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## Right to Refuse Antipsychotic Medication: A Proposal for Legislative Consideration

### I. INTRODUCTION

One of the most divisive issues confronting psychiatry and law today is whether or not involuntarily confined mental patients in state institutions have a right to refuse treatment with powerful antipsychotic drugs. Open hostility has developed between medical professionals attempting to provide institutional care and legal professionals representing patients who assert individual rights.<sup>1</sup> Because of recent court decisions which have held that the involuntarily committed mentally ill have a qualified constitutional right to refuse antipsychotic medication,<sup>2</sup> this issue is now an immediate concern for states. These recent decisions illustrate judicial schizophrenia regarding the basic issue of what constitutional analysis to apply in defining a right to refuse treatment, and also indicate judicial discord in defining the scope of such a right.

Antipsychotic medication<sup>3</sup> is widely accepted and commonly used in mental institutions.<sup>4</sup> These drugs are effective in altering patients' moods, behavior, and thoughts. Critics dispute the drugs' effectiveness and claim that they are used primarily to control behavior.<sup>5</sup> In the current state

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<sup>1</sup>See, e.g., Dix, *Realism and Drug Refusal: A Reply to Applebaum and Gutheil*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 180 (1981).

<sup>2</sup>See *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978) (motion for preliminary injunction), 476 F. Supp. 1294 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

<sup>3</sup>See *infra* note 19 and accompanying text.

<sup>4</sup>See *infra* note 20 and accompanying text.

<sup>5</sup>See *infra* notes 22-23 and accompanying text. The district court in *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), cited a study by Dr. George Crane which concluded that psychotropic drugs are widely prescribed by hospital staff doctors to solve problems in managing patients. *Id.* at 1299 (quoting Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Science 124, 125 (1973)). The district court also observed that state hospitals for the mentally ill were understaffed, and that patients had trouble seeing a psychiatrist. 476 F. Supp. at 1299. In a previous decision, the same court found that doctors in state mental

mental institutions.<sup>4</sup> These drugs are effective in altering patients' moods, behavior, and thoughts. Critics dispute the drugs' effectiveness and claim that they are used primarily to control behavior.<sup>5</sup> In the current state mental health system, where care is often provided by an insufficient number of poorly trained and overwhelmed staff, the inappropriate and extensive use of involuntary medication is a threatening reality to mental patients.<sup>6</sup> All researchers agree that these antipsychotic drugs have serious and potentially permanent side effects.<sup>7</sup>

Some patients, faced with institutional drug abuse and its debilitating side effects, have objected to antipsychotic medication and have sought to establish in court their rights to refuse treatment. Yet, legal challenges raised on common law theories such as informed consent have generally been unsuccessful, because the institutionalized mentally ill traditionally are excluded from such protections.<sup>8</sup> Likewise, state statutory remedies are often either nonexistent or vague and applied with uncertainty.<sup>9</sup>

Challenges based on constitutional principles which protect individuals from unwarranted government interference are proving more successful. Recently, two federal appellate courts have expressly recognized a qualified constitutional right to refuse antipsychotic medication.<sup>10</sup> Unfortunately, these courts have been imprecise in defining the standards and procedures a state must follow if it seeks to override such a refusal. Although the

health facilities did not have sufficient time for each patient. 462 F. Supp. 1131, 1136 (D.N.J. 1978).

As a result of conditions like those found by the New Jersey district court, drugs are often given by untrained staff in improper dosages for extended periods of time and are used in combinations with other drugs. 476 F. Supp. at 1300-03 (inadequate diagnosis, administration, and monitoring of drug treatment described). See *In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981). In *Roe*, the court noted that other courts "have identified abuses of antipsychotic medication by those claiming to act in an incompetent's best interests." *Id.* at \_\_\_\_ n.\_\_\_\_, 421 N.E.2d at 53 n.11. See also Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 463-64 (1977) (Mental hospitals that are understaffed, overcrowded, and underfinanced can lead to questionable practices in drug prescription and treatment.).

<sup>4</sup>476 F. Supp. at 1299.

<sup>7</sup>See *infra* notes 34-43 and accompanying text.

<sup>8</sup>Although many courts will discuss the common law doctrine of informed consent, most cases hold that a mental patient's right to refuse antipsychotic drug treatment is based on constitutional grounds. See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915, 929 (N.D. Ohio 1980) (holding based on fourteenth amendment); *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) (holding based on constitutional right to privacy).

<sup>9</sup>See *infra* notes 74-77 and accompanying text.

<sup>10</sup>*Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980); *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978) (motion for preliminary injunction), 476 F. Supp. 1294 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

courts agree that states, through their police powers, have an inherent ability to protect the lives and well-being of their citizens and can forcibly administer medication to patients in an "emergency," courts disagree on a definition of "emergency."<sup>11</sup> Additionally, courts do not agree on the scope of the states' *parens patriae*<sup>12</sup> power to care for those who cannot care for themselves. The United States Supreme Court has demanded that any remedy for forcible administration of antipsychotic drugs should be sought through the state.<sup>13</sup> Therefore, whether or not a patient may refuse antipsychotic drugs depends solely upon the jurisdiction in which the right is asserted, and most states have not addressed this issue.<sup>14</sup>

As more states are faced with the overwhelming evidence of institutional abuse of antipsychotic medication and as an increasing number of courts are confronted with the intense controversy in this developing constitutional law area, the need for useful procedures designed to protect patients' rights will become critical. This Note offers a legislative proposal creating guidelines for protecting the rights of the involuntarily committed mental patient to refuse forcible administration of antipsychotic drugs.<sup>15</sup> The second section of the Note examines the traditional absence of common law and state law remedies for those complaining of forced medication in state hospitals. This section will also trace the development of a federal right to refuse such medication. The third section turns to the proposed guidelines for legislative consideration. The system established by the United States District Court for New Jersey in *Rennie v. Klein*<sup>16</sup> provides the framework for this proposal. The proposal adds several modifications to increase its adaptability and use.

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<sup>11</sup>See *infra* note 81.

<sup>12</sup>The state may intercede as *parens patriae* to provide for persons under actual or legal incapacity. Under this power, the state provides for the adjudication of incompetence, the appointment of a guardian, and the treatment of a patient in the absence of consent. See, e.g., *Winters v. Miller*, 446 F.2d 65, 70-71 (2d Cir. 1971). See also *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980). The court determined that the state may impose antipsychotic drugs on patients through its *parens patriae* power, but only if the patient is incapable of deciding for himself. *Id.* at 935.

<sup>13</sup>*Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>14</sup>See *infra* notes 72-78 and accompanying text.

<sup>15</sup>This Note and its proposal is limited to adults who are involuntarily committed to state mental hospitals. Minors present special problems beyond the scope of this Note. Likewise, the "voluntary" patient who theoretically may refuse any medication and who may leave the hospital at will is not included in this work. Studies indicate, however, that many of these "voluntary" patients are coerced into treatment, unaware of their rights to leave the hospital and are as much confined as prisoners. See, e.g., *Emery v. State*, 26 Utah 2d 1, 4, 483 P.2d 1296, 1298 (1971).

<sup>16</sup>462 F. Supp. 1131, 1148 (D.N.J. 1978) (motion for preliminary injunction), 476 F. Supp. 1294 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

## II. Recognizing a Right

### A. Realities of the Current System

In the 1950's, with the discovery of a "remarkable" class of antipsychotic drugs,<sup>17</sup> psychiatry began a new era in the treatment of psychosis, the most severe of mental disorders.<sup>18</sup> Active treatment with these tranquilizing drugs effectively alters mental patients' moods, behavior, and thought processes.<sup>19</sup> The use of these drugs has become the predominant form of treatment. Studies indicate that nearly every patient in some state hospitals receive regular administration of these drugs.<sup>20</sup>

Antipsychotic drugs are most commonly used in treating patients diagnosed as schizophrenics.<sup>21</sup> The drugs, by influencing chemical transmissions in the brain, sedate the schizophrenic and suppress psychotic

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<sup>17</sup>See Cole & Davis, *Antipsychotic Drugs*, 2 A. FREEMAN & H. KAPLAN, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY II, 1921 (2d ed. 1975); Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 SCIENCE 124 (1973).

<sup>18</sup>AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980). Psychosis is a severe mental disorder that is characterized by a generalized failure of functioning. There are two major categories of psychoses: Those associated with organic brain disorders (brain injury or brain disease), and those not attributable to physical conditions. The latter category is further divided into three groups: The schizophrenias, characterized by disorders of thought; the major affective disorders, characterized by disturbances of mood; and the paranoid states, characterized by a system of delusions. *Id.*

<sup>19</sup>Antipsychotic drugs, also called neuroleptics or major tranquilizers, are a subclass of psychotropic drugs—drugs for the treatment of psychiatric problems. Antipsychotics include several chemical compounds. The four major groups of compounds used in the treatment of schizophrenia are the rauwolfia derivatives, the phenothiazine derivatives, the butyrophenones, and the thioxanthene derivatives. Better known trade names of antipsychotics used in the United States are: Thorazine (brand of chlorpromazine), Halidol (brand of haloperidol), Prolixin (brand of fluphenazine), and Navane (brand of thiothexene). Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Rights to Refuse Treatment*, 72 NW. U.L. REV. 461, 474 n.77 (1977). See also C. Kornetsky, PHARMACOLOGY: DRUGS AFFECTING BEHAVIOR 81-101 (1976). In general, the drugs affect both the activity and inhibitory chemical transmissions to the brain. Because the drugs' purposes are to reduce the level of psychotic thinking, it is virtually undisputed that they are mind altering. *Id.*

<sup>20</sup>See Mason, Nerviano & DeBurger, *Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals*, 38 DISEASES OF THE NERVOUS SYSTEM 541 (1977). A study of drug administration concluded that in four state hospitals more than 93% of the patients were receiving antipsychotic medication. *Id.* at 541.

<sup>21</sup>Schizophrenia is a condition characterized by thought disorders that may be accompanied by delusions, hallucinations, attention deficits, and bizarre motor activity. The DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, *supra* note 18, names thought disorders as the predominant symptom. Clinicians generally try to classify schizophrenia into four types according to predominant symptoms: simple schizophrenia (characterized by apathy and withdrawal from social interaction but without bizarre symptoms), hebephrenic schizophrenia (most severe disintegration of personality characterized by hallucinations, delusions, and fantasy), catatonic schizophrenia (characterized by either excessive motor activity or by a mute, stuporous state), paranoid schizophrenia (characterized by delusions of persecution, grandeur, or both).

symptoms such as delusions, hallucinations, and other disorders.<sup>22</sup> Often, treatment with antipsychotic drugs leads to a shortened period of confinement,<sup>23</sup> especially if the schizophrenia is acute.<sup>24</sup> However, antipsychotic drugs do not cure mental illness, and patients generally relapse when removed from the medication.<sup>25</sup> Additionally, the drugs' effectiveness in aiding chronic schizophrenia<sup>26</sup> is clearly disputed; some schizophrenics never improve and others deteriorate.<sup>27</sup>

Unfortunately, antipsychotic drugs are prescribed not only to those diagnosed as schizophrenic, but also to those misdiagnosed as suffering from the illness.<sup>28</sup> Misdiagnosis may be as high as fifty percent.<sup>29</sup> Current diagnostic approaches are imperfect and imprecise, even when used by the most qualified psychiatrists.<sup>30</sup> Additionally, society provides disincentives for those persons working in mental institutions, which results in the employment of less than the most qualified psychiatrists. "Many, if not most, of the medical staff of state mental hospitals turn out to be

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<sup>22</sup>See Byck, *Drugs and the Treatment of Psychiatric Disorders*, THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 152 (L. Goodman & A. Gilman, eds. 1975). One authority noted that a single dose of chlorpromazine will cause the subject to experience a fall in blood pressure, increased heart rate, a decrease in respiratory rate, decreased salivary secretion, constriction of the pupils, and decreased motor activities. *Id.* at 152-200. See also L. Hollister, CLINICAL USE OF PSYCHOTHERAPEUTIC DRUGS (1973).

<sup>23</sup>See C. Kornetsky, PHARMACOLOGY: DRUGS AFFECTING BEHAVIOR 81-101 (1976).

<sup>24</sup>The court in *Rennie v. Klein*, 476 F. Supp. 1294, noted that "[t]he drugs are most useful in diffusing schizophrenic thought patterns during acute psychotic episodes." *Id.* at 1298 (citations omitted).

<sup>25</sup>Comment, *Madness & Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 WIS. L. REV. 497, 539 (1980) (citing Kinross-Wright & Charalompous, *A Controlled Study of a Very Long-Acting Phenothiazine Preparation*, 1 INT'L J. NEUROPSYCH. 66 (1965). See also Comment, *supra*, at 539 n.26 (citing Rothstein, *An Evaluation of the Effects of Discontinuation of Chlorpromazine in Chronic Patients*, 23 DISORDERS OF THE NERVOUS SYS. 522 (1962)).

<sup>26</sup>Schizophrenia is considered chronic if the psychotic patient has deteriorated over a long period of time, or if the patient has been hospitalized for more than two years. Davidson & Hearle, ABNORMAL PSYCHOLOGY 582 (1974).

<sup>27</sup>See, e.g., Davis, *Recent Developments in the Drug Treatment of Schizophrenia*, 133 AM J. PSYCHIATRY 208 (1976).

<sup>28</sup>See Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250 (1973). The author described an experiment that involved twelve normal "pseudopatients" who were admitted to a state mental institution. Eleven of these pseudopatients were diagnosed as schizophrenic and one as manic-depressive. *Id.* at 258 n.10. The researcher concluded that the mental hospital poses a special environment where the meaning of behavior can be misinterpreted. *Id.* at 257.

<sup>29</sup>See Pope & Lipinski, *Diagnosis in Schizophrenia and Manic-Depressive Illness: A Reassessment of the Specificity of "Schizophrenic" Symptoms in the Light of Current Research*, 35 ARCH. GEN. PSYCHIATRY 811 (1978) (describing unreliability in diagnosis).

<sup>30</sup>For a review of studies concerning the reliability and validity of psychiatric evaluations, see Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 699-732 (1974).

poorly trained in comparison with psychiatrists from other settings."<sup>31</sup> The institutional setting is one of overworked staff and insufficient resources, and care of the mentally ill has evolved into a system of inexpensive, convenient, and involuntary care. The court in *Davis v. Hubbard*,<sup>32</sup> for example, described the situation:

[T]he testimony at trial established that the prevalent use of psychotropic drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of the staff and for punishment. . . .

Psychotropic drugs are . . . freely prescribed . . . by both licensed and unlicensed physicians [who] . . . regularly prescribe drugs . . . without regard to whether he is personally assigned to the patient or whether he has even seen the patient. It is not unusual for attendants to recommend a certain dosage or increased dosage. . . . Further, when dealing with an especially disturbed patient, attendants can obtain additional medication by submitting appropriate forms to the pharmacy when there is no physician available.<sup>33</sup>

Not only are patients faced with the prevalent misuse of the potent antipsychotic drugs, but patients often must cope with inappropriate drug prescriptions. Even the most qualified of clinicians have encountered great difficulty in deciding which of the drugs to prescribe for particular schizophrenics.<sup>34</sup> Each drug's action upon certain symptoms is frequently unpredictable.<sup>35</sup> According to several investigators, "Drugs are chosen by custom and rumored repute, and dosage is commonly adjusted upward until the patient either responds or develops toxic symptoms; alternatively, a fixed dosage is used, based on previous experience or local practice."<sup>36</sup>

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<sup>31</sup>Langley, *Viewpoint: A Commentary By APA's President*, 60 PSYCHIATRIC NEWS 22 (1980). See 2 *Drugs in Institutions: Hearings Before the Subcommittee To Investigate Juvenile Delinquency of the Senate Comm. on the Judiciary*, 94th Cong., 1st Sess. (1975). Nearly 50% of the psychiatrists in state institutions are graduates of foreign medical schools. These psychiatrists are seldom licensed to practice in the state and few of them are fluent in English. *Id.* at 171. See also Knesper & Hirtle, *Strategies to Attract Psychiatrists to State Mental Hospital Work*, 38 ARCH. GEN. PSYCHIATRY 1135 (1981). In 1980, the number of psychiatrists in state mental institutions in 32 of 50 states averaged two per 100 inpatients. *Id.* at 1135.

<sup>32</sup>506 F. Supp. 915, 926 (N.D. Ohio 1980).

<sup>33</sup>*Id.* at 926-27 (footnote and citations omitted).

<sup>34</sup>Properly prescribed antipsychotic drugs produce only temporary symptomatic relief in those patients accurately diagnosed. However, an accurate diagnosis is rare and proper prescription of the drug is even more uncertain. See *Rennie v. Klein*, 462 F. Supp. 1131, 1139-40.

<sup>35</sup>462 F. Supp. at 1139-40.

<sup>36</sup>May, Van Putten, Yale, Potepan, Jenden, Fairchild, Goldstein & Dixon, *Predicting Individual Responses to Drug Treatment in Schizophrenia: A Test Dose Model*, 162 J. NERVOUS & MENTAL DISEASE 177, 178 (1976).

Unfortunately, the "toxic" side effects that accompany use of antipsychotic drugs are many. "All the antipsychotic drugs induce a variety of disorders of the central nervous system as side effects."<sup>37</sup> The patient may experience increased heart rate, congestion, jaundice, skin reactions, vision impairment, changes in cellular composition of the blood, parkinsonism, loss of libido, loss of secretion of certain hormones, and allergic reactions.<sup>38</sup> The most serious among these side effects is tardive dyskinesia, a potentially irreversible brain disorder. It is "characterized by rhythmical, repetitive, involuntary movements of the tongue, face, mouth, or jaw, sometimes accompanied by other bizarre muscular activity."<sup>39</sup> Tardive dyskinesia is not limited to patients who have been treated with antipsychotic drugs for long periods of time; the effects can appear within weeks.<sup>40</sup> Moreover, up to one-half of all long term hospitalized schizophrenics may be affected by the disorder.<sup>41</sup> Although side effects tend to diminish when treatment is stopped, tardive dyskinesia has no known cure, and is generally not discovered until its grotesque manifestations become seriously disabling.<sup>42</sup>

Generally, drug therapy with antipsychotics is the treatment of diseases of unknown causes by drugs of unknown consequences. Despite the uncertain benefits and the certain risks, antipsychotic medication continues to be the chief form of treatment for involuntarily confined mental patients.<sup>43</sup> Yet, while the dangers of overmedication and improper ap-

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<sup>37</sup>Rennie v. Klein, 653 F.2d 836, 843 (3rd Cir. 1981) (citing Plotkin, *supra* note 5, at 474-78).

<sup>38</sup>653 F.2d at 843-44. Many studies indicate a wide variety of effects ranging from simple dry mouth to death. *Id.* It is beyond the scope of this Note to catalogue all the possible side effects. See C. Kornetsky, PHARMACOLOGY: DRUGS AFFECTING BEHAVIOR 81-101 (1976).

<sup>39</sup>Rennie v. Klein, 462 F. Supp. at 1138 (citations omitted) (possible link between psychotropic drugs and suicidal depression). Tardive dyskinesia usually causes the muscles to produce continual involuntary chewing and lip motions and facial contractions, thereby subjecting the victims to severe embarrassment. Davis v. Hubbard, 506 F. Supp. 915, 929 (N.D. Ohio 1980).

<sup>40</sup>See Burke, Fahn, Jankovic, Marsden, Lang, Gollomp & Ilson, *Tardive Dystonia: Late-Onset and Persistent Dystonia Caused by Antipsychotic Drugs*, 32 NEUROLOGY 1335 (1982). This study consisted of 42 patients who developed a type of tardive dyskinesia with two months of treatment. *Id.* at 1335.

<sup>41</sup>That such a staggering percentage of hospitalized schizophrenics may be affected was established by medical testimony in Rennie v. Klein, 476 F. Supp. 1294, 1300 (1979). See also Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1980) (Two studies placed the prevalence of tardive dyskinesia among schizophrenics at 50% and 56%, with an outpatient prevalence rate of 41%).

<sup>42</sup>Comment, *supra* note 25, at 533 n.163. See Davis v. Hubbard, 506 F. Supp. 915, 929 (N.D. Ohio 1980); Rennie v. Klein, 476 F. Supp. 1294, 1300 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

<sup>43</sup>See *supra* note 42. See also Chandler & Child, (CAL. STATE ASSEMBLY OFFICE OF RESEARCH, THE USE & MISUSE OF PSYCHIATRIC DRUGS IN CALIFORNIA MENTAL HEALTH PROGRAMS), (1977).

plication lead to patient protest, patients commonly refuse such treatment to no avail.<sup>44</sup>

### B. *An Absence of Remedies?*

Confronted with the alarming degree of institutional abuse of antipsychotic medication, patients have turned to the courts for help.<sup>45</sup> An involuntarily confined mental patient may attempt to assert a legal right to refuse treatment through common law, statutory law, and constitutional provisions. Historically, however, these have proved to be inadequate tools in prescribing limitations upon state mental health systems.

1. *Common Law*.—Under common law, any unauthorized touching constitutes a battery,<sup>46</sup> even if that touching takes place for the purpose of rendering medical care.<sup>47</sup> Thus, physicians operate under the obligation to obtain the patient's consent before proceeding with treatment. This doctrine of informed consent,<sup>48</sup> as well as the common law tort of battery,<sup>49</sup> zealously guards "sane" persons from unwanted medical treatment. In contrast, involuntarily confined mental patients often have been excluded from the protections afforded by the doctrine of informed consent.<sup>50</sup> For them, a recovery based upon battery for forcible medication is not attained,<sup>51</sup> because courts hold that traditional torts are inapplicable to the forced medication of the mentally ill.<sup>52</sup> Similarly, medical malpractice

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<sup>44</sup>See Rachlin, *One Right Too Many*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975). "The usual practice is to give medication intramuscularly to those patients who do not cooperate with the oral route . . . . [The patients are] physically restrained, pants removed, injected with antipsychotic drugs through a hypodermic needle . . . at times in full view of other patients or staff." *Id.* at 101. See also *Mills v. Rogers*, 457 U.S. 291, (1982).

<sup>45</sup>See *infra* notes 50-53.

<sup>46</sup>See generally W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18, at 101-06 (4th ed. 1971).

<sup>47</sup>*Id.*

<sup>48</sup>The doctrine of informed consent reflects that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). See also *In re Brook's Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (N.Y. Sup. Ct. 1962).

<sup>49</sup>See W. PROSSER, *supra* note 46, § 10, at 37. See also *Pratt v. Davis*, 118 Ill. App. 161 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906); *Woodbridge v. Worcester St. Hosp.*, 384 Mass. 38, 423 N.E.2d 782 (1981) (court denied tort action).

<sup>50</sup>See, e.g., *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976).

<sup>51</sup>See, e.g., *Lojuk v. Quandt*, 706 F.2d 1456, 1467 (7th Cir. 1983) (affirming dismissal of battery action brought by schizophrenic patient who was subjected to electric shock therapy without his consent); *Rogers v. Okin*, 478 F. Supp. 1342, 1383 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650, 663 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Cox v. Hecker*, 218 F. Supp. 749 (E.D. Pa. 1963), *aff'd*, 330 F.2d 958 (3d Cir. 1964), *cert. denied*, 379 U.S. 823 (1964).

<sup>52</sup>See, e.g., *Lojuk v. Quandt*, 706 F.2d 1456 (7th Cir. 1983); *Rogers v. Okin*, 478 F. Supp. 1342, 1383 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650, 663 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).



actions for forcible medication have been unsuccessful.<sup>53</sup>

Nevertheless, careful analysis demonstrates that little support exists for the broad proposition that psychiatric treatment of the mentally ill cannot be remedied using common law principles.<sup>54</sup> Informed consent is found to exist when three conditions are met: The physician makes a reasonable disclosure to the patient of the treatment risks; a voluntary decision concerning treatment is made by the patient; and, the patient is competent to make such a decision.<sup>55</sup> The disclosure requirement theoretically poses little problem in situations involving mental patients.<sup>56</sup> Although empirical studies cast doubt on a patient's ability to assimilate information provided by the physician and to use this information in reaching a decision regarding treatment, these problems are no less prevalent in the "sane" world.<sup>57</sup> Furthermore, most courts reject the argument that voluntariness poses any substantial problem for the mental patient.<sup>58</sup>

The required element of competency to make informed decisions has traditionally represented a significant obstacle in applying the doctrine of informed consent to the involuntarily confined mental patient.<sup>59</sup> Before a patient can be involuntarily committed, a court must determine that he suffers the requisite degree of mental illness.<sup>60</sup> Despite the fact that these involuntary commitment proceedings are extremely brief,<sup>61</sup> courts

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<sup>53</sup>See, e.g., *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>54</sup>See generally Note, *A Common Law Remedy for Forcible Medication of the Institutionally Mentally Ill*, 82 COLUM. L. REV. 1720 (1982).

<sup>55</sup>See generally W. PROSSER, *supra* note 46, § 18, at 104-05; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970).

<sup>56</sup>See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (requiring disclosure of all risks, benefits and alternative treatments that a "reasonable patient" would require to make a well-informed decision). Most commentators recommend that psychiatrists comply with the *Canterbury* standard. See Mills, Hsu & Berger, *Informed Consent: Psychiatric Patients and Research*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 119-32 (1980).

<sup>57</sup>See Grundner, *On the Readability of Surgical Consent Forms*, 302 N. ENG. J. MED. 900, 901-02 (1980).

<sup>58</sup>Often, people in mental hospitals make few important decisions and are eager to please physicians and staff. See generally E. GOFFMAN, *ASYLUMS* (1961). This suggests that these patients are particularly susceptible to coercion, force, and duress. Nevertheless, most courts reject suggestions that institutionalized patients cannot give voluntary consent. See, e.g., *Kaimowitz v. Michigan Dep't of Mental Health*, No. 73-19434-AW, slip op. at 21 (Cir. Ct., Wayne County, Mich. July 10, 1973), excerpted in 2 PRISON L. REP. 433, 476 (1973) (court noting that the law has long recognized that a patient, institutionalized or not, can give valid consent).

<sup>59</sup>A single test for incompetency does not seem to exist. The usual presumption, in law and in medicine, is that an adult is considered competent until proven incompetent. Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCH. 279, 282 (1977).

<sup>60</sup>Procedures for involuntary commitment are prescribed by state statute.

<sup>61</sup>See, e.g., *Kendall v. True*, 391 F. Supp. 413, 415 (W.D. Ky. 1975) (average length of a commitment hearing is six minutes).

and psychiatrists have historically held the view that the commitment decision ipso facto resulted in an incompetency determination.<sup>62</sup> However, as the science of psychiatry develops and as the attitude toward the mentally ill becomes more realistic, the body of applicable law should also change to reflect the realities of general mental illness versus total mental incompetence.<sup>63</sup> The assumption that a patient who was committed by the courts is also incompetent to make decisions concerning his treatment is not necessarily correct.<sup>64</sup> At a commitment hearing, the only issue decided is whether the patient is dangerous or substantially unable to care for himself.<sup>65</sup> These patients presumptively retain all other civil rights. The United States Supreme Court has determined that in a hospital setting the patient must be incapable of making a competent decision concerning treatment before the state's *parens patriae* power can be exerted and drugs forcibly administered.<sup>66</sup> Additionally, most state statutes attempt to distinguish grounds for commitment from incompetency.<sup>67</sup> Recent court decisions recognize that mental illness and commitment do not presumptively imply incompetence and an inability to participate in treatment decisions.<sup>68</sup> Likewise, psychiatric authorities agree that there is not necessarily any relationship between commitment and the ability to make

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<sup>62</sup>See, e.g., *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976) (holding that the state needs to assume the decisionmaking role for one presumptively unable to do so rationally for himself). This merger of deciding incompetency with the commitment determination may, in part, be a result of the imprecise terminology used in most civil commitment statutes. Words such as "insane," "lunatic," and "crazy" foster the notion that a mentally ill person is totally incapable of rational thought. See Plotkin, *supra* note 5, at 483.

<sup>63</sup>See *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974).

<sup>64</sup>See, e.g., JOINT INFORMATION SERVICE OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, *PSYCHIATRIC POINTS OF VIEW REGARDING LAWS AND PROCEDURES GOVERNING MEDICAL TREATMENT OF THE MENTALLY ILL* 232, 237.

<sup>65</sup>See, e.g., *Colyar v. Third Dist. Ct. for Salt Lake County*, 469 F. Supp. 424 (D.C. Utah 1979) (Utah's statute requiring that commitment necessarily meant incompetence was found overly broad and impermissibly vague); *Bay v. Board of Registrars of Voters of Belchertown*, 368 Mass. 631, 332 N.E.2d 629 (1975) (finding commitment is not intended to involve a determination of competency).

<sup>66</sup>*Addington v. Texas*, 441 U.S. 418, 426-27 (1979). Under its *parens patriae* power, a state may order psychiatric treatment of a patient in the absence of consent. *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971).

<sup>67</sup>Several states expressly distinguish civil commitment and legal incompetency. E.g., ALASKA STAT. § 47.30.070 (1) (Supp. 1983); ARIZ. REV. STAT. ANN. § 36-506(A) (1979) (Supp. 1975-83); FLA. STAT. § 393.12 (Supp. 1974-83); IDAHO CODE § 66-346(a) (Supp. 1984); IND. CODE § 16-14-1.6-4 (Supp. 1984); KAN. STAT. ANN. § 59-2930 (Supp. 1984).

<sup>68</sup>See *Lojuk v. Quandt*, 706 F.2d 1456 (7th Cir. 1983), *cert. denied*, 404 U.S. 985 (1972); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650, 663 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). *But see A.E. and R.R. v. Mitchell*, No. C-78-466 (D. Utah 1980) (summarized in 5 MEN. DIS. L. REP. 154 (1981)) (court determined all committed persons were incompetent to make decisions).

rational decisions.<sup>69</sup> For the sake of efficiency and economy,<sup>70</sup> however, hospital regulations rarely discriminate between legally competent and incompetent patients, and presume that all involuntarily committed patients are incapable of consenting to treatment.<sup>71</sup>

Undoubtedly, the application of the common law doctrine of informed consent to the treatment of the involuntary mental patient requires the court to carefully balance the interests of both the state and the individual. In the balance, most courts have been reluctant to allow recovery involving the committed patient's right to refuse antipsychotic drugs.<sup>72</sup> Courts generally apply the doctrine to the private relationship between the doctor and the patient and are understandably reluctant to employ the doctrine in limiting the state's power over mental patients. Thus, courts look to statutory or constitutional remedies as a source of relief for mental patients expressing a right to refuse antipsychotic medication.

2. *State Statutes.*—Mental patients, in their search for a legal right to refuse drug treatments, are also foreclosed from the legal protections derived from statutes. State statutes are “a patchwork of inconsistencies and omissions,”<sup>73</sup> and judicial interpretations of these statutes also tend to be inconsistent. More specifically, a state mental patient's statutory right to refuse treatment with antipsychotic drugs is generally non-existent.<sup>74</sup> Some states do allow a patient to refuse medication, unless the attending physician determines such refusal would result in a deterioration of the patient's condition.<sup>75</sup> Given the bias of the medical attendant and the strained environment of the state institution,<sup>76</sup> even these statutes have the practical effect of offering the involuntary patient

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<sup>69</sup>See *supra* note 64, at 237 (“It must be clearly understood that the establishment of a mental illness does not, ipso facto, warrant a finding of incompetency. . . . From a medical point of view there is not, necessarily, any connection between the two.”). Thus, hospitalized mental patients have been permitted to engage in business transactions, write checks, file income tax returns, and conduct other independent matters typically recognized to require competence.

<sup>70</sup>See *supra* text accompanying note 5.

<sup>71</sup>It would be more logical to presume that the involuntary patient is capable of consenting to treatment unless the court has made an individual determination to the contract. See *infra* note 121.

<sup>72</sup>See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980).

<sup>73</sup>Plotkin, *supra* note 5, at 498.

<sup>74</sup>See, e.g., CONN. GEN. STAT. ANN. § 17-206d(b) (West Supp. 1983-84) (“Involuntary patients may receive medication and treatment without their consent. . . .”); IND. CODE §16-14-1.6-7 (Supp. 1979) (absent a petition to the court, involuntary patients have no right to refuse treatment). Several state statutes ignore procedures necessary for drug administration or refusal by involuntary patients. E.g., Alabama, Arkansas, Hawaii, Maine, and West Virginia.

At least one state specifically allows the involuntary mental patient to refuse “chemotherapy.” IOWA CODE ANN. §229.23(2) (West Supp. 1983).

<sup>75</sup>See, e.g., FLA. STAT. §393.13(3)(F) (Supp. 1974-83); GA. CODE §88.502.6(b) (Supp. 1982).

<sup>76</sup>See *supra* notes 5-6 and accompanying text.

no right to refuse. Several statutes do require procedural safeguards, such as informed consent, before certain "unusual" treatments may be used.<sup>77</sup> These statutes are typically vague, however, and their application to antipsychotic drug treatment is uncertain. Absent specific statutory grants of a right to refuse treatment with antipsychotic medication, courts have declined to find such a right.<sup>78</sup> Thus, mental patients are left with little control over the form their treatment will take.

Without applicable common law rights or consistent statutory rights, these patients presently can look only to the Constitution. Yet even at its most protective state, a constitutional right to refuse drugs, without supportive state statutes, proves limited in its effect. While the United States Constitution may define the minimum protections for patient autonomy, effective protection of a liberty interest results from supporting a recognized intertwining of the constitutional right with state law protections.<sup>79</sup>

3. *Constitutional Law.*—Confronted with evidence of the widespread institutional abuse of antipsychotic medication and with the absence of common law remedies for forced medication or state laws granting a right to refuse medication, federal courts recently have expressly recognized a constitutional right to refuse drugs.<sup>80</sup> Unfortunately, these courts have reached widely divergent conclusions on the scope of that right and on the specific procedures a state must follow if it seeks to override a refusal to submit to certain treatments.<sup>81</sup> Additionally, these courts disagree on the standards to be applied when protecting the patient's right.<sup>82</sup> Although courts concur that the state's inherent power to protect the

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<sup>77</sup>See, e.g., CONN. GEN. STAT. §17-206(d) (Supp. 1983) (safeguards for psychosurgery or ECT by substituted consent); DEL. CODE ANN. §16-5161 (Supp. 1982) (safeguards for experimental drugs or procedures); FLA. STAT. §393.13(3)(F)(1) (Supp. 1974-83) (no unnecessary or excessive medication); MONT. CODE ANN. §53-21-148 (1981) (safeguards for unusual or hazardous treatment procedures).

<sup>78</sup>See *In re B*, 156 N.J. Super. 231, 383 A.2d 760 (1977) (finding forced administration of antipsychotic drugs possible because these drugs were not listed as "intrusive drugs" in the statute); see also *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976).

<sup>79</sup>See *infra* notes 133-35 and accompanying text.

<sup>80</sup>Early courts and commentators disagreed on the constitutional theory involved in a right to refuse medication. See, e.g., *Scott v. Plante*, 532 F.2d 939 (3d Cir. 1976); (possible violation of first, eighth, or fourteenth amendments); *Knecht v. Gellman*, 488 F.2d 1136, 1139 (8th Cir. 1973) (eighth amendment); *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). For a discussion comparing the different constitutional bases for a right to refuse antipsychotic medication see *Cort, Judicial Schizophrenia: An Involuntarily Confined Mental Patient's Right to Refuse Antipsychotic Drugs*, 51 UMKC L. REV. 74, 83 (1982).

<sup>81</sup>*Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980); *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978) (motion for preliminary injunction), 476 F. Supp. 1294 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983). The remaining text of this section will discuss these differences in detail.

<sup>82</sup>See *supra* note 81 and accompanying text.

well-being of its citizens can be invoked to justify forcible medication in an emergency, courts inconsistently define "emergency."<sup>83</sup> Neither is there agreement on the scope of the state's *parens patriae* powers to care for those who cannot care for themselves.<sup>84</sup> Nevertheless, these recent cases have established a qualified constitutional right to refuse administration of antipsychotic drugs, and this right may well be recognized by other courts.

In *Rennie v. Klein*,<sup>85</sup> mental patients bringing suit under the Civil Rights Act<sup>86</sup> challenged the practice of forcible medication in New Jersey mental hospitals. The United States District Court for New Jersey concluded that involuntarily committed patients have a substantive constitutional right to refuse medication,<sup>87</sup> and it announced a three-step procedure to ensure due process when the state seeks to override a refusal. First, the treating physician must inform the patient about his condition, his need for a particular drug, his right to refuse the drug, the risks or benefits of the drug, and other alternative treatments. Second, if written, informed consent is not obtained, the institution must refer the matter to an independent "Patient Advocate."<sup>88</sup> Third, independent psychiatrists must conduct an informal hearing and issue a written opinion.<sup>89</sup> For patients found incompetent by the court, the same procedures must be followed with the aid of a court-appointed guardian.<sup>90</sup>

The district court pointed out that, in New Jersey, commitment alone does not include a finding of incompetency; thus, an involuntarily confined patient must be presumed competent absent a contrary formal finding.<sup>91</sup> From this, the court found that even though some drug refusal is prompted by irrational components of psychosis, refusals can be predicated on a "quite rational desire to avoid unpleasant side effects and a realistic appraisal that the medication is not helping one's condition."<sup>92</sup>

In analyzing the constitutional issues, the court found the right to refuse medication to be included under the evolving constitutional right to privacy.<sup>93</sup> This right was considered broad enough to protect one's

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<sup>83</sup>See *supra* note 81 and accompanying text.

<sup>84</sup>See *supra* note 81 and accompanying text.

<sup>85</sup>476 F. Supp. 1294 (D.N.J. 1979), 462 F. Supp. 1131 (D.N.J. 1978).

<sup>86</sup>42 U.S.C. §1983 (1981). This act prohibits government officials from interfering with the civil rights of citizens.

<sup>87</sup>462 F. Supp. at 1145.

<sup>88</sup>476 F. Supp. at 1313-15. Patient advocates would be directly appointed, supervised, and paid by the central state agency, not by the mental hospital, and would be "trained attorneys, psychologists, social workers, registered nurses or paralegals." *Id.* at 1313.

<sup>89</sup>*Id.* at 1314-15.

<sup>90</sup>*Id.* at 1314.

<sup>91</sup>462 F. Supp. at 1145.

<sup>92</sup>476 F. Supp. at 1305.

<sup>93</sup>462 F. Supp. at 1143-44. The court found no violation of the eighth amendment prohibition against cruel and unusual punishment nor of the first amendment right of freedom of expression. *Id.* at 1143-44.

mental processes from government interference, and could only be overridden in emergencies or when the state can show a "strong countervailing interest."<sup>94</sup> The court defined an emergency as "a sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital."<sup>95</sup> In such an emergency, the patient could be forcibly medicated. In the absence of an emergency, but when the attending physician believes medication is necessary for the treatment, the state may exercise its *parens patriae* powers.<sup>96</sup>

On appeal, the Third Circuit Court of Appeals modified and remanded the district court's preliminary rulings.<sup>97</sup> The appeals court held that in a nonemergency situation, the forcible administration of antipsychotic drugs to involuntarily committed mental patients who have never been adjudicated incompetent must be the least restrictive means of treatment in order to be constitutional.<sup>98</sup> Nevertheless, the court stated that due process does not require a prior adversary hearing before an independent decision maker for each patient. The court found that it is sufficient that the regulations adopted by New Jersey are followed. These regulations require that, except in emergencies, the patient first be informed of his condition, of the need for a drug, of its possible effects and of his right to refuse.<sup>99</sup> If the patient refuses, then he is allowed to participate in a discussion by a treatment team concerning recommended medication.<sup>100</sup> Finally, if the treatment team affirms the necessity of the medication, the matter is referred to the medical director of the institution. If the director agrees, the patient's refusal is overridden.<sup>101</sup>

The court of appeals based its finding of a limited right to refuse medication on the due process clause of the fourteenth amendment rather than the right to privacy.<sup>102</sup>

Although the United States Supreme Court granted certiorari for *Rennie v. Klein*,<sup>103</sup> the Court vacated the Third Circuit's decision and remanded the case for reconsideration in light of the recent Supreme Court decision in *Youngberg v. Romeo*.<sup>104</sup> The *Romeo* decision, in the

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<sup>94</sup>*Id.* at 1144.

<sup>95</sup>476 F. Supp. at 1313.

<sup>96</sup>*Id.* at 1314.

<sup>97</sup>653 F.2d 836, 852 (3d Cir. 1981) (en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

<sup>98</sup>653 F.2d at 845.

<sup>99</sup>*Id.* at 848-49.

<sup>100</sup>653 F.2d 836.

<sup>101</sup>*Id.* at 849.

<sup>102</sup>653 F.2d at 843, 844.

<sup>103</sup>457 U.S. 291 (1982).

<sup>104</sup>102 S. Ct. 2452 (1982). The United States Supreme Court, in a single stroke and without receiving briefs or hearing arguments on the case, remanded the *Rennie* case back to the Third Circuit Court of Appeals for reconsideration in light of *Romeo*. 102 S. Ct. 3506 (1982). Despite the Court's reluctance to face the issue of the scope of a right to refuse treatment, the majority in *Romeo* was willing to go further than it ever had before. Justice Powell's decision recognized liberty interests protected by the due process clause of

context of an institution for the mentally retarded, stated that restrictions on patients' liberties for therapy could not be considered constitutional violations unless the professional judgment was so poor as to represent a deviation from the usual standard of care.<sup>105</sup> The Supreme Court thus declined to adopt, although it did not reject, a "least intrusive means" analysis as the sole standard for a mental patient's right to refuse treatment.<sup>106</sup>

In its reconsideration of *Rennie* in light of the Supreme Court's opinion in *Romeo*, the Third Circuit was called upon to determine whether or not the Supreme Court intended the professional judgment standard to be the sole basis in a decision to administer medication against the protests of an involuntarily committed mentally ill patient.<sup>107</sup> Only three of the ten judges joined in determining that the professional judgment standard is a standard separate and distinct from the least intrusive means test.<sup>108</sup> These judges, in an opinion written by Circuit Judge Garth, read into the Supreme Court's remand an implicit disapproval of the least intrusive means test in circumstances involving the involuntarily committed mentally ill. Thus, Judge Garth concluded, although "involuntarily committed mentally ill patients have a constitutional right to refuse administration of antipsychotic drugs," the "decision to administer such drugs against the patient's will must be based on accepted professional judgment and [the] procedures specified in New Jersey Administrative Bulletin 78-3 satisfied due process requirements in such regard."<sup>109</sup>

The seven other judges comprising the Third Circuit panel did not detect such a narrow message from the Supreme Court.<sup>110</sup> These judges, in three different concurring opinions and in one dissent, strongly articulated concerns for the welfare of the patient and of society as requiring a consideration of possible alternatives and the use of drugs and incorporation of the least restrictive alternative test as a part of the professional judgment standard.<sup>111</sup>

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the fourteenth amendment, a right to personal security and a right to freedom from bodily restraint. 102 S. Ct. at 2462.

<sup>105</sup>102 S. Ct. at 2462. In order to recover damages, "the decision by the professional [must be] such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." *Id.* (footnote omitted).

<sup>106</sup>See *infra* notes 154-56 and accompanying text.

<sup>107</sup>*Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983).

<sup>108</sup>Circuit Judge Garth was joined by Circuit Judges Aldisert and Hunter.

<sup>109</sup>720 F.2d 266, 267 (This quoted material is found in the reporter's summary; it is not part of the court's official opinion.).

<sup>110</sup>Chief Judge Seitz was joined here by Circuit Judges Adams, Weis, Higginbotham, Sloviter, Becker, and Gibbons.

<sup>111</sup>*Rennie v. Klein*, 720 F.2d 266, 270-77. Judge Adams concluded that the operative meaning of "professional judgment" is amorphous and most definitely necessitates a consideration of alternative choices in treatment. *Id.* at 271-72. Judges Becker and Seitz found that a decision to administer drugs is fact sensitive and requires a consideration of harmful side effects and alternatives to drugs. *Id.* at 273-74. Judges Weis, Higginbotham,

Ultimately, six of these seven judges concurred with Judge Garth's opinion; however, the concurrences were premised entirely on the fact that any professional decision to override a mental patient's refusal of medication must follow procedures specified in the New Jersey Administrative Bulletin 78-3. Significantly, the procedures within the Bulletin include considerations of the least intrusive alternatives.

The second federal court to find a constitutional right to refuse forcible medication was the First Circuit Court of Appeals in *Rogers v. Okin*.<sup>112</sup> In *Rogers*, patients challenged medication practices in a Massachusetts state hospital. The district court concluded that there is a constitutional right to refuse medication which can only be overridden in an emergency and not for purposes of treatment under the *parens patriae* powers.<sup>113</sup> The court defined emergency in terms of a substantial likelihood of physical harm to self or others.<sup>114</sup> For nonemergency circumstances, the district court imposed a requirement of informed consent.<sup>115</sup>

On appeal to the First Circuit, the district court's order was modified slightly.<sup>116</sup> The appellate court expanded the definition of emergency to include a balancing by physicians of relevant interests, including the necessity for immediate medical response in order to prevent or decrease the likelihood of a deterioration of the patient's clinical condition.<sup>117</sup> Also, the court remanded the case "for consideration of alternative means for making incompetency determinations in situations where any delay could result in significant deterioration of the patient's mental health".<sup>118</sup> Evidently, the court was calling for practical flexibility in determining incompetency.

The United States Supreme Court granted certiorari in *Rogers*;<sup>119</sup> but while the case was pending, a significant decision was rendered by the highest court of Massachusetts.<sup>120</sup> Because of this decision, the Supreme Court refused to decide the precise question of the right of an involuntary mental patient to refuse antipsychotic medication.<sup>121</sup> The Supreme Court noted that both the substantive and the procedural aspects of such a

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and Sloviter regretted the retreat of the court from advancements in applying the least intrusive means test and found that the Supreme Court had no intention of preventing the use of such a test. *Id.* at 274-76. Circuit Judge Gibbons dissented in an opinion expressing a need for even stronger protections for a mental patient's right to refuse treatment. *Id.* at 277 (referring to *Rennie v. Klein*, 653 F.2d 836, 865-70 (3d Cir. 1981)).

<sup>112</sup>478 F. Supp. 1342 (D. Mass. 1979).

<sup>113</sup>*Id.* at 1369. The court used the right to privacy as its constitutional basis.

<sup>114</sup>*Id.* at 1365, 1369.

<sup>115</sup>*Id.* at 1367-68.

<sup>116</sup>634 F.2d 650 (1st Cir. 1980).

<sup>117</sup>*Id.* at 656-67.

<sup>118</sup>*Id.* at 660.

<sup>119</sup>*Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>120</sup>*In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981).

<sup>121</sup>*Mills v. Rogers*, 457 U.S. 291 (1982).



right were intertwined with state law,<sup>122</sup> and remanded the case to the lower court for reconsideration in light of *In re Guardianship of Roe*.<sup>123</sup>

In *Roe*, a father was appointed as guardian for his noninstitutionalized incompetent son.<sup>124</sup> The father sought authority to consent to the forcible administration of antipsychotic drugs for his son. The Supreme Judicial Court of Massachusetts denied the father's request, holding that except in an emergency, the "substituted judgment" of an incompetent must be exercised by a judge, not a guardian, in cases of forced medication.<sup>125</sup> Only an overwhelming state interest would suffice in allowing forced medication.<sup>126</sup> Although the Massachusetts court emphasized that its holding was limited to noninstitutionalized incompetents, the United States Supreme Court found the case applicable in *Rogers*.<sup>127</sup> The *Roe* case indicated that the state might recognize liberty interests of a broader scope than those recognized by federal law, thus requiring greater procedural due process protection than the minimum required by the Constitution to protect federal rights.<sup>128</sup> The Supreme Court's decision in *Rogers* suggested that the Court may not use the *Romeo* standard (requiring unusual deviation from standard professional judgment in decisions to treat institutionalized patients forcibly) in cases involving the rights of mental patients. Nevertheless, the remand leaves uncertain both the scope of the federal right to refuse antipsychotic medication and the standards to be used by state mental institutions in order to protect this right.

As the Supreme Court suggested in *Rogers*,<sup>129</sup> the federal right to refuse treatment is a question with both substantive and procedural aspects. The substantive issue involves identification of the conditions under which competing state interests might outweigh the constitutionally recognized liberty interest in avoiding unwanted administration of drugs. The cases reveal no general agreement on the criteria that must be applied to determine whether refusals may be overridden. On the most fundamental level, disagreement exists as to whether, in nonemergency situations, a determination of incompetency is always necessary. The *Rogers* court suggested it is necessary.<sup>130</sup> However, *Rennie* holds that a patient's

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<sup>122</sup>*In re Guardianship of Roe*, 383 Mass. 415, \_\_\_\_, 421 N.E.2d 40, 50 (1982). The *Roe* decision indicated that a state might recognize liberty interests of a broader scope than those recognized under federal law, thus requiring greater procedural due process protection than the minimum required by the United State Constitution to protect the individual's federal rights. *Id.* at \_\_\_\_, 421 N.E.2d at 51.

<sup>123</sup>*Id.*

<sup>124</sup>*In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981).

<sup>125</sup>*Id.*

<sup>126</sup>*Id.*

<sup>127</sup>457 U.S. at 301.

<sup>128</sup>*Id.*

<sup>129</sup>*See id.* (1982). This suggests that if the state law provides a substantive right, this right will receive federal procedural due process protection.

<sup>130</sup>*Id.*

risk of harm to self or others may be sufficient.<sup>131</sup> In addition, the courts disagree as to the definition of an emergency situation; some courts hold that an emergency includes the threat of deterioration of the patient if he refuses drugs.<sup>132</sup>

The procedural issue concerns the standards required for determining when a patient's liberty interest actually is outweighed in a particular instance. While the Constitution defines the minimum, the true protections of due process are dependent upon the more extensive liberty interests recognized by state law.<sup>133</sup> Therefore, a right to refuse that will be accompanied by adequate procedural safeguards must be derived from the states. Presently, the states that have adopted legislative protections for a right to refuse medication are in the minority.<sup>134</sup> As this constitutional area develops<sup>135</sup> and more federal courts address the rights of the mental patient, legislatures will seek to construct guidelines to protect these rights.<sup>136</sup>

### III. Proposal for Legislative Consideration

#### A. Introduction

The growing concern for defining and protecting involuntarily committed patients' rights for drug refusal demands alternatives to the present chaos in this area. The essence of the current proposal is to provide involuntarily committed mental patients with procedural protections for a qualified right to refuse forcible administration of antipsychotic drugs.<sup>137</sup> Federal courts in both *Rennie* and *Rogers* provided that a mentally ill individual, despite involuntary commitment, is still competent to parti-

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<sup>131</sup>*Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979).

<sup>132</sup>*Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>133</sup>*See* *Mills v. Rogers*, 457 U.S. 291 (1982).

<sup>134</sup>*See infra* note 136.

<sup>135</sup>Recently, the court in *In re Anderson v. State*, 135 Ariz. App. 578, 663 P.2d 570 (1982), concluded that Arizona law and due process require considerably more than the minimum requirements of the federal Constitution, and that the procedures presently utilized in the Arizona State Hospital to deal with involuntarily committed mental patients refusing medication were deficient as a matter of law. This recent decision was made in light of *Rogers* and strongly suggests that states will take a new look at statutory construction in dealing with patient refusal of forced medication. *See People ex rel. Medina*, \_\_\_ Colo. App. \_\_\_, 662 P.2d 184 (1982). In reviewing the recent federal court decisions of *Rogers* and *Rennie*, the court determined that a mentally incompetent patient may decline drug treatment. The court looked to the state statute to provide guidelines in protecting the interests of this patient in light of a fourth amendment right to refuse treatment. *Id.* at \_\_\_, 662 P.2d at 186. *See also Clites v. State*, 322 N.W.2d 917 (Iowa Ct. App. 1982) (recognizing a violation of industry standards by hospital in light of *Rennie* and *Rogers*).

<sup>136</sup>Several states have adopted a right to refuse antipsychotic medication. *E.g.*, N.J. STAT. ANN. §30:4-24.2(d)(1) (West 1981); 50 PA. STAT. ANN. §7203 (Purdon Supp. 1982).

<sup>137</sup>The procedures outlined by the district court in *Rennie v. Klein*, 476 F. Supp. 1294, provide the framework for this proposal, with many modifications and alterations.

cipate in his own treatment decisions and has a constitutional right to do so.<sup>138</sup> Only in the event that this mentally ill patient has also been adjudged incompetent or when an emergency situation exists may the state's *parens patriae* power override the patient's own treatment refusal.<sup>139</sup> Therefore, a basic assumption of this proposal is that the mentally ill usually can and should make their own treatment decisions. Also, each case should be handled independently and directly rather than through the substituted judgment of a court-appointed guardian.

The proposal, to be effective, must appeal to both the mental health and the legal systems. The psychiatrist who wishes to provide the best possible medical care is caught in a quandry when an involuntarily committed patient refuses treatment. The physician faces an ethical conflict of either providing quality medical care against the patient's wishes or giving what he might believe is inadequate care consistent with the patient's demands. The lawyer, in protecting the constitutional rights of his client, the patient, must insist upon procedural protections which are often expensive and lengthy. Meanwhile, the patient is caught in a treatment limbo. This proposal addresses these concerns in its provisions.

### B. Proposed Statute

#### Section 1. General Purposes of the Act

- (a) All individuals have a fundamental right to make informed decisions about treatment with antipsychotic medication.
- (b) This Act is designed to:
  - (1) Ensure the right of a competent individual to refuse treatment with antipsychotic medication;
  - (2) Reduce the risk that an involuntarily committed individual will receive antipsychotic drug treatment that will not serve his best interests; and
  - (3) Provide procedural safeguards to protect a right to refuse medication, the benefits of which are not outweighed by administrative costs.
- (c) This Act shall be construed to protect the fundamental right of the individuals to make treatment choices.

The primary objective of legislative action in the area of drug refusal will be to protect the patient's fundamental right to make choices about

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<sup>138</sup>See *supra* note 81 and accompanying text.

<sup>139</sup>*Id.* The courts suggest that a determination of incompetency necessitates a separate adjudication from that of commitment. See *supra* note 68 and accompanying text. A large number of state statutes are consistent with this opinion. See *supra* note 67 and accompanying text. Also, recent case decisions are consistent with this. See, e.g., *Anderson v. State*, 135 Ariz. App. 578, 663 P.2d 570 (1982) (an involuntary mental patient who has not been adjudged incompetent could not be subjected to forced medication with antipsychotic drugs); *People ex rel. Medina*, \_\_\_ Colo. App. \_\_\_, 662 P.2d 184 (1982) (finding that even when an incompetent patient refuses treatment with drugs, the drugs cannot be forced without a court hearing).

his treatment. Necessarily, legislatures will be concerned with the expense of any proposal. This proposal anticipates constitutional development in the area of a right to refuse treatment with antipsychotic medication;<sup>140</sup> and, when constitutional rights are involved, costs may become secondary. However, this proposal recognizes that a truly practical regulatory provision cannot be extremely expensive to implement nor involve burdensome administrative requirements. Patient interests are better protected when useful legislation is not impeded by excessive complexities.

## Section 2. Definitions

As used in this Act:

- (a) "Involuntary patient" refers to an individual admitted to a hospital under a judicial certificate.
- (b) "Antipsychotic medication" refers to a class of psychotropic drugs used in the treatment of schizophrenic symptoms.
- (c) "State hospital" refers to public hospitals for care, treatment, training, and detection of persons who are mentally ill and supervised by State Department of Mental Health.
- (d) "Psychiatrist" refers to a medical doctor who has completed the required psychiatric residency.
- (e) "Patient advocate" refers to a person with such a degree or experience that the individual can be termed a psychologist, psychiatrist, medical doctor, attorney, registered nurse, or social worker.
- (f) A patient has the "competency" to make informed decisions to refuse treatment with antipsychotic medication if either:
  - (1) The patient has been committed without being adjudicated incompetent; or
  - (2) The patient, despite an incompetency adjudication
    - (a) evidences a choice in treatment and
    - (b) evidences that this choice is based on rational reasons and outcomes.
- (g) "Informed consent" refers to consent based on:
  - (1) An understanding of the nature, consequences, and possible side effects of the drug,
  - (2) An understanding of possible alternatives, and
  - (3) A decision formed voluntarily under conditions free from duress.
- (h) "Emergency" refers to a situation in which the life of the patient is in immediate danger or the life or well-being of others is in danger due to the symptomatic behavior of the patient. This definition does not require an imminent danger of physical deterioration to the patient himself.

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<sup>140</sup>See *supra* notes 2, 133 and accompanying text.

- (i) "Medical director" refers to the highest medical administrator of the state hospital.

Commitment to a mental hospital does not in and of itself imply that the patient is incompetent to make decisions about treatment.<sup>141</sup> A patient should be considered incompetent only if he is adjudicated incompetent by a court. This may require a second proceeding or, ideally, may be treated as a second issue at the commitment hearing. It is imperative, however, that a separate determination be made. The court, in authorizing appropriate treatment or in considering competency to refuse treatment, could consider: (1) the intrusiveness of the treatment by weighing the irreversibility, side effects, and efficiency of the drug, and (2) the availability of any less restrictive alternatives based on psychiatric testimony.<sup>142</sup>

The degree to which a patient needs to be competent in order to participate in his treatment decisions is not adequately defined at law. Some patients have no desire to participate in treatment decisions; others exhibit hallucinations or delusions that cloud their capacity to make competent decisions. These factors would be considered in a competency hearing.<sup>143</sup> In the event that an involuntarily committed patient who has also been adjudicated incompetent expresses a desire to refuse medication, due process procedures would be triggered.<sup>144</sup>

The definition of any emergency situation that would allow medical personnel to medicate refusing patients forcibly has been the subject of much disagreement among courts.<sup>145</sup> This proposal suggests that the accepted definition of emergency requires that there be an immediate risk of serious danger to the patient or substantial risk of danger to the life or well being of others because of the patient's uncontrolled symptomatic behavior. This broad definition might be more realistically enforced in a typical hospital setting than would a narrow definition. The word "immediate" is included in the definition, however, to lessen the possibility that medication would be forcibly administered at the slightest indication of difficulty.

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<sup>141</sup>The district court in *Rogers v. Okin*, 478 F. Supp. at 1361, concluded that most involuntarily committed mental patients, although somewhat impaired in their relationship to reality, can perceive the benefits, risks, and discomfort resulting from treatment. *Id.* See *supra* notes 65-67 and accompanying text.

<sup>142</sup>Courts have recognized the need for such weighing of interests. See *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (establishing factors for a court to consider in weighing whether a patient would want to be treated). See also *Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded*, 134 AM. J. PSYCHIATRY 354-55 (1977).

<sup>143</sup>See Roth & Meisel, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279-84 (1977) (refusal based on a delusion, such as a belief the drug is poison, is not based on competent decisionmaking and probably will not be allowed).

<sup>144</sup>See Section 5 of legislative proposal for a discussion of due process requirements.

<sup>145</sup>See *supra* notes 129-36 and accompanying text.

The court in *Rennie v. Klein*<sup>146</sup> required a "sudden significant change" in its definition of emergency. Such a restriction does not seem workable because some patients may enter the hospital with violent behavior that is threatening to self or others. Thus, the hospital staff might have difficulty determining that this is a "sudden" and "significant" change in behavior.

The court in *Rogers v. Okin*<sup>147</sup> included in its definition of emergency a situation in which treatment is necessary to prevent "significant deterioration of the patient's mental health."<sup>148</sup> The present proposal eliminates this provision in its definition. Such a vague provision could easily lend itself to abuse. Also, a right to refuse treatment, if it is to be a complete right, includes the right to refuse treatment, even that deemed beneficial.

### Section 3: Informed Consent

- (a) An involuntarily committed patient in a state hospital may not be given antipsychotic medication unless:
  - (1) The patient has signed a consent form for the particular drug; or
  - (2) An emergency is deemed to exist, and the physician, consistent with the professional judgment standard, has determined the drug to be the least restrictive alternative, as defined in Section 4.
- (b) Informed consent shall be obtained through the following procedures:
  - (1) A licensed physician shall discuss with the patient, in language the patient can understand:
    - (a) the expected benefits of the proposed drug;
    - (b) the proposed drug's nature, degree, duration, and probability of side effects and significant risks commonly known by the medical profession, including any possibility of irreversibility of the side effect;
    - (c) the availability of reasonable alternative treatments and why the physician recommends a particular treatment;
    - (d) that the patient has a right to accept or refuse the proposed drug and that if he consents, he has the right to revoke that consent for any reason at any time prior to or between treatments.
  - (2) The patient shall sign a written consent form which shall include:
    - (a) a description of the treatment to which he has consented;

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<sup>146</sup>*Rennie v. Klein*, 476 F. Supp. at 1313.

<sup>147</sup>*Rogers v. Okin*, 634 F.2d at 660 (1st Cir. 1980).

<sup>148</sup>*Id.*

- (b) a description of the purposes, benefits, risks, and possible consequences of the drug use;
  - (c) a statement of the right to refuse the drug;
  - (d) a notice that the patient has a right to retract his present consent to treatment;
  - (e) a statement of the right of the patient to have an advocate assist him in possible review hearings.
- (3) Written, informed consent is deemed given when the patient, without duress or coercion, clearly and explicitly manifests consent to drug treatment on the standard consent form.
- (a) the physician may urge the proposed drug as the best one, but may not use, in an effort to gain consent, any reward or threat, express or implied, nor any form of inducement or coercion. No one shall be denied any benefits for refusing treatment;
  - (b) a person shall not be deemed incapable of refusal solely by virtue of being diagnosed as mentally ill or abnormal;
  - (c) written consent shall be given only after twenty-four (24) hours have elapsed from the time the information described in subsection (l) has been given.

Although written consent forms for the administration of drugs have not been the traditional practice in the medical profession, this requirement will help ensure that the involuntarily committed state hospital patient has been contacted and informed of his treatment plan.<sup>149</sup> State hospitals are typically overcrowded and understaffed.<sup>150</sup> Patients in such a setting have been carelessly prescribed drugs, yet have little or no recourse.<sup>151</sup> Studies reveal that few state hospital patients can even identify the medication they take.<sup>152</sup> Consent forms will inevitably raise the knowledge of the patients concerning their drug therapy, thereby increasing patient competency to make decisions concerning such treatment.

This proposal suggests that patients be given the right to withdraw their consent once it is given. It makes no difference whether this retraction is oral or written. Once the patient has withdrawn his consent, however, a new consent form would need to be signed in order to administer the drug.

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<sup>149</sup>A recent study by Geller, *State Hospital Patients and their Medication—Do They Know What They Take?*, 139 AM. J. PSYCHIATRY 5 (1982), found that 54% of mental hospital patients demonstrated no understanding of the medication they were regularly taking, and only 8% could indicate a name and intended effect of at least one medication they were taking. This research suggests that the majority of patients are not being informed of their drug treatment, and, in turn, are not giving informed consent. See also CAL. WELF. & INST. CODE §5326.2 to .5 (West Supp. 1974-83) (providing a very detailed informed consent procedure for all treatment in general).

<sup>150</sup>See *supra* notes 31-32 and accompanying text.

<sup>151</sup>See *supra* notes 23-32 and accompanying text.

## Section 4: Forcible Administration of Antipsychotic Drugs

- (a) Antipsychotic drugs may be forcibly administered in an emergency situation.
- (b) Procedures include:
  - (1) An emergency shall be declared to exist only by a licensed physician.
  - (2) Antipsychotic drugs shall be administered only if the physician, using standard professional judgment, determines that no other less intrusive alternative is available.
  - (3) Only a licensed physician will administer the drug.
  - (4) Emergency administration with antipsychotic medication may be given for up to one week. A longer period will require a review hearing, as provided in Section
  - (5) Any drug used must be the least intrusive option possible under the circumstances.
  - (6) At any time an emergency is declared, the physician shall make a written report of such situation and of his action.

In order to reduce the possibility of abuse of the emergency exception to forcible drug administration, only a licensed physician may declare a situation an emergency.<sup>153</sup> Even in an emergency, antipsychotic drugs should not be given until the physician determines that no less intrusive alternative treatment exists.<sup>154</sup> This determination includes a requirement for a consideration of any prior experience the patient has had with antipsychotic medication. If the patient has experienced severe side effects, the physician should vigorously explore treatment alternatives.<sup>155</sup> In order for application of a less intrusive alternative to be practical, discretion should be left with the attending physician subject to an analysis of whether the physician's treatment substantially departed from standard professional judgment in light of the requirement of choosing the less intrusive alternative.<sup>156</sup>

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<sup>152</sup>See *supra* note 149 and accompanying text.

<sup>153</sup>See Section 2 of the legislative proposal for a definition of an emergency situation.

<sup>154</sup>In *Vitex v. Jones*, 445 U.S. 480 (1980), the United States Supreme Court required that even when justifying the use of drugs under the *parens patriae* theory, the use must always be the least intrusive infringement since, with the use of powerful drugs, there is always the danger that the results of the medication may be worse than the illness. See also *People ex rel. Medina*, \_\_\_\_ Colo. App. \_\_\_\_, 662 P.2d 184, 186 (1982) (emphasizing the use of the least intrusive means).

The Third Circuit in *Rennie v. Klein*, 720 F.2d 266, held that the Supreme Court remand in *Rennie* indicated that physicians will be held to a professional judgment standard in their administration of antipsychotic drugs. The majority of judges concluded, however, that the least intrusive means test is necessarily a part of the professional judgment standard, and that any professional decision to override a mental patient's refusal of medication must follow procedures specified in a state bulletin which expressly included considerations of the least intrusive alternative. See *supra* notes 107-11 and accompanying text.

<sup>155</sup>Consideration of the least intrusive means is consistent with the observation of the court in *Rogers*, 478 F. Supp. at 1365.

<sup>156</sup>For an excellent discussion of the less restrictive alternative see, Comment, *The*



### Section 5: Internal Review Hearing

- (a) An internal review hearing, conducted by a medical director, is required when an involuntarily committed patient's refusal of administration of antipsychotic medication is contrary to the physician's judgment.
- (b) Procedure and Notice:
  - (1) The hearing will be requested by either the physician, the patient, or the patient's representative or advocate.
  - (2) The patient, his advocate or his representative, and physician shall receive adequate notice.
  - (3) The hearing shall be held within forty-eight (48) hours of the request.
- (c) Purpose of the hearing:
  - (1) The hearing shall determine whether the patient's treatment decision was in fact informed and voluntary. The hospital bears the burden of persuasion by a preponderance of the evidence that consent was informed and voluntary.
  - (2) The medical director has the power to approve the administration of drugs only if:
    - (a) an emergency exists; or
    - (b) the evidence establishes that the patient lacks the capacity to make a competent treatment decision, that the patient's reasons for refusing medication are irrational, that no less intrusive alternative is available, and that the proposed drug is consistent with the patient's best interests and outweighs possible dangers or risks.
  - (3) The medical director shall maintain written records of his decision and the reasons for such decision. These records shall be available for examination by the patient's representative and shall state precisely the basis for the decision.
  - (4) A copy of the written decision shall be given to the patient, his representative, and the advocate.
  - (5) The patient is entitled to seek review of the internal review hearing decision.

The internal review hearing<sup>157</sup> is an important component in the

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*Scope of the Involuntarily Committed Mental Patient's Right to Refuse Treatment with Psychotropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine*, 28 VILL. L. REV. 102 (1982-83). Also, the Supreme Court in *Ingraham v. Wright*, 430 U.S. 651 (1977), found that compelled medication must be the least restrictive means available and that when the cost-benefit ratio of that means is unacceptable it may be eliminated. There must be a careful balancing of the patient's interests against institutional and therapeutic interests furthered by administering the drug.

<sup>157</sup>The basis of the review hearing is suggested in *Rennie v. Klein*, 476 F. Supp. 1294, 1313-15 (D.N.J. 1979). The court entered an order requiring the detailed review procedure, including requirements for a written consent form. The decision was partially reversed and

statutory scheme for a variety of reasons. The procedure not only gives weight to patient concerns and facilitates the discovery of possible drug abuse, the hearing also assures that the patient receives procedural protection of his right to refuse medication.<sup>158</sup> At the same time, the responsibility for the hearing is on those most competent to make a medical decision, the medical professionals.<sup>159</sup> The primary element in this section is the direct review of the individual case rather than the use of a court-appointed guardian to act as a substitute decision-maker. Although due process generally requires judicial hearings, a program that incorporates the procedural safeguards of patient representation, patient advocates, and statutorily delineated procedures for proceedings can meet the requirements of due process,<sup>160</sup> even though court time is not used. Typically when a patient refuses medication, his competence is rendered questionable by his own mental illness, and a guardian is appointed by the court to "stand in" for the patient.<sup>161</sup> However, in practice, the guardianship process proves to be an illusory solution.<sup>162</sup> If the appointment of a guardian is required for a large number of incompetent patients who might refuse medication, courts will be flooded with such petitions, the valuable time of mental health staff and lawyers will be consumed, and millions of dollars will be spent. Also, many basic clinical problems are posed by guardianship: Guardianship results in infringement of the patient's right to prompt, effective treatment in urgent cases; the patient's ability to assume responsibility of his treatment is undercut; and often, guardians are not equipped to understand the complex issues involved in a treatment decision to protect the patient's best interests.<sup>163</sup>

The right to refuse medication presents a unique need for the accommodation of constitutional requirements of due process and patient rights in light of the practical realities of scarce mental health resources. The individual case approach not only helps assure procedural protection

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remanded by the Third Circuit Court of Appeals, 653 F.2d 836 (3d Cir. 1981), *cert. denied*, 458 U.S. 1119 (1981) since New Jersey's procedures already allowed for an internal review.

<sup>158</sup>As the Supreme Court explained in *Parham v. J.R.*, 442 U.S. 584 (1979), informal medical investigative techniques are not inconsistent with due process in the civil commitment context. Similarly, the same types of determinations would not violate due process when applied to the forcible administration of drugs. It makes no difference that the actual decisionmaker is employed by and responsible to the state bureaucracies. *Id.* at 607-13.

<sup>159</sup>This is consistent with the observation of the court in *Rennie*, 476 F. Supp. at 1313-15.

<sup>160</sup>See *supra* note 158 and accompanying text. Additionally, the Supreme Court in *Ingraham v. Wright*, 430 U.S. 651 (1977), recognized that there are at least several potential side effects that powerful medication can induce and that these intrusions negatively affect liberty interests that are protected by the due process clause.

<sup>161</sup>UNIFORM PROBATE CODE § 5-312(a)(3)(1977). "A guardian may give any consent or approval that may be necessary to enable the ward to receive medical or other professional care. . . ."

<sup>162</sup>See Gutheil, Shabiro, & St. Clair, *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 AM. J. PSYCHIATRY 347 (1980).

<sup>163</sup>Guardians are often difficult to find and many are ambivalent about the patient's needs and rights. There is also a danger of incompetent and weak willed guardians. *Id.*

for the protesting patient but also is more easily handled in the out-of-court setting. The primary protections of the program are provided by the specific procedures which must be followed, the patient advocate, and the unconditional right to appeal.

#### Section 6: Patient Advocate

- (a) Each hospital shall have a patient advocate available to represent patients without cost in all review procedures.
- (b) The advocate must represent the patient's stated position and desires.

A basic element in the protection of the patient's due process rights is his right to representation at the internal review hearing. Patients may choose outside representation or may be represented by the patient advocate.<sup>164</sup> The patient advocate may or may not be associated with the hospital. In *Rennie v. Klein*,<sup>165</sup> the court suggested that advocates be directly appointed, supervised, and paid by the central state agency, and that these advocates could be attorneys, psychologists, social workers, or registered nurses. From a due process standpoint, an independently employed advocate has obvious advantages.<sup>166</sup> However, attempting to create an entirely independent system designed simply to protect potential patient interests is not realistic, given the funding structure of the mental health system. This proposal suggests that the due process rights of the refusing patient may be satisfactorily protected by a patient advocate associated with the hospital. Although this raises the potential for conflicting interests because of the pressures hospital staff might exert on the advocate, the proposal's requirement that the patient advocate must represent the patient's stated position and desires regarding medication serves to ensure the advocate's independent role in protecting the patient's rights. Additionally, the patient always has the right to independent representation and the right to appeal to an independent psychiatrist.

The patient advocate could assist patients in attempting to learn about their medication and their right to refuse medication. The advocate could also help screen patients for the appropriateness of a guardian, for commitment, or for forced medication.

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<sup>164</sup>A patient advocate was suggested in *Rennie v. Klein*, 476 F. Supp. at 1313. The advocate program could easily be expanded to the benefit of both the hospital and the patient.

<sup>165</sup>*Id.*

<sup>166</sup>From a due process standpoint, the sole representation of the patient by an individual employed by the hospital may raise questions concerning the medical bias of the proceedings. However, the advocate system is an attempt at compromise, necessitated by the financial constraints opposing change in the mental health system and the multitudinous legal problems of an indigent or deprived population demanding attention. Often the patient advocate, as a part of the mental health system, may help assure that clinical alternatives have been explored. The legal system has limitations when dealing with the diagnosis and treatment of mental illness.

### Section 7: Appeal to an Independent Psychiatrist

- (a) The patient, patient representative, or patient advocate may appeal the decision of the internal review hearing to an independent psychiatrist.
- (b) The independent psychiatrist shall be appointed by the court and shall not be a staff member of the state hospital.
- (c) Procedures for appeal:
  - (1) The appeal must be made in writing within one week of receipt of the decision of the internal review hearing.
  - (2) The independent psychiatrist must review the internal review hearing decision within three weeks.
- (d) Procedures at appeal:
  - (1) The independent psychiatrist may use his discretion in requesting evidence, interviewing patients or hospital personnel, and reviewing records.
  - (2) The independent psychiatrist shall privately examine the patient before his decision.
  - (3) The independent psychiatrist shall deliver his opinion, in writing, within one week after his hearing.
  - (4) If the independent psychiatrist determines that the patient should be forcibly medicated, this decision shall state a maximum time for administering such medication, not to exceed six months.

The appeal is a protection of due process rights for the protesting patient. The advantage of a system using an independent psychiatrist as a reviewer is the increased likelihood of a correct decision by a qualified medical person, especially as compared to a time consuming judicial review performed by someone outside the medical profession.<sup>167</sup> The fact that the psychiatrist is independent is important to allow review of the situation out of the clinical chain of command. This provision is analogous to a "second opinion," and protects the patient from the possibility of mistreatment or no treatment at all. The hospital staff has the burden of persuasion on the issues.

### IV. Conclusion

This proposal is not intended to represent the only appropriate method for protecting the rights of involuntarily confined mental patients in state

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<sup>167</sup>The use of an independent psychiatrist as decisionmaker was dictated by the district court in *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981)(en banc), *vacated and remanded*, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983). Although the circuit court decision did not dictate such use, it did not preclude a state from adopting such a system if it desired. 653 F.2d at 854. Since the independent psychiatrist is appointed by the court, his required deadlines are court enforceable.

hospitals who refuse treatment with antipsychotic drugs. Additionally, this proposal could be expanded to include protections for the voluntary patient, protections for private hospital patients, and protections for patients from other forms of therapy and treatment. Many factors unique to individual states will influence the quality of and approach to mental health system evaluations. This proposal represents a realistic procedure for safeguarding rights in a developing constitutional area. Legislatures could use this proposal as a framework from which to judge existing regulatory systems or for designing new ones. In general, the proposal provides elements which allow for maximum patient autonomy in treatment decisions while respecting the medical professional's judgment and discretion to provide timely treatment when necessary.

VICKI ANDERSON

