IN THE

United States Court of Appeals

FOR THE FIRST CIRCUIT

No. 79-1649

RUBIE ROGERS, *et al.*,
Appellants,

v.

ROBERT OKIN, M.D., *et al.*,
Appellees.

On Appeal from the United States District Court for the District of Massachusetts

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The American Psychiatric Association respectfully moves for leave to file the attached brief amicus curiae. Although consent from counsel for the appellants, Rubie Rogers, *et al.*, was obtained for a brief amicus curiae by the Association in No. 79-1648, *Rogers* v. *Okin*, consent could not be obtained for this brief.

This case raises important issues concerning the liability of psychiatrists working in state mental hospitals for treatment practices found to have violated patients' constitutional rights. As the nation's largest organization of qualified doctors of medicine specializing in psychiatry, the American Psychiatric Association has a significant

interest in, and concern about, issues bearing on the quality of care for patients in state mental hospitals and the ability of psychiatrists to provide treatment in accordance with reasonable medical practice. This interest and concern is particularly strong in this case where the decision will greatly affect the concerns and the work of the Association and its members. For these reasons, the American Psychiatric Association seeks leave of this Court to file the attached brief.

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. Almost 26,000 of the nation's approximately 33,000 psychiatrists are members. Psychiatrists have the principal responsibility for providing expert testimony in civil commitment proceedings and for providing treatment to those who suffer from mental illness. The Association has participated as amicus curiae in numerous cases involving mental health issues, including *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975); *Addington* v. *Texas*, 99 S.Ct. 1804 (1979); *Parham* v. *J.R.*, 99

S.Ct. 2493 (1979); and *Rogers* v. *Okin*, No. 79-1648. The instant case, which presents the question of whether psychiatrists in a state psychiatric hospital are liable in damages for treatment practices found to have violated patients' constitutional rights, will have important implications for the future of treatment in state psychiatric hospitals. Resolution of the issues in this case will greatly affect the concerns and the work of the Association and its members.

STATEMENT OF THE CASE

A full description of the case is contained in amicus' prior brief to this Court, filed February 28, 1980, relating to the district court's ruling on plaintiffs' claims for injunctive relief with respect to the medication practices at the May and Austin units of Boston State Hospital. Accordingly, only those facts relevant to the district court's disposition of plaintiffs' damage claims against defendant doctors will be set out here.

The district court ruled that defendants had violated plaintiffs' constitutionally protected privacy right to refuse all psychiatric medications in nonemergency situations. *Rogers* v. *Okin*, 478 F.Supp. 1342, 1364 (D.Mass. 1979). To evaluate plaintiffs' damage claims, the court then made findings with respect to the forcible medication of each plaintiff during the period prior to the entry of the temporary restraining order in 1975. The court found that five of the plaintiffs had on some occasion been forcibly medicated.[1] It nevertheless declined to award dam-

[1] The court inferred that plaintiff Rogers had been forcibly medicated in nonemergency situations because she often was medicated despite her objection even though her behavior was not sufficiently out of control as to have required seclusion during the several months she was in the ward. *Rogers* v. *Okin*, 478 F.Supp. 1342, 1375-76 (D. Mass. 1979). Because plaintiff Wadsworth was forcibly medicated when he was already in seclusion, the court found there was no emergency justifying the medication. *Id.* at 1376. The court

ages against any of the defendants for forcibly medicating these plaintiffs, finding that the defendants were protected from liability by a valid good faith immunity defense. In particular, the court stated that the "prime constitutional issue here—the right to refuse treatment—was not one that a doctor was bound to anticipate in 1973." *Id.* at 1382. The court also relied on the "less than desirable conditions in which defendants were required to deal with plaintiffs," finding that the "facilities and support staff at Boston State were marginal, at best," and that "the patient population was extremely demanding, both in terms of numbers and their potential for disruptive behavior." *Id.* at 1383. Thus, the court concluded that under the relevant case law defendants were entitled to immunity and that "[t]o hold them liable in damages, given the totality of the circumstances presented by the evidence in this case, would be unfair to them and contrary to the public interest." *Ibid.*

With respect to seclusion, the court held that defendants' seclusion practices violated Massachusetts law, which limited the use of nonconsensual seclusion to "cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide." M.G.L. Ch. 123 § 21. The court found that seclusion was used as a mode of treatment to modify behavior which would not fall within the definition of emergency, 476 F.Supp. at 1374, and that the plaintiffs had been secluded in violation of the procedural requirements of Massachusetts law. *Id.* at 1375. On this basis alone, the court ruled that defendants' failure to adhere to state law "violated plaintiffs' due process 'liberty interest' under the Fourteenth Amendment." *Id.* at 1375. It then analyzed each

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also found that plaintiffs Hunt, Bybel and Colleran were forcibly medicated in nonemergencies "as part of a psychotherapeutic program." *Id.* at 1378 (footnote omitted).

individual plaintiffs' seclusion claims, and found that five plaintiffs had been secluded in nonemergency situations.[2]

After holding that plaintiffs' due process liberty interests had been violated by defendants' seclusion practices, the court applied the same analysis used in assessing plaintiffs' medication claims and held that defendants were entitled to good faith immunity for their seclusion actions. It ruled that all the seclusion and medication actions "were intended as treatment, not punishment." *Id.* at 1382. Additionally, the court gave substantial consideration to the circumstances at Boston State Hospital:

> Defendants did not have the luxury of detached, leisurely reflection as they faced the innumerable crises that characterized daily living on the Austin and May wards. They met those crises decisively, with the purpose of restoring plaintiffs to self control. *Id.* at 1383.

The court also rejected plaintiffs' state tort law claims, holding that the law governing traditional intentional

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[2] Plaintiff Wadsworth, who entered seclusion after assaulting one attendant and threatening others with a coat hanger, was found to have been maintained in seclusion at some points when no emergency justified his stay. *Id.* at 1376-77. One of plaintiff Warner's five seclusions, which was imposed according to the records because he was " 'creating a disturbance on other wards' " and was " 'obnoxious, instigating trouble with patients and staff,' " was deemed unwarranted because that conduct did not pose an emergency. *Id.* at 1377. The court also held that one of plaintiff Bolden's 60 seclusions, imposed after he had sex with another patient, was improper because evidence in the record indicated that he no longer was out of control when he was returned to seclusion after a doctor's appointment. *Ibid.* For plaintiff Hunt, the court ruled that although she "was chronically out of control during much of 1974," some of the seclusions in that period were not in emergency situations. *Id.* at 1379 (footnote omitted). In those circumstances, "seclusion was used as a treatment modality and not a restraint." *Ibid.* (footnote omitted). Similarly, the court held that plaintiff Bybel, who was secluded for more than 1,000 hours over a two-year period, was "out of control during much of her stay . . . but . . . was occasionally secluded in nonemergencies." *Id.* at 1380 (footnotes omitted).

torts, such as assault, battery and false imprisonment, did not apply in the context of institutionalized mental care since involuntary hospitalization necessarily involves nonconsensual touching and restraint of patients. In the court's view, claims in this setting are more appropriately considered under the law governing malpractice, where liability is determined by reference to the defendants' conformance to reasonable medical practice. *Id.* at 1383-84.

Applying malpractice principles, the court held that defendants' actions in forcibly medicating and secluding patients in nonemergencies were not negligent. The medicated patients showed improvements, and the forcible medication, although found to be a violation of plaintiffs' constitutional rights, was not "inconsistent with accepted medical standards." *Id.* at 1386. Similarly, with respect to the malpractice seclusion claims, the court held that nonemergency seclusion was not a departure from reasonable medical standards. "The weight of the evidence persuades this court that defendants' decision to seclude was a reasonable means of maintaining some stability and order in the ward without causing disproportionate harm to the person secluded." *Id.* at 1388-89 (footnote omitted).

ARGUMENT

I. ASSUMING THAT PLAINTIFFS' CONSTITUTIONAL RIGHTS WERE VIOLATED BY NONEMERGENCY FORCIBLE MEDICATION AND SECLUSION, DEFENDANTS ARE ENTITLED TO A GOOD FAITH IMMUNITY FROM DAMAGES.

Even accepting the district court's determination that plaintiffs have a constitutional right to be free from forcible medication and seclusion except in emergency situations, the court correctly found that the facts of this case provided defendants a good faith immunity from liability.[3]

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[3] The issue of damages in a § 1983 case do not arise, of course, unless a constitutional violation has been established. In our earlier

The Supreme Court has established that certain categories of state officials possess a qualified immunity from liability for damages under 42 U.S.C. § 1983. *Wood* v. *Strickland*, 420 U.S. 308 (1975); *Scheuer* v. *Rhodes*, 416 U.S. 232 (1974). This immunity protects officials from damage liability for official actions found to have been taken in good faith. Doctors such as defendants practicing in state hospitals are, without question, among the class of public officials protected by a qualified immunity. *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975); *Downs* v. *Sawtelle*, 574 F.2d 1 (1st Cir.), *cert. denied*, 99 S.Ct. 278 (1978).

The test for determining whether an individual official is entitled to immunity in each case includes both an objective and a subjective component. As the Supreme Court stated in *Wood* v. *Strickland*, *supra*, 420 U.S. at 322, an official is subject to liability for damages under § 1983

> "if he knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of the [individual], or if he took the action with the malici-

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brief we demonstrated that, contrary to the ruling below, the forced medication practices challenged in this case were not in violation of the Constitution. Moreover, in amicus' view, the decision below fails to establish that the challenged seclusion practices amount to a constitutional violation. The district court relied on nothing more than the fact that the seclusion practices were found to violate state law. 478 F.Supp. at 1375. But while state law may provide the basis for invoking *procedural* due process with respect to a state-created liberty interest, *Meachum* v. *Fano*, 427 U.S. 215 (1976), there is no comparable justification for creating independent *substantive* constitutional rights. Significantly, in this case, the court issued no procedural due process standards with respect to seclusion, but rather created a new substantive constitutional right based simply on state law. In so doing, it committed error. *See Paul* v. *Davis*, 424 U.S. 693, 701 (1976); *Beaumont* v. *Morgan*, 427 F.2d 667, 761 n.2 (1st Cir.), *cert. denied*, 400 U.S. 882 (1970). Hence, there is no constitutional violation and thus no need for the court to even reach the question of defendants' good faith immunity.

> ous intention to cause a deprivation of constitutional rights or other injury to the [individual]."

The Court further explained that a damages award against an official would be appropriate only if he

> "acted with such an impermissible motivation or with such disregard of the [individual's] clearly established constitutional rights that his action cannot reasonably be characterized as being in good faith." *Id.*

For constitutional purposes, malice which would deprive a defendant of immunity includes "wanton neglect," *Harper* v. *Cserr*, 544 F.2d 1121, 1125 (1st Cir. 1976) and " 'reckless indifference to the rights of the individual citizen.' " *Kelley* v. *Dunne*, 344 F.2d 129, 133 (1st Cir. 1965) quoting *Vigoda* v. *Barton*, 348 Mass. 478, 204 N.E.2d 441, 446 (1965). Whether for purposes of immunity a particular action is "wanton or reckless depends in part on the context in which it occurs." *Downs* v. *Sawtelle, supra*, 574 F.2d at 13. Thus a determination of good faith immunity requires examination of all the circumstances under which the actions complained of were taken.

In this case, the court specifically found that in the "totality of the circumstances presented by the evidence," 478 F.Supp. at 1383, defendants were entitled to a good faith immunity from liability for damages. The issue of an official's good faith immunity is peculiarly a question for the trier of fact. *See Downs* v. *Sawtelle, supra*, 574 F.2d at 13; *Duchesne* v. *Sugarman*, 566 F.2d 817, 829-30 (2d Cir. 1977). The court's findings on defendants' good faith are amply supported by the record. Since those findings plainly are not "clearly erroneous" under the standards of Rule 52(a), Fed.R.Civ.P., the trial court's findings of good faith immunity with respect to plaintiffs' claims of unconstitutional forcible medication and seclusion should be affirmed.

A. Defendants Are Entitled To A Good Faith Immunity From Liability For Any Forcible Medication Of Plaintiffs In Nonemergencies.

Assuming that nonemergency forcible medication would violate plaintiffs' rights and assuming that plaintiffs established that any of the defendants had forcibly medicated any of the plaintiffs in nonemergencies,[4] the district court was entirely correct in applying the Supreme Court's good faith immunity tests to find defendants immune. In determining the validity of a proffered good faith immunity defense, the court must consider the state of the law during the relevant time period: "[A]n official has, of course, no duty to anticipate unforeseeable constitutional developments." *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 577; *Wood* v. *Strickland*, *supra*, 420 U.S. at 322. As the district court here found, no defendant could reasonably have anticipated in the relevant period 1973-75 that civilly committed patients would be found to have a right to refuse medication except in the limited emergency situations defined by the district court. No previous decision had recognized any such rights. Indeed, the only Massachusetts case at that time discussing forcible medication had remarked that the failure to administer medication involuntarily to refusing patients was "inconsistent with good practice." *Nason* v. *Superintendent of the Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908, 912 n.7 (1968). Thus, defendants could not reasonably have known that forcibly medicating patients in nonemergencies violated their constitutional rights.

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[4] In view of the court's finding of good faith immunity, it made no findings concerning the individual responsibility of any of the defendants for the particular instances in which constitutional rights were violated. Thus, plaintiffs have failed to establish that any of the doctors were responsible for any particular instance of nonemergency forcible medication or seclusion. Such individualized findings of personal responsibility would, of course, be essential to the award of damages.

As found by the district court, moreover, plaintiffs could not demonstrate that defendants acted with the "impermissible motivation" necessary to permit an award of damages. *See Wood* v. *Strickland*, *supra*, 420 U.S. at 322. The court found that defendants intended forcible medication "as treatment," 478 F.Supp. at 1382, that it was consistent "with accepted medical standards," *id.* at 1386, that the medication was "of significant value in treating psychotic patients," *ibid.*, and that "most [patients] showed eventual improvement from the medication," *ibid.* Combined with the court's findings concerning the "less than desirable conditions," *id.* at 1383, under which defendants worked and their absence of responsibility for those conditions, *id.* at 1385, the findings concerning defendants' bona fide and reasonable treatment purpose and their clear inability to predict the later establishment of a constitutional right to refuse medication require affirmance of the district court's immunity decision.

B. Defendants Are Entitled To A Good Faith Immunity From Liability For Any Seclusion Of Plaintiffs In Nonemergencies.

Assuming plaintiffs have established that defendants have violated plaintiffs' constitutional rights by permitting plaintiffs to be secluded in nonemergencies and without compliance with the procedures set out in Mass. D.M.H. Reg. § 223.02, the district court again correctly ruled that defendants have a good faith immunity from damage liability. In the first instance, defendants could not have anticipated in 1973 that a federal court in 1979 would make the unprecedented decision that violation of a state statute would by itself constitute a violation of plaintiffs' constitutional rights. Since no court then or since had ruled that seclusion of civilly committed patients was unconstitutional except in "the occurrence of, or serious threat of, extreme violence, personal injury, or attempted

suicide," M.G.L. Ch. 123 § 21, defendants certainly could not be found to have disregarded "clearly established constitutional rights," *Wood* v. *Strickland, supra,* 420 U.S. at 322. As the district court properly recognized, "defendants are not charged with a duty to anticipate then unchartered constitutional developments." 478 F.Supp. at 1382.

Defendants' arguable violation of a state statute does not deprive them of immunity. The relevant test is whether defendants "knew or reasonably should have known" that their conduct violated plaintiffs' constitutional rights, *see Wood* v. *Strickland, supra,* 420 U.S. at 322; not whether they "knew or reasonably should have known" that their conduct might be in violation of a state statute. Even if the conduct violated a state statute, knowledge of that fact would in no way inform defendants that their conduct might also violate plaintiffs' constitutional rights. *Cf. Paul* v. *Davis,* 424 U.S. 693 (1976).

It would be especially unreasonable to impute knowledge of a constitutional violation from violation of a state statute where, as here, the statutory standard is so difficult to apply. As the district court found "it is difficult to predict a bona-fide emergency with any certainty." 478 F. Supp. at 1389 n.72. Establishing constitutional damage liability on noncompliance with such a statutory mandate where "the prelude to an unequivocable emergency [is termed] a 'gray zone,'" *id.,* would create liability under circumstances clearly at odds with the Supreme Court's good faith immunity standards. Far from leaving an official liable only where he acted "with such an impermissible motivation or with such disregard of the [individual's] clearly established constitutional rights that his action cannot reasonably be characterized as being in good faith," *Wood* v. *Strickland, supra,* 420 U.S. at 322, such a ruling would leave an official liable where he could not have anticipated any constitutional violation and

where, as found by the district court, he acted in furtherance of "reasonable medical practice." 478 F.Supp. at 1389.

As the district court's opinion demonstrates, there can be no doubt that defendants were totally devoid of any malicious motivation. While admittedly it is not dispositive that defendants acted in the best interests of their patients if in so doing defendants knew or reasonably should have known they were violating plaintiffs' constitutional rights, *see Perez* v. *Rodriguez Bou*, 575 F.2d 21, 23 (1st Cir. 1978); *Downs* v. *Sawtelle*, *supra*, 574 F.2d at 12, where defendants had no reason to know of any such asserted constitutional rights, the absence of any malicious motivation is an important consideration.

The district court found that in those instances where seclusion was employed in nonemergencies, it was used "as a treatment modality and not as punishment." 478 F. Supp. at 1374. The use of seclusion was not "a departure from reasonable medical standards," *id.* at 1388, and was not an unreasonable response to behavior that was disruptive but not sufficiently threatening to constitute an emergency. *Ibid.* It concluded that "defendants' decision to seclude was a reasonable means of maintaining some stability and order on the ward, without causing disproportionate harm to the person secluded." *Id.* at 1389 (footnote omitted). Moreover, as the court also found, the use of seclusion as treatment "to strengthen and maintain a patient's sense of control" and "to improve the patient's ability to cope" was "reasonable medical practice." *Ibid.* (footnote omitted). *See* Gutheil, *Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient*, 135 Am.J.Psychiat. 325 (1978); Mattson & Sacks, *Seclusion: Uses and Complications*, 135 Am.J.Psychiat. 1210 (1978).

C. Failure To Provide A Good Faith Immunity To Doctors Under The Circumstances Of This Case Will Jeopardize Patient Care In State Hospitals And Unfairly Penalize Doctors For Acting In Accordance With Reasonable Medical Practice.

A decision to hold the doctors in this case personally liable for damages for violation of plaintiffs' constitutional rights by means of their treatment actions—actions that the district court determined were in conformity with accepted and reasonable standards of medical practice—will redound to the detriment of all civilly committed patients. Rather than risk possible damages, doctors will avoid medicating or secluding patients except in situations where the emergency is clear—that is, where the violent or self-destructive behavior has actually occurred. Since predictions of when physical harm will occur are difficult to make, *see* A. Stone, Mental Health and Law: A System in Transition, 27-36 (1975) ; Amer. Psychiat. Ass'n., Task Force Report No. 8: *Clinical Aspects of the Violent Individual*, 23-24 (1974), and since a psychiatrist will be liable in damages only when he wrongly predicts that physical injury will result, psychiatrists will wait until actual violence has occurred before secluding or forcibly medicating patients. This paralysis of the medical staff will work to the detriment of all patients. Patients and staff will be exposed to increased danger of assault and the therapeutic environment will be destroyed.

The quality of care will also deteriorate because the state psychiatric hospitals will be unable to attract competent physicians. These hospitals are already struggling to obtain sufficient numbers of competent psychiatrists, as the district court recognized. *See* 478 F.Supp. at 1384-85. *See generally* Note, *Psychiatry in the Public Sector*, 30 Hosp. & Comm. Psychiat. 749 (1979). If the doctors are subject to damages each time they wrongly predict whether a patient's current behavior is likely to deterio-

rate into assaultive or self-destructive behavior, few competent psychiatrists will agree to work under those conditions.

It is, moreover, wholly unfair and inappropriate to hold individual physicians liable for damages for violation of constitutional rights where their conduct was entirely in accord with reasonable medical practice and where the conditions under which they labored were far from optimal. The district court's findings are significant:

> These resources were barely adequate. For most patients, Boston State was the end of the treatment line. Its prime function was to deal with the most disturbed and potentially violent patients, those for whom local mental health clinics could not care. . . . But defendants had little control over the quality or quantity of staff or physical resources. Like front line surgeons, they were required to work with what they had. The court concurs with the position of the American Psychiatric Association that it would be unjust and unreasonable for courts to hold psychiatrists personally and individually responsible for resource deficiencies that are actually the responsibility of society. *Id.* at 1384-85 (footnotes omitted).

II. THE DISTRICT COURT CORRECTLY RULED THAT DEFENDANTS WERE NOT LIABLE BASED ON THEIR SECLUSION AND MEDICATION PRACTICES FOR DAMAGES UNDER MASSACHUSETTS LAW.

The district court rejected plaintiffs' state law tort claims for assault, battery and false imprisonment on the ground that those torts could not be literally applied to the activities in a state mental hospital. The court instead ruled that the appropriate standard for liability in these circumstances is the traditional law of malpractice, 478 F.Supp. at 1383-84, and found that defendants were not guilty of malpractice for their seclusion and medication

practices. *Id.* at 1384-89. Amicus considers these decisions to constitute a sensible and sensitive application of tort principles to the circumstances prevailing in a state psychiatric facility.[5]

A. Traditional Intentional Tort Theories Should Not Be Applied To Treatment Practices For Civilly Committed Patients In State Psychiatric Facilities.

The district court held that applying plaintiffs' claims for false imprisonment, assault and battery to the medication and seclusion practices in a state mental hospital was unreasonable even as a matter of "[c]ommon sense." *Id.* at 1383. Individuals who are involuntarily hospitalized are invariably "touched or restrained against their wills." *Ibid.* "To impose liability on physicians for good faith, non-negligent touchings and restraints would impede if not immobilize the administration [of a state mental hospital]." *Ibid.*

This is not to say that no behavior by a physician or staff towards a hospitalized patient can be a proper subject of an action for assault or battery. For example, if a staff member were to beat a patient or to force upon a patient nonemergency, nonconsensual treatment for medical problems unrelated to the mental illness for which the

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[5] Although the district court correctly ruled that defendants were not liable in damages to plaintiffs on their state law tort claims, the court erred in holding that defendants could be vicariously liable for the medication or seclusion practices of other individuals. As public officials, defendants cannot under Massachusetts law be held liable for the action of other state employees, *see, e.g., Desmarais* v. *Wachusett Regional School District*, 360 Mass. 591, 276 N.E.2d 691 1971); *Somers* v. *Osterheld*, 335 Mass. 24, 138 N.E.2d 370 (1956), or for the actions of individuals who are not their employees, *see, e.g. Campbell* v. *Thornton*, 368 Mass. 528, 333 N.E.2d 442 (1975); *Withington* v. *Jennings*, 253 Mass. 484, 149 N.E.2d 201 (1925). Since the district court did not find that any individual psychiatrist was responsible for any instance of forcible medication or nonemergency seclusion of any of the plaintiffs, no liability in damages can be found.

patient was committed, there is no reason not to apply ordinary tort principles. But where the touchings or restraints at issue are aimed at treating the mental illness that required the patient's involuntary hospitalization, the appropriate inquiry is whether the treatment practices were in conformance with accepted medical practice.

In reaching its conclusion that malpractice principles rather than ordinary intentional tort theories were the appropriate basis for plaintiffs' state law claims, the district court relied on decisions from other states indicating that damages would not lie if the challenged conduct was appropriate treatment, *see Morgan* v. *State*, 337 N.Y.S.2d 536 (1972); *Hammer* v. *Rosen*, 198 N.Y.S.2d 65 (1960), and noting the inappropriateness of applying the usual definition of intentional torts to contacts between patients and attendants. *See O'Donoghue* v. *Riggs*, 440 P.2d 823, 828 n.2 (Wash. 1968):

> We do not wish to be understood as in any manner suggesting that the usual and ordinary definition of a battery applies to all intentional contact between a patient in a mental hospital and an attendant, even though the patient may find the personal contact offensive. . . . [T]he reasonable use of force may be necessary within a mental hospital in the proper care and treatment of a patient and in order to protect him or others from harm. 440 P.2d at 828 n.2.

Any other approach would be unworkable. The day-to-day problems of treatment of a seriously mentally ill population simply do not allow the kind of "measured" behavior that can be expected in noninstitutional settings. When the physician's behavior deviates from established practice, then he can be held liable in tort.[6]

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[6] Even if the traditional Massachusetts tort law of assault, battery and false imprisonment were held to apply to institutional settings, defendants in this case would be protected against a damage judgment under the state law doctrine of good faith immunity, *See Gildea*

B. Defendants Are Not Liable In Damages For Malpractice For The Seclusion And Medication Practices About Which Plaintiffs Complain Since They Were All Consistent With Reasonable Medical Practice.

As the district court pointed out, the standard of care owed in Massachusetts by a physician to a patient is whether the physician " 'has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession.' " 478 F.Supp. at 1384, quoting *Brune* v. *Belinkoff*, 354 Mass. 102, 235 N.E.2d 793, 798 (1968). One consideration in applying the standard, moreover, is " 'the medical resources available to the physician . . . [so that] some allowance is thus made for the type of community in which the physician carries on his practice.' " *Id.* The district court's findings that defendants' seclusion and forcible medication practices constituted treatment within acceptable medical standards are correct and should be affirmed. In any event, they surely are not "clearly erroneous" under the standards set by Rule 52(a), Fed.R.Civ.P.

As the court noted, 478 F.Supp. at 1386 n.62, there was substantial evidence both in medical literature and in the expert testimony in this case that the medication practices at issue were within accepted medical standards. And, as the court found, the defendants' medication practices resulted in eventual improvement in most patients' conditions and were of significant value in their treatment. *Id.* at 1386. Regardless of whether these practices may be found to have violated plaintiffs' constitutional rights, they were clearly consonant with established medical practice thereby precluding liability for malpractice.

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v. *Ellershaw*, 363 Mass. 800, 298 N.E.2d 847 (1973); *Vigoda* v. *Baron*, 348 Mass. 478, 204 N.E.2d 441 (1965). The district court's findings of fact establish that all of defendants' medication and seclusion practices were performed in good faith, and they thus are immune under state law as well as federal law.

With respect to plaintiffs' seclusion claims, the district court's findings are equally unassailable. Despite any possible constitutional problems posed by the seclusion practices, those practices were acceptable treatment and did not constitute "a departure from reasonable medical standards." *Id.* at 1388. The use of seclusion as treatment "to strengthen and maintain a patient's sense of control" and "to improve the patient's ability to cope," *id.* at 1389, cannot be deemed malpractice.

CONCLUSION

For the foregoing reasons, amicus curiae, the American Psychiatric Association, urges this Court to affirm the decision below insofar as it holds that defendants are not liable in damages to plaintiffs for their medication or seclusion actions.

Respectfully submitted,

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