary to each hospital, clinic, and physician's office and any other facility that performs breast implants; and

(4) provide the physician inserting the breast implant with a statement to be signed by the patient acknowledging receipt of the standardized written summary.

[¶8] Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian sections, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery or labor-delivery-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which were continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinal, epidurals and general anesthesia, and

⁸ Footnote by Standler. This paragraph on breast implants added by Massachusetts Laws 1993, chapt. 110, § 146 (19 June 1993).

its annual percentage of women breast-feeding upon discharge from said hospital.⁹

[¶9] Every facility shall require all persons who provide care to victims of sexual assault to be provided with medically and factually accurate written information prepared by the commissioner about emergency contraception. Every female rape victim of childbearing age who presents at a facility after a rape shall promptly be provided with medically and factually accurate written information prepared by the commissioner about emergency contraception. Facilities that provide emergency care shall promptly offer emergency contraception at the facility to each female rape victim of childbearing age, and shall initiate emergency contraception upon her request. For each facility initiating emergency contraception, the administrator, manager or other person in charge thereof shall annually report to the department of public health the number of times emergency contraception is administered to victims of rape under this section. Reports made pursuant to this section shall not identify any individual patient, shall be confidential and shall not be public records as defined by clause twenty-sixth of section 7 of chapter 4. The department of public health shall promulgate regulations to carry out this annual reporting requirement.¹⁰

[¶10] A facility shall require all persons, including students, who examine, observe or treat a patient or resident of such facility to wear an identification badge which readily discloses the first name, licensure status, if any, and staff position of the person so examining, observing or treating a patient or resident; provided, however, that for the purposes of this paragraph, the word facility shall not include a community day and residential setting licensed or operated by the department of developmental services.¹¹

Massachusetts General Laws, Chapter 111, § 70E (enacted 1979, current 15 July 2012).

Violation of any of these patient rights is medical malpractice.¹²

⁹ Footnote by Standler. This paragraph on maternity patients revised by Massachusetts Acts 1987, chapt. 480, § 2 (10 Nov 1987); replaced by Massachusetts Acts 1989, chapt. 155 (19 June 1989).

¹⁰ Footnote by Standler. This paragraph on emergency contraception added by Massachusetts Acts 2005, chapt. 91, §§ 3, 4 (19 Sep 2005).

¹¹ Footnote by Standler. This paragraph on identification badges added by Massachusetts Laws 1996, chapt. 445 (24 Dec 1996).

¹² See part of §70E not quoted above: “[¶] Any person whose rights under this section are violated may bring, in addition to any other action allowed by law or regulation, a civil action under sections sixty B to sixty E, inclusive, of chapter two hundred and thirty-one.” Chapter 231, §60B to §60E, is the Massachusetts medical malpractice statute.

my comments

Notice in § 70E that breast cancer patients, recipients of breast implants, maternity patients, and female rape victims get *more specific* informed consent than other patients. I suggest this result is the result of two independent causes: (1) failure of physicians to provide adequate information about alternative treatments and (2) lobbying of the legislature by feminist groups.

For example, breast cancer was traditionally (before the 1970s) treated by radical mastectomy, because surgeons believed that treatment offered the best chance of survival. Later, it became known that less disfiguring surgery could provide equally good chances of survival in some patients.¹³

For example, silicone gel breast implants became available in 1962. Some of the implants leaked silicone into women's bodies, allegedly causing systemic problems.¹⁴ Because of lack of evidence of safety, in 1992, the U.S. Government's Food and Drug Administration temporarily stopped sales of silicone implants in the USA.¹⁵

As a third example, some physicians refused to give female rape victims information about the availability of emergency contraception (e.g., the morning-after pill), because some physicians believed that life began at conception and emergency contraception was therefore a kind of abortion, which was prohibited by the physician's religion. This failure to provide the information, and also to fail to refer to a colleague who would provide the information, was an appalling breach of the physician's fiduciary duty to the patient.

Each of the major hospitals in the Boston area has a webpage on patients' rights.¹⁶ Some of these webpages may contain promises on which patients can justifiably rely in choosing a hospital, in addition to the legal rights in § 70E.

¹³ George J. Annas, "Breast Cancer: the treatment of choice," 10 HASTINGS CENTER REPORT 27 (April 1980); Susan G. Nayfield, G.C. Bongiovanni, M.H. Alciati, R.A. Fischer, L. Bergner, "Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives," 86 JOURNAL OF THE NATIONAL CANCER INSTITUTE 1202 (17 Aug 1994); Rachel Andersen-Watts, "The Failure of Breast Cancer Informed Consent Statutes," 14 MICHIGAN JOURNAL GENDER & LAW 201 (2008).

¹⁴ See, e.g., Marcia Angell, "Shattuck Lecture — Evaluating the health risks of breast implants," 334 New England Journal of Medicine 1513 (6 June 1996); Jack W. Snyder, "Silicone Breast Implants," 18 JOURNAL OF LEGAL MEDICINE 133 (June 1997).

¹⁵ David A. Kessler, 326 NEW ENGLAND JOURNAL OF MEDICINE 1713 (18 June 1992).

¹⁶ See my list of links at: <http://www.rbs2.com/prmlinks.htm> .

I searched in medical journals for commentary during the late 1970s on the development and enactment of the Massachusetts patients' rights statute, to get more information on the reasons and history. In 1975, the Massachusetts Medical Society published a position paper opposing the draft statute on patients' rights.¹⁷ Alan Meisel, a law professor at the University of Pittsburgh and a nationally known expert on health law, replied:

The authors of the position paper of the Massachusetts Medical Society in criticizing the Massachusetts Patients' Bill of Rights [citation omitted] completely overlook a basic fact: that the medical profession exists to provide succor to the ill and injured. Like so many criticisms of efforts — whether judicial, legislative, regulatory, or nongovernmental — to assure that patients obtain medical services as if they were suffering human beings rather than pieces of machinery on an assembly line, the position paper starts with the assumption, though admittedly unarticulated, that patients exist to satisfy the needs of the medical profession to exercise their art.

If physicians were providing medical care to patients in a satisfactory manner — and what is satisfactory must be judged in large part from the patient's perspective if the medical profession truly exists to serve the patient, and not vice-versa — we would not be witnessing the proliferation of legislation, regulation, and lawsuits that have been common in the last decade. The point is that recognition is finally being given to the fact that professions (and commerce and industry) exist to serve people, rather than the other way around.

Professional, heal thyself.

Alan Meisel, "Lawyers, Doctors and Patient Rights," 294 NEW ENGLAND JOURNAL OF MEDICINE 282-283 (29 Jan 1976). Unfortunately, I see a huge discontinuity between the views on informed consent in (1) the medical profession and (2) judges and lawyers. One can expect more government regulation of the medical profession, as a frustrated society attempts to get respect and informed consent from physicians. This essay is not the place to discuss *why* physicians have been resistant to informed consent, but I am not optimistic that enacting a patients' rights statute will change the attitude of physicians. A patients' rights statute will certainly *not* change the shortage of physicians, which underlies brief visits and lack of opportunity to communicate.

When the Massachusetts statute § 70E was passed in 1979, William J. Curran, a law professor at Harvard Medical School, wrote in the NEW ENGLAND JOURNAL OF MEDICINE about this new statute. I wish he had explained to physicians *why* the statute was enacted. The closest he comes to informing physicians of *why* is his final paragraph:

One last point: I have not discussed the alleged reason for passage of a law such as this. Most commonly it is said that the act is an affirmation of growing consumer power and of public-disclosure laws. However, those who direct more biting criticism toward hospitals and doctors may say that the time has come to change hospitals from remote citadels ruled by kings and knights in white armor to more commonplace community facilities where the language is understandable to patients and families and their concerns prevail over unnecessary and repressive technical or managerial interests. I am sure that today's

¹⁷ "Position of the Massachusetts Medical Society with respect to Senate Bill No. 1948," 293 NEW ENGLAND JOURNAL OF MEDICINE 828 (16 Oct 1975). Some of this Position was written by anonymous lawyers, because four U.S. Supreme Court cases are cited and the arguments are legalistic. See George J. Annas, Letter, 294 NEW ENGLAND JOURNAL OF MEDICINE 283 (29 Jan 1976) ("This critique was prepared entirely by lawyers and uses only legal arguments.").

physicians will support the objectives of this act in the interest of improved patient care, even though they, along with other professionals, may occasionally reminisce about the days before medical practice was so regulated.

William J. Curran, “Law-Medicine Notes — Massachusetts Patients’ Bill of Rights: Cabbages, Kings, Sausages and Laws,” 301 NEW ENGLAND JOURNAL OF MEDICINE 1433, 1434 (27 Dec 1979). Curran was amazingly vague, in apparently trying to avoid offending physicians who subscribe to the JOURNAL. In his first sentence, he says “alleged reason” instead of the plural “reasons”. There are many different reasons why the public was dissatisfied with delivery of health care by hospitals and physicians. His second sentence says unknown sources suggest “consumer power”, when judicial opinions speak of “informed consent” as necessary for “human dignity”.¹⁸ His third sentence comes closer to the Truth, but is marred with the imagery of “kings and knights in white armor”. The vague phrase “unnecessary and repressive technical or managerial interests” should have been something plainer — specifically mentioning lack of informed consent, fraudulent concealment of mistakes, treating patients as defective appliances on an assembly line¹⁹ (see Prof. Meisel’s 1976 letter, above), If physicians are to change their behavior, they first need to understand *why* the old, paternalistic physician-patient relationship is obsolete and *unsatisfactory*.

George J. Annas, a professor of law at Boston University Medical School, has written a detailed explanation of why § 70E contains specific informed consent for breast cancer treatments. A patient received a presumptive diagnosis of breast cancer and her physician “insisted she check into the hospital immediately for a biopsy and possible radical mastectomy.” The physician refused to provide informed consent, refused to postpone for one week to give the patient time to think, and refused to refer the patient to a surgeon who would provide informed consent. This extraordinary patient went to a medical school library and obtained her own information. She found a surgeon who performed a lumpectomy. Then she contacted a Massachusetts State Senator to introduce legislation to prevent other women from having her experience. George J. Annas, “Breast Cancer: the treatment of choice,” 10 HASTINGS CENTER REPORT 27, 27-28 (April 1980). This story makes clear that some of the current regulation of physicians is the result of past abuse of patients by physicians.

¹⁸ *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 427 (Mass. 1977) (“human dignity” requires that a patient be able to refuse medical treatment). See also *Thor v. Superior Court*, 855 P.2d 375, 382 (Cal. 1993) (“This value reflects our society’s long-standing tradition of recognizing the unique worth of the individual. We respect human dignity by granting individuals the freedom to make choices in accordance with their own values. The principle of autonomy is the moral basis for the legal doctrine of informed consent, which includes the right of informed refusal.” quoting with approval Hastings Center Report, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying (1987) p. 7); *In re Gardner*, 534 A.2d 947, 950 (Me. 1987) (same).

¹⁹ Mostly, I am thinking of brief — sometimes only a minute or two — visits of a physician to a patient’s hospital room, and not taking the time to communicate with patients. The same perfunctory observations commonly occur in physician’s offices, which produces a hasty, and possibly erroneous, diagnosis and treatment.

Rights for Specific Situations

records (Ch. 111, §70)

The Massachusetts statute about hospital records says:

... such records and similar records kept by the hospital or clinic, except a hospital or clinic under the control of the department of mental health,²⁰ may be inspected by the patient to whom they relate, the patient's attorney upon delivery of a written authorization from said patient, the duly appointed executor or administrator of the deceased person's estate or the attorney for such executor or administrator upon delivery of a written authorization from such executor or administrator, and a copy shall be furnished upon the request and a payment of a reasonable fee, which for the purposes of this section shall mean a base charge of not more than \$15 for each request for a hospital or clinic medical record; a per page charge of not more than \$0.50 for each of the first 100 pages of a hospital or clinic medical record that is copied per request; and not more than \$0.25 per page for each page in excess of 100 pages of a hospital or clinic medical record that is copied per request, Any such record or any part or portion thereof may be destroyed [by the health-care provider, hospital, or clinic] 20 years after the discharge or the final treatment therein of the patient to whom it relates.

The reasonable fee under this section may be adjusted to reflect the consumer price index for medical care services, such that the base amount and the per page charge shall be increased by the proportional consumer price index in effect as of October of the calendar year in which the request is made, rounded to the nearest dollar. A hospital or clinic may also charge an additional fee to cover the cost of postage, other priority mailing and preparation of an explanation or summary of the hospital or clinic medical record if so requested.

Massachusetts General Law, chapter 111, § 70 (current July 2012). The charge for copying the record was enacted in 2003 and increases annually.

In 1986, a baby suffered neonatal sepsis and meningitis within five hours of his birth, causing permanent brain damage. The hospital “lost” the relevant medical records for 18 hours of treatment and observation, including the results of blood cultures and initial treatment (if any) with antibiotics. In considering the hospital’s spoliation of essential evidence, the court noted the statutory duty to keep records. *Keene v. Brigham and Women's Hospital*, 786 N.E.2d 824, 833-835 (Mass. 2003) (“... we conclude that the [trial] judge was within his authority in ordering the sanction of default on the issue of liability.”).

²⁰ Footnote by Standler: for mental health records, see page 27, below.

HIV test confidentiality (Ch.111, §70F)

Confidentiality of test for antibodies to human T-cell lymphotropic virus type III.

No health care facility, as defined in section seventy E, and no physician or health care provider shall (1) test any person for the presence of the HTLV-III antibody or antigen without first obtaining his written informed consent; (2) disclose the results of such test to any person other than the subject thereof without first obtaining the subject's written informed consent; or (3) identify the subject of such tests to any person without first obtaining the subject's written informed consent.

Massachusetts General Law, Chapter 111, § 70F (enacted 1986, current July 2012).

Commonwealth, v. Luis W. Ortiz, Not Reported in N.E.2d, 2001 WL 34129741 (Mass. 2001) (Sosman, J.) (“As worded, § 70F provides absolute confidentiality for HIV testing.”).

in-vitro fertilization (Ch.111L, §4)

(a) A physician or other health care provider who provides a patient with in vitro fertilization therapy shall provide the patient with timely, relevant and appropriate information sufficient to allow that patient to make an informed and voluntary choice regarding the disposition of any pre-implantation embryos or gametes remaining following treatment. The physician shall present the patient with the options of storing, donating to another person, donating for research purposes or otherwise disposing of or destroying any unused pre-implantation embryos, as appropriate. The department shall prescribe and provide for use by physicians and other health care providers who treat patients for infertility through in vitro or any other process where an egg is extracted from a woman the following 2 documents, in multiple languages as determined by the department:

(1) an informational pamphlet, describing the procedure by which an egg is extracted from the patient, including all short and long-term potential health impacts of the procedure on the patient, any drugs or devices to be used, including whether they have received approval from the United States Food and Drug Administration, the risks involved, any discomfort and side effects that may be experienced, any alternatives which the patient may have and their attendant risks and benefits, medical treatment available to the patient should complications arise, and that the particular treatment may involve currently unforeseeable risks to the patient, embryo or fetus. A physician or other health care provider treating a woman with a procedure by which an egg is intended to be extracted shall provide the patient with this pamphlet or a legible copy thereof, and provide any other treatment information which may be specific to the patient's treatment; and

(2) an informed consent form, stating that the patient has been given and has reviewed and understands the informational pamphlet described in clause (1), has consulted with her physician or health care provider concerning the general procedures and her specific medical situation, and understanding the procedure, process and risks, consents to proceed with the procedure or process. The informed consent form shall also contain a "Notes" section, to be completed by the physician or health care provider. This notes section shall contain any medical information, alternative procedures, medicines, devices, considerations or risks relevant to the specific patient's informed consent to proceed and shall be completed by the physician or health care provider in each case. A physician or other health care provider treating a woman by a procedure by which an egg is intended to be extracted shall provide the patient with this form or a legible copy thereof, and shall keep a signed copy of this document in the patient's medical file.

(b) No physician or other health care provider shall provide this treatment before providing the patient with both the informational pamphlet and the informed consent form and without receiving, in return, a complete and fully executed informed consent form from the patient. A physician or other health care provider shall seek such informed consent only under circumstances that provide the prospective patient reasonable opportunity to consider whether or not to receive such treatment and that minimize the possibility of coercion or undue influence. The information that is given to the patient shall be in language understandable to the patient.

Massachusetts General Law, Chapter 111L, § 4 (enacted 2005, current July 2012).

The last sentence of § 4(b) puts the entire burden of understanding on the physician, regardless of the intellectual level of the patient. The legislature ignored the possibility — the desirability — that the patient read library books to increase the patient's ability to comprehend technical medical information.

tuberculosis (Ch.111, §94C)

The procedure for involuntary commitment of patients with tuberculosis to a treatment center is:
Any justice or associate justice of the district court may commit to the tuberculosis treatment center established under section ninety-four D, for prolonged hospitalization, any person afflicted with active tuberculosis and residing in or present in the jurisdiction of the court, concerning whom a petition has been filed in accordance with sections ninety-four A and ninety-four B.

The procedure for commitment shall be as follows: —

(1) If the petition is filed by the commissioner of public health or his agent under section ninety-four A in a nonemergency situation, the court shall appoint two physicians experienced in the diagnosis, care and treatment of tuberculosis to examine the person and report to the court on his condition and on his willingness and ability to accept

proper medical treatment, and to give their opinion on whether or not it would be a serious danger to the public health to allow the person to be unhospitalized. Neither of these physicians shall be on the full-time staff of a state, county or municipal tuberculosis hospital.

The court shall give the person notice of his right to a hearing on the matter of his commitment. If the person does not request a hearing, the judge may order his commitment on the basis of the physicians' reports. If a hearing is requested, the court shall allow the person a reasonable time to prepare his case. The court need not see the person or hear him in open court if it is deemed inadvisable by the physicians because of his contagious condition. If, however, it is determined that the person cannot be present because of his condition, he must be given notice of this fact and of his right to have counsel and witnesses present at the hearing. In the latter case, the court shall appoint legal counsel to represent the person's interests at the hearing if he does not have his own legal counsel.

If the judge finds the person is afflicted with tuberculosis and is unwilling or unable to accept proper medical treatment, and is thereby a serious danger to the public health, the judge shall commit the person to the care and custody of the commissioner, to be cared for and treated at the tuberculosis treatment center.

(2) If the petition is filed by the superintendent of the tuberculosis treatment center under section ninety-four A or ninety-four B, or under section ninety-four B by the superintendent or manager of another sanatorium or hospital, the judge shall give notice to the patient of his right to a hearing on the matter of his commitment. If a hearing is requested it shall be granted and the commitment procedure and medical examination shall be conducted in compliance with paragraph (1). If no hearing is requested the judge may, on the basis of the petition of the superintendent and on such other evidence as he may require, order the person committed.

Massachusetts General Law, Chapter 111, § 94C (enacted 1956, current July 2012).

In my search of Westlaw on 17 July 2012, I found no Massachusetts cases involving this tuberculosis statute.

reporting some injuries (Ch.112)

These laws and regulations are important because they are exceptions to physician-patient confidentiality.²¹ They are also important legal duties for physicians.

STDs (§12)

Any registered physician or surgeon who knows or has reason to believe that any person is infected with a venereal disease as defined under section six of chapter one hundred and eleven may disclose such information to any person from whom the infected person has received a promise of marriage or to the parent or guardian of such person if a minor. Such information given in good faith by a registered physician or surgeon shall not constitute a slander or libel.

Massachusetts General Law, Chapter 112, § 12 (enacted 1948, current July 2012).

reporting treatment of wounds, burns, overdose (§12A)

Every physician attending or treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or examining or treating a person with a burn injury affecting five per cent or more of the surface area of his body, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the colonel of the state police and to the police of the town where such physician, hospital, sanatorium or institution is located or, in the case of burn injuries, notification shall be made at once to the state fire marshal and to the police of the town where the burn injury occurred. Every physician attending or treating a case of wound or injury caused by a knife or sharp or pointed instrument shall, if in his opinion a criminal act was involved, report such case forthwith to the police authorities of the town in which he attended or treated such wound or injury.

Massachusetts General Law, Chapter 112, § 12A (current July 2012).

²¹ See, e.g., Wendy K. Mariner, "Mission Creep: Public Health Surveillance and Medical Privacy," 87 BOSTON UNIV. LAW REVIEW 347 (April 2007).

reporting treatment of victim of rape or sexual assault (§12A 1/2)

Every physician attending, treating, or examining a victim of rape or sexual assault, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the department of criminal justice information services and to the police of the town where the rape or sexual assault occurred but shall not include the victim's name, address, or any other identifying information. The report shall describe the general area where the attack occurred. Massachusetts General Law, Chapter 112, § 12A 1/2 (current July 2012).

reporting communicable diseases

Massachusetts General Laws, Chapter 111, sections 1, 3, 5, 6, 7, 94C, 109, 110, 110B, 111 and 112 and Chapter 111D, Section 6 require physicians to report some diseases to the state government. The details are in Code of Massachusetts Regulations 105 CMR 300. The list of reportable diseases includes: diphtheria, hepatitis, Human Immunodeficiency Virus (HIV), measles, meningitis, rheumatic fever, rubella, sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis), tetanus, tuberculosis, methicillin-resistant Staphylococcus aureus (MRSA), and many more.

For links to Massachusetts state webpages on reporting by physicians, see my HTML webpage at: <http://www.rbs2.com/prmlinks.htm> .

Mental Health

involuntary commitment (Ch.123, §5)

The statute for involuntary commitment of a person for psychiatric treatment says:

Whenever the provisions of this chapter require that a hearing be conducted in any court for the commitment or further retention of a person to a facility or to the Bridgewater state hospital or for medical treatment including treatment with antipsychotic medication, it shall be held as hereinafter provided. Such person shall have the right to be represented by counsel and shall have the right to present independent testimony. The court shall appoint counsel for such person whom it finds to be indigent and who is not represented by counsel, unless such person refuses the appointment of counsel. The court may provide an independent medical examination for such indigent person upon request of his counsel or upon his request if he is not represented by counsel. The person shall be allowed not less than two days after the appearance of his counsel in which to prepare his case and a hearing shall be conducted forthwith after such period unless counsel requests a delay. Notice of the time and place of hearing shall be furnished by the court to the department, the person, his counsel, and his nearest relative or guardian. The court may hold the hearing at the facility or said hospital.

Massachusetts General Law, Chapter 123, § 5 (current July 2012). This statute has a long history, back to the year 1834.

legal capacity of mental patients (Ch.123, §24)

A Massachusetts statute says:

No person shall be deemed to be incompetent

- to manage his affairs,
- to contract,
- to hold professional or occupational or vehicle operators licenses or
- to make a will

solely by reason of his admission or commitment in any capacity to the treatment or care of the department or to any public or private facility, nor shall departmental regulations restrict such rights.

Massachusetts General Law, Chapter 123, § 24 (enacted 1986, current July 2012) (formatting added by Standler).

Note that an admitted or committed mental patient is *also* competent to give consent to treatment, unless the patient has been specifically found *incompetent* by a court. *Matter of Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981); *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308 (Mass. 1983), and Massachusetts General Law, Ch. 123, §8B (quoted below).

consent to antipsychotic medication (Ch.123, §8B)

Consent to treatment with antipsychotic medication for any patient who has been committed to treatment is in another statute:

(a) With respect to any patient who is the subject of a petition for a commitment or an order of a commitment for care and treatment under the provisions of sections seven, eight, fifteen, sixteen or eighteen, the superintendent of a facility or medical director of the Bridgewater state hospital may further petition the district court or the division of the juvenile court department in whose jurisdiction the facility is located (i) to adjudicate the patient incapable of making informed decisions about proposed medical treatment, (ii) to authorize, by an adjudication of substituted judgment, treatment with antipsychotic medications, and (iii) to authorize according to the applicable legal standards such other medical treatment as may be necessary for the treatment of mental illness.

(b) A petition filed under this section shall be separate from any pending petition for commitment and shall not be heard or otherwise considered by the court unless the court has first issued an order of commitment on the pending petition for commitment.

(c) Whenever a court receives a petition filed under the provisions of this section, such court shall notify the person, and his nearest relative or guardian of the receipt of such petition and of the date a hearing on such petition is to be held. The hearing shall be commenced within fourteen days of the filing of the petition unless a delay is requested by

the person or his counsel, provided that the commencement of such hearing shall not be delayed beyond the date of the hearing on the commitment petition if the petition was filed concurrently with a petition for commitment.

(d) After a hearing on the petition regarding antipsychotic medication treatment the court shall not authorize medical treatment unless it (i) specifically finds that the person is incapable of making informed decisions concerning the proposed medical treatment, (ii) upon application of the legal substituted judgment standard, specifically finds that the patient would accept such treatment if competent, and (iii) specifically approves and authorizes a written substituted judgment treatment plan. The court may base its findings exclusively upon affidavits and other documentary evidence if it (i) determines, after careful inquiry and upon representations of counsel, that there are not contested issues of fact and (ii) includes in its findings the reasons that oral testimony was not required.

(e) The court may delegate to a guardian who has been duly appointed by a court of competent jurisdiction the authority to monitor the antipsychotic medication treatment process to ensure that an antipsychotic medication treatment plan is followed, provided such a guardian is readily available for such purpose. Approval of a treatment plan shall not be withheld, however, because such a guardian is not available to perform such monitoring. In such circumstances, the court shall monitor the treatment process to ensure that the treatment plan is followed.

(f) Any authorization for treatment that is ordered pursuant to the provisions of this section shall expire at the same time as the expiration of the order of commitment that was in effect when the authorization for treatment was ordered; provided that subsequent authorizations may be ordered and any party may at any time petition the court for modification of a medical treatment authorization that has been ordered pursuant to the standards and procedures established in this section.

Massachusetts General Law, Chapter 123, §8B (enacted 1986, current July 2012).

This statute was passed in response to a judicial opinion, *Rogers vs. Commissioner of the Department of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (Mass. 1983); see also *Rogers v. Okin*, 738 F.2d 1, 6-7 (1stCir. 1984). The following quotations from judicial opinions clarify the above statutory rights.

The statute needs a definition of “antipsychotic medication”.

We use the term “antipsychotic drugs” to refer to medications such as Thorazine, Mellaril, Prolixin and Haldol²² that are used in treating psychoses, particularly schizophrenia. *Rogers v. Okin*, 634 F.2d 650, 653, n.1 (1stCir. 1980), quoted in *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308, 310, n.3 (Mass. 1983). The reason for the concern about this class of drugs is that they are associated with common and serious side effects that may be permanent (i.e., persisting indefinitely after the drug is discontinued). See, e.g., *Rogers v. Okin*, 478 F.Supp. 1342, 1360 (D.Mass. 1979); Robert Byck, “Drugs and the Treatment of Psychiatric Disorders,” in Louis Goodman and Alfred Gilman, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* at 152-173 (5thed. 1975).

The fact that a psychiatric patient is involuntarily confined to a mental ward of a hospital does *not* imply that the patient is incompetent to give informed consent to therapy. As the U.S. Court of Appeals in Boston said:

... the fact that Massachusetts law provides for a separate proceeding for determinations of legal incompetency, Mass.Gen.Laws Ann. ch. 123 § 25, strongly implies that the commitment proceeding itself is not intended to be a determination that the individual lacks the capacity to make his own treatment decisions. Cf. *Boyd v. Bd. of Registrars of Voters of Belchertown*, 368 Mass. 631, 635-36, 334 N.E.2d 629 (1975) (“profound” distinction between commitment and determination of incompetency). This implication is explicitly confirmed in another section of the statute that recognizes the ability and right of a committed patient to refuse electroconvulsion treatment and lobotomies. Mass.Gen.Laws Ann. ch. 123 § 23. Finally, as a factual matter, the district court found, 478 F.Supp. at 1364, and defendants concede, that not all patients institutionalized for mental illness are incapable of making their own treatment decisions. [footnote omitted]

Rogers v. Okin, 634 F.2d 650, 659 (1stCir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982) (Ordered U.S. Court of Appeals to consider subsequent Massachusetts state law expressed in *Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981), because state law might provide more rights than federal constitutional law.).

The Massachusetts Supreme Court held:

We conclude that only if a patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs, may the Commonwealth invoke its police powers without prior court approval to treat the patient [footnote omitted] by forcible injection of antipsychotic drugs over the patient’s objection.

Rogers vs. Commissioner of the Department of Mental Health, 458 N.E.2d 308, 321-322 (Mass. 1983).

In a nonemergency situation, a psychiatric patient — even a mentally *in*competent patient — has the right to refuse antipsychotic drugs. If the patient is unable to give “informed consent”, then a court-appointed guardian will need to make a substituted judgment of what the patient

²² Footnote by Standler: The judge used the brand names. The generic names are chlorpromazine, thioridazine, fluphenazine, and haloperidol.

would want, if the patient were competent. *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308, 314-316 (Mass. 1983).

restraints (Ch. 123, §21)

Antipsychotic drugs can be used as a chemical restraint in violent patients. The use of restraints, both physical and chemical, is covered by a Massachusetts statute:

Restraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide; provided, however, that written authorization for such restraint is given by the superintendent or director of the facility or by a physician designated by him for this purpose who is present at the time of the emergency or if the superintendent or director or designated physician is not present at the time of the emergency, non-chemical means of restraint may be used for a period of one hour provided that within one hour the person in restraint shall be examined by the superintendent, director or designated physician. Provided further, that if said examination has not occurred within one hour, the patient may be restrained for up to an additional one hour period until such examination is conducted, and the superintendent, director, or designated physician shall attach to the restraint form a written report as to why the examination was not completed by the end of the first hour of restraint.

....

No order for restraint for an individual shall be valid for a period of more than three hours beyond which time it may be renewed upon personal examination by the superintendent, director, authorized physician or, for adults, by a registered nurse or a certified physician assistant; provided, however, that no adult shall be restrained for more than six hours beyond which time an order may be renewed only upon personal examination by a physician. The reasons for the original use of restraint, the reason for its continuation after each renewal, and the reason for its cessation shall be noted upon the restraining form by the superintendent, director or authorized physician or, when applicable, by the registered nurse or certified physician assistant at the time of each occurrence.

When a designated physician is not present at the time and site of the emergency, an order for chemical restraint may be issued by a designated physician who has determined, after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally examined the patient, that such chemical restraint is the least restrictive, most appropriate alternative available; provided, however, that the medication so ordered has been previously authorized as part of the individual's current treatment plan.

No person shall be kept in restraint without a person in attendance specially trained to understand, assist and afford therapy to the person in restraint. The person may [be] in attendance immediately outside the

room in full view of the patient when an individual is being secluded without mechanical restraint; provided, however, that in emergency situations when a person specially trained is not available, an adult, may be kept in restraint unattended for a period not to exceed two hours. In that event, the person kept in restraints must be observed at least every five minutes; provided, further, that the superintendent, director, or designated physician shall attach to the restraint form a written report as to why the specially trained attendant was not available. The maintenance of any adult in restraint for more than eight hours in any twenty-four hour period must be authorized by the superintendent or facility director or the person specifically designated to act in the absence of the superintendent or facility director; provided, however, that when such restraint is authorized in the absence of the superintendent [or] facility director, such authorization must be reviewed by the superintendent or facility director upon his return.

No "P.R.N." or "as required" authorization of restraint may be written.

Massachusetts General Law, Chapter 123, § 21 (enacted 1986, current July 2012).

mental health rights (Ch.123, §23)

Patients who receive psychological or psychiatric treatment from either

- (1) the State Hospitals,
 - (2) community mental health centers, or
 - (3) at any facility "operated by, licensed by[,] or contracting with the department of mental health"
- have the following rights:

Such persons may exercise the rights described in this section without harassment or reprisal, including reprisal in the form of denial of appropriate, available treatment. The rights contained herein shall be in addition to and not in derogation of any other statutory or constitutional rights accorded such persons.

Any such person shall have the following rights:

(a) reasonable access to a telephone to make and receive confidential telephone calls and to assistance when desired and necessary to implement such right; provided, that such calls do not constitute a criminal act or represent an unreasonable infringement of another person's right to make and receive telephone calls;

(b) to send and receive sealed, unopened, uncensored mail; provided, however, that the superintendent or director or designee of an inpatient facility may direct, for good cause and with documentation of specific facts in such person's record, that a particular person's mail be opened and inspected in front of such person, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by such person. Reasonable assistance shall be provided to such person in

writing, addressing and posting letters and other documents upon request;

(c) to receive visitors of such person's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other persons and to avoid serious disruptions in the normal functioning of the facility or program and shall be sufficiently flexible as to accommodate individual needs and desires of such person and the visitors of such person.

(d) to a humane psychological and physical environment. Each such person shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing and in toileting. Nothing in this section shall be construed to require individual sleeping quarters.

(e) to receive at any reasonable time as defined in department regulations, or refuse to receive, visits and telephone calls from a client's attorney or legal advocate, physician, psychologist, clergy member or social worker, even if not during normal visiting hours and regardless of whether such person initiated or requested the visit or telephone call. An attorney or legal advocate working under an attorney's supervision and who represents a client shall have access to the client and, with such client's consent, the client's record, the hospital staff responsible for the client's care and treatment and any meetings concerning treatment planning or discharge planning where the client would be or has the right to be present. Any program or facility, or part thereof, operated by, licensed by or contracting with the department shall ensure reasonable access by attorneys and legal advocates of the Massachusetts Mental Health Protection and Advocacy Project, the Mental Health Legal Advisors Committee, the committee for public counsel services and any other legal service agencies funded by the Massachusetts Legal Assistance Corporation under the provisions of chapter 221A, to provide free legal services. Upon admission, and upon request at any time thereafter, persons shall be provided with the name, address and telephone number of such organizations and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or legal advocates from such organizations; provided, however, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to persons by such attorneys or legal advocates. The department shall promulgate rules and regulations further defining such access. Nothing in this paragraph shall be construed to limit the ability of attorneys or legal advocates to access clients records or staff as provided by any other state or federal law.

....

In addition to the rights specified above and any other rights guaranteed by law, a mentally ill person in the care of the department shall have the following legal and civil rights: to wear his own clothes, to keep and use his own personal possessions including toilet articles, to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, to have access to individual storage space for his private use, **to refuse shock treatment, to refuse lobotomy**,²³ and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent [of such facility] or his designee and a statement of the reasons for any such denial entered in the treatment record of such person.

Massachusetts General Law, Chapter 123, § 23 (enacted 1986, current July 2012).

defects in § 23

The last paragraph of § 23 really needs revision. It is not clear whether the ability of the “superintendent or his designee” to override patients’ rights refers (a) only to rights in the final paragraph of § 23 or (b) to rights in the entire § 23. It may be appropriate for the “superintendent or his designee” to deny minor rights, such as allowing the patient “to wear his own clothes”. It is *not* appropriate for the “superintendent or his designee” to deny the patient the use of mail or telephone for contact with people outside the facility, because such communication is a way of informing outsiders of abuse of patients in the facility. And — most importantly — the “superintendent or his designee” *must not* be allowed to deny a patient the right to refuse either shock treatment or lobotomy.²⁴

²³ Boldface added by Standler.

²⁴ *Rogers vs. Commissioner of the Department of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983) (“The defendants argue that they, as doctors, should be responsible for making treatment decisions for involuntarily committed patients, whether competent or not. We do not agree. ‘Every competent adult has a right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks[,] however unwise his sense of values may be in the eyes of the medical profession.’ *Harnish v. Children’s Hospital*, ... 439 N.E.2d 240, 242 (Mass. 1982), quoting *Wilkinson v. Vesey*, 295 A.2d 676 (R.I. 1972).”); Ellen Wright Clayton, “From *Rogers* to *Rivers*: The Rights of the Mentally Ill to Refuse Medication,” 13 *AMERICAN JOURNAL OF LAW & MEDICINE* 7 (1987) (“... unless treatment refusals are reviewed outside mental institutions, patients’ rights will rarely receive appropriate deference.”).

In doing legal research for this essay, I found a statement of law by the Massachusetts Supreme Court:

We note that G.L. c. 123, § 23, provides that a patient in the care of the [D]epartment [of Mental Health] may not under any circumstances undergo lobotomy or shock treatment without the written consent of his guardian or nearest living relative.

Woodbridge v. Worcester State Hospital, 423 N.E.2d 782, 785, n.6 (Mass. 1981).²⁵

Because this judicial opinion is before the enactment of the current version of Ch. 123, § 23, I looked at the prior law — which was added by the 1970 session laws. The 1970 law said:

... to refuse shock treatment, to refuse lobotomy, and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person; and provided, further, that shock treatment or lobotomy shall not be performed on any such person without the written consent of said person's legal guardian or his nearest living relative.

Massachusetts Acts 1970, Chapter 888, at page 851 (enacted 1970, repealed 1986).

The final clause, about written consent of the patient's guardian or nearest living relative, was deleted in the 1986 revision of this statute, probably because the clause *presumes* that the patient himself is *unable* to consent, and is therefore inconsistent with *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308 (Mass. 1983). Ironically, the current version of this statute gives the patient *less* protection than the 1970 version of this statute, because the current version does *not* mention written consent for either shock treatment or lobotomy.

The last four lines of the current § 23, which allow “the superintendent or his designee” to deny mental patients their right to refuse either shock therapy or lobotomy, are outrageous. If a patient himself is *unable* to consent, then consent should be obtained from either (1) a court-appointed guardian or (2) an agent appointed by the patient at an earlier time when the patient was mentally competent. The current statute allows a physician to deny the patient's right to refuse treatment, which allows continuing abuses of institutionalized psychiatric patients. In the context of a health-care proxy, Massachusetts General Law, chap. 201D, § 3, specifically prohibits “an operator, administrator, or employee of a facility” from serving as an agent for a patient.

I suggest deleting lobotomy and electro-convulsive therapy from § 23, and inserting them along with the current existing right to refuse antipsychotic medication in § 8B. Notice that § 23 (except for the terse mentions of lobotomy and shock therapy) does *not* concern medical treatment of mentally ill patients, so it is the wrong place to discuss the right to refuse medical treatment, informed consent, substituted judgment, etc. Further, psychosurgery, electro-convulsive therapy, and antipsychotic medication all have the possibility of *permanent* changes in a patient's brain, so they should be considered together and a high level of consent required.

²⁵ Woodbridge was put in a “locked seclusion room” at the Worcester State Hospital, where he remained without supervision for 105 minutes. While locked away, Woodbridge “gouged the retinas of both eyes with his thumbs”, leaving him completely blind. The court held there was no liability for the state.

In my search of Westlaw on 17 July 2012, I found no cases in Massachusetts involving consent to a lobotomy. On 17 July 2012, there were 27 cases in Massachusetts that mention electro-convulsive therapy, but only as a part of the facts of the case, *not* involving consent to shock therapy. There is one reported case alleging medical malpractice from “unnecessary or excessive” psychosurgery and electro-convulsive therapy, but the judicial opinion was at an early state of litigation and did not resolve the substantive issues. *Kapp v. Ballantine*, 402 N.E.2d 463 (Mass. 1980).

right to see psychotherapy record (Ch. 112, § 12CC)

In general, all medical patients have the right to have a paper copy of their record of medical/surgical treatment, see Massachusetts General Laws, Chapter 111, § 70E, (g) in first bundle (quoted above at page 6). The general medical/surgical record statute is Chapter 111, § 70 (part quoted above at page 13). Rights of mental patients to see their psychotherapy record are contained in:

A health care provider who maintains records for a patient treated or examined by such provider shall permit inspection of such records by such patient or an authorized representative of the patient, and upon request a copy of such patient's record shall be furnished upon payment of a reasonable fee, as defined in section 70 of chapter 111

For purposes of this section, in the case of a psychotherapist the term "records" in this section shall mean, at the discretion of the psychotherapist, the patient's entire record maintained by such psychotherapist or a summary of the patient's record. If in the reasonable exercise of his professional judgement, the psychotherapist believes providing the entire record would adversely affect the patient's well-being, in such instances, the psychotherapist shall make a summary of the record available to the patient. If a patient requests the entire record, notwithstanding a determination that providing said record is deemed to adversely affect the patient's well-being, the psychotherapist shall make the entire record available to either the patient's attorney, with the patient's consent, or to such other psychotherapist as designated by the patient. For the purpose of this section the word "psychotherapist" shall mean any person defined as such by section twenty B of chapter two hundred and thirty-three or licensed pursuant to section eighty-four of chapter thirteen.

Massachusetts General Law, Chapter 112, § 12CC (current July 2012).

The details about mental health recordkeeping are in Massachusetts General Law, Chapter 123, § 36.

duty to warn potential victims of mental patient (Ch.123, §36B)

A psychotherapist has a legal duty to warn patient's potential victims, and such reporting is *not* a violation of the psychotherapist's legal duty of confidentiality.

(1) There shall be no duty owed by a licensed mental health professional to take reasonable precautions to warn or in any other way protect a potential victim or victims of said professional's patient, and no cause of action imposed against a licensed mental health professional for failure to warn or in any other way protect a potential victim or victims of such professional's patient **unless:**²⁶

(a) the patient has communicated to the licensed mental health professional an explicit threat to kill or inflict serious bodily injury upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat, and the licensed mental health professional fails to take reasonable precautions as that term is defined in §1; or

(b) the patient has a history of physical violence which is known to the licensed mental health professional and the licensed mental health professional has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury against a reasonably identified victim or victims and the licensed mental health professional fails to take reasonable precautions as that term is defined by said §1.

Nothing in this paragraph shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to potential victim or victims.

(2) Whenever a licensed mental health professional takes reasonable precautions, as that term is defined in §1 of chapter 123, no cause of action by the patient shall lie against the licensed mental health professional for disclosure of otherwise confidential communications.

Massachusetts General Law, Chapter 123, § 36B (enacted 1989, current July 2012).

The phrase "Reasonable precautions" is defined in Chapter 123, §1:

any licensed mental health professional shall be deemed to have taken reasonable precautions, as that term is used in § 36B, if such professional makes reasonable efforts to take one or more of the following actions as would be taken by a reasonably prudent member of his profession under the same or similar circumstances: —

(a) communicates a threat of death or serious bodily injury to the reasonably identified victim or victims;

(b) notifies an appropriate law enforcement agency in the vicinity where the patient or any potential victim resides;

(c) arranges for the patient to be hospitalized voluntarily; [or]

²⁶ Boldface added by Standler.

(d) takes appropriate steps, within the legal scope of practice of his profession, to initiate proceedings for involuntary hospitalization. Massachusetts General Law, Chapter 123, § 1 (enacted 1989, current July 2012).

The Massachusetts Legislature enacted § 36B in response to *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334 (Calif. 1976), a landmark case in this area. As a result of § 36B, Massachusetts duty-to-warn law is statutory, not common law. *Shea v. Caritas Carney Hospital, Inc.*, 947 N.E.2d 99, 108 (Mass.App.Ct. 2011).

Massachusetts Right-to-Refuse Medical Treatment

There is a longstanding common-law legal right in the USA for all adult patients to have the right to refuse medical treatment, even if the treatment would prolong their life, and even if their choice is foolish or unwise according to physicians or judges. This right has two origins: (1) freedom from battery, recognition of autonomy, and the right of self-determination, and (2) a corollary of “informed consent” which arises from the physician’s fiduciary duty to the patient. See the technical details in my separate essay, Legal Right to Refuse Medical Treatment in the USA, <http://www.rbs2.com/rrmt.pdf>. Here, I list the most significant Massachusetts judicial opinions on the right to refuse medical treatment:

- *Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 (Mass. 1977) (“... we recognize a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.”);
- *Lane v. Candura*, 376 N.E.2d 1232, 1236 (Mass.App. 1978) (Adult patient may refuse lifesaving amputation of gangrenous leg. “The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.”);
- *Harnish v. Children's Hosp. Medical Center*, 439 N.E.2d 240, 242 (Mass. 1982) (“Every competent adult has a right ‘to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks[,] however unwise his sense of values may be in the eyes of the medical profession.’ *Wilkinson v. Vesey*, 110 R.I. 606, 624, 295 A.2d 676 (1972).”), quoted with approval in *Shine v. Vega*, 709 N.E.2d 58, 63 (Mass. 1999);
- *Taft v. Taft*, 446 N.E.2d 395 (Mass. 1983) (Pregnant woman needed sutures in her cervix to continue pregnancy. Woman refused on religious grounds. Court held that sutures could *not* be ordered.);

- *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633-634 (Mass. 1986) (“It is in recognition of these fundamental principles of individual autonomy that we sought, in *Saikewicz*, to shift the emphasis away from a paternalistic view of what is ‘best’ for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved, whether that person be competent or incompetent.”);
- *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1021 (Mass. 1991) (Jehovah’s Witness, who was mother of minor child, had right to refuse blood transfusion. “It is for the individual to decide whether a particular medical treatment is in the individual’s best interests. As a result, ‘[t]he law protects [a person’s] right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.’ *Lane v. Candura*, 6 Mass.App.Ct. 377, 383, 376 N.E.2d 1232 [at 1236] (1978).”), quoted with approval in *Shine v. Vega*, 709 N.E.2d 58, 63 (Mass. 1999);
- *Shine v. Vega*, 709 N.E.2d 58, 63-65 (Mass. 1999) (conscious patient being treated in emergency room had right to refuse intubation);

informed consent

Massachusetts General Laws, Chapter 111, § 70E tersely says that medical patients have the right “to informed consent to the extent provided by law”. What does the qualifier “to the extent provided by law” mean? My separate essay, *Legal Right to Refuse Medical Treatment in the USA*, <http://www.rbs2.com/rmt.pdf>, explains in detail that there are two broad exceptions to an absolute right to refuse medical treatment:

1. an *unconscious* patient in a hospital emergency room is presumed to want the best available medical treatment, including blood transfusions — the emergency exception.
2. *Saikewicz* and progeny asserted four state interests to be balanced against an individual’s right of autonomy: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession. In Massachusetts, these four state interests appear to always be inferior to the individual’s right.

In my opinion, Massachusetts should make the right to refuse medical treatment absolute, by enacting a statute to abolish these four state interests in the context of refusing medical treatment. See, e.g., George J. Annas, et alia, “The Right to Refuse Treatment: A Model Act,” 73 *AMERICAN JOURNAL OF PUBLIC HEALTH* 918 (August 1983).

Physicians are on notice that failure to obtain informed consent in nonemergency situations is medical malpractice.

Thus, a method of treatment of high risk, but rendered in a non-negligent manner without informed consent of the patient, may result in liability. *Precourt v. Frederick*, 395 Mass. at 696, 481 N.E.2d 1144 [1149 (Mass. 1985)]; *Feeley v. Baer*, 424 Mass. 875, 877, 878 n. 4, 679 N.E.2d 180 (1997). See *Burnet v. Spokane Ambulance*, 54 Wash.App. 162, 169, 772 P.2d 1027 (1989), *rev'd on other grounds*, 131 Wash.2d 484, 933 P.2d 1036 (1997). *Roukounakis v. Messer*, 826 N.E.2d 777, 780 (Mass.App. 2005).

In 1982, the Massachusetts Supreme Court explained:

We hold, therefore, that a physician's failure to divulge in a reasonable manner to a competent adult patient sufficient information to enable the patient to make an informed judgment whether to give or withhold consent to a medical or surgical procedure constitutes professional misconduct.

While we recognize that a patient ordinarily cannot make an intelligent decision whether to undergo a medical or surgical procedure without receiving from the physician information significant to the decision, *Canterbury v. Spence*, [464 F.2d 772] at 780, 782 [(D.C.Cir. 1972)], we also recognize that there are limits to what society or an individual can reasonably expect of a physician in this regard. Medical matters are often complex. Recommendations of treatment frequently require the application of considerable medical knowledge gained through extensive training and experience. Communication of scientific information by the trained physician to the untrained patient may be difficult. The remotely possible risks of a proposed treatment may be almost without limit. The patient's right to know must be harmonized with the recognition that an undue burden should not be placed on the physician. These interests are accommodated by the rule that we adopt today, that **a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure.**²⁷ The information a physician reasonably should possess is that information possessed by the average qualified physician or, in the case of a specialty, by the average qualified physician practicing that specialty. *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793 (1968). *Haggerty v. McCarthy*, 344 Mass. 136, 139, 181 N.E.2d 562 (1962). What the physician should know involves professional expertise and can ordinarily be proved only through the testimony of experts. See *id.* at 139-142, 181 N.E.2d 562. *Wilkinson v. Vesey*, ... 295 A.2d 676 [682 (R.I. 1972)]. However, the extent to which he must share that information with his patient depends upon what information he should reasonably recognize is material to the plaintiff's decision. *Canterbury v. Spence*, [464 F.2d 772 (D.C.Cir. 1972)] at 787. *Wilkinson v. Vesey*, *supra* at 627-628, 295 A.2d 676. "Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment." *Id.* at 627, 295 A.2d 676. The materiality determination is one that lay persons are qualified to make without the aid of an expert. *Canterbury v. Spence*, *supra* at 784-785. *Wilkinson v. Vesey*, *supra* at 625, 295 A.2d 676. Appropriate information may include the nature of the patient's condition, the nature and probability of risks involved, the benefits to be reasonably expected, the inability of the physician to predict results, if that is the

²⁷ Boldface added by Standler.

situation, the irreversibility of the procedure, if that be the case, the likely result of no treatment, and the available alternatives, including their risks and benefits. *Canterbury v. Spence*, supra at 781-783, 787-788. The obligation to give adequate information does not require the disclosure of all risks of a proposed therapy, *Wilkinson v. Vesey*, supra at 627, 295 A.2d 676, or of information the physician reasonably believes the patient already has, such as the risks, like infection, inherent in any operation. *Canterbury v. Spence*, supra at 788. *Harnish v. Children's Hospital Medical Center*, 439 N.E.2d 240, 242-243 (Mass. 1982). Cited with approval in *Vasa v. Compass Medical, P.C.*, 921 N.E.2d 963, 965 (Mass. 2010) (“Doctors have a duty to inform patients of available options for medical treatment and the material risks that each option entails. This duty ensures that patients can make informed decisions regarding their health care. [citation omitted]”).

nondisclosure

There are some judicial opinions in other states that suggest a physician can withhold material information from a patient in some cases. In 1982, the Massachusetts Supreme Court briefly mentioned such a possible withholding of information by a physician:

We recognize that despite the importance of the patient's right to know, there may be situations that call for a privilege of nondisclosure. *Cobbs v. Grant*, ... 502 P.2d 1 [, 12 (Cal. 1972)].²⁸ For instance, sound medical judgment might indicate that disclosure would complicate the patient's medical condition or render him unfit for treatment. “Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs” (footnotes omitted). *Canterbury v. Spence*, [464 F.2d 772] at 789 [(D.C.Cir. 1972)].

Harnish v. Children's Hospital Medical Center, 439 N.E.2d 240, 244 (Mass. 1982).

The Massachusetts Supreme Court in *Harnish* did not make any decision on this physician's alleged privilege of nondisclosure, because the issue was not relevant in that case. In my search of Westlaw on 22 July 2012, I found no judicial opinion in Massachusetts that has mentioned this alleged “privilege of nondisclosure” since *Harnish* in the year 1982. I suggest that the law in the 1970s and early 1980s was more deferential to physicians than modern law, although the issue is not resolved in Massachusetts cases. Unless the patient explicitly waives informed consent, the

²⁸ Footnote by Standler: *Cobbs v. Grant* says: “Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. (E.g., see discussion of informing the dying patient: Hagman, *The Medical Patient's Right to Know*, supra, 17 U.C.L.A.L.Rev. 758, 778.) Any defense, of course, must be consistent with what has been termed the ‘fiducial qualities’ of the physician-patient relationship. *Emmett v. Eastern Dispensary & Casualty Hospital*, (D.C.Cir. 1967) ... 396 F.2d 931, 935.”

better practice is for a physician to always inform a mentally competent patient of risks and alternatives.

The law of informed consent becomes clearer when one backs away from traditional physician-patient relationships, in which a physician paternalistically determines what is “best” for a patient, and instead looks at the law of agency. The patient is the principal who hires the physician as an agent, to do specialized work for the patient and to advise the patient. The principal is entitled to full disclosure of all relevant information from the agent. *Spritz v. Brockton Savings Bank*, 25 N.E.2d 155, 156 (Mass. 1940) (“The principal has a right to be informed of all material facts known to the agent in reference to the transaction in which he is acting for his principal, and good faith requires a disclosure of such facts by the agent. [citing six cases]”); *Gagnon v. Coombs*, 654 N.E.2d 54, 62 (Mass.App. 1995).

Massachusetts End-of-Life Cases

In contrast to the statutory requirement for a court-appointed guardian and substituted judgment before an incompetent mental patient receives antipsychotic drugs on a non-emergency basis (Massachusetts General Law, Chapter 123, § 8B, quoted at page 19-22, above), there is no statutory basis in Massachusetts for end-of-life decisions that involve substituted judgment. Instead, Massachusetts has a long string of judicial decisions for the disconnection of a ventilator, ending feedings through a tube into the stomach, or refusing life-prolonging medical treatment. Some of these judicial decisions involve children or profoundly retarded people, who were never mentally competent, however those decisions are relevant to this essay, because the judges first decided what rights a mentally competent adult would have, and then gave incompetent patients the same rights.

- *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (profoundly retarded 67 y old man *not* treated for leukemia);
- *Matter of Spring*, 405 N.E.2d 115 (Mass. 1980) (incompetent adult person allowed to stop receiving life-prolonging hemodialysis);
- *Custody of A Minor*, 434 N.E.2d 601, 609 (Mass. 1982) (Do not resuscitate order for terminally ill child was valid.);
- *Matter of Hier*, 464 N.E.2d 959 (Mass.App. 1984) (patient could refuse feeding tube), *review denied*, 465 N.E.2d 261 (Mass. 1984);
- *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986) (discontinue food and hydration to patient in persistent vegetative state);
- *Guardianship of Doe*, 583 N.E.2d 1263 (Mass. 1992) (discontinue food and hydration to patient in persistent vegetative state).

For more information on these kinds of cases, see my separate essay, Annotated Legal Cases Involving Right-to-Die in the USA, at: <http://www.rbs2.com/rtd.pdf> .

Conclusion

I hope this list of statutes and court cases helps inform people in Massachusetts of their legal rights. However, as explained in the disclaimer on page 3, this document is *not* a substitute for legal advice from an attorney who is licensed to practice law and who is familiar with health law.

It would be nice if the Massachusetts legislature would fix the defects in their statutes that I have identified.

This document is at **www.rbs2.com/prm.pdf**

My most recent search for statutes on this topic was on 16-18 July 2012.
first posted 20 July 2012, revised 18 Aug 2012

See my collection of links for this essay at: <http://www.rbs2.com/prmlinks.htm> .

Annotated list of my essays on health law at <http://www.rbs2.com/ihealth.htm>