The Right to Refuse Treatment and the Abolition of Involuntary Hospitalization of the Mentally Ill†

EMANUEL TANAY, M.D.*

Introduction

Civil commitment involves abridgment of civil rights of the mentally ill person. The involuntarily hospitalized patient is deprived of many elementary rights "which the average citizen takes for granted, such as visitation, written communication and compensation for work."[1]

Furthermore, the committed patients often have been deprived of various rights dealing with their functioning in the society, such as right to marry, to sue for divorce, to exercise control over their property, to vote, to drive an automobile.

The limitations imposed upon the committed patients can be divided into those which occur within the institution itself and those which affect patient's rights outside the hospital. In the first category, we have the restrictions dealing with freedom of movement, correspondence, visitation, and being subjected to various treatment procedures. In the second category, we have restrictions imposed by law in regard to marriage, divorce, voting, holding office, capacity to execute a will, and the exercise of control over one's property. The extent of these legal constraints has varied. The present trend in the law is to extend civil rights to the mentally ill.

This paper concerns itself with the right to refuse treatment while committed and residing in an institution.

I. The Consent Requirement

A person may not be subjected to treatment or medical procedures without his consent.[2] The law has recognized certain exceptions to the usual requirement of consent to medical care and treatment in a serious emergency. If the individual is unable to consent, the law supplies consent for him. Thus, an unconscious person who is brought to a hospital may have his consent to essential care and treatment supplied by the law on the assumption that he would have consented if he had been able to do so. See Prosser, *Law of Torts* 103 (4th ed. 1971), where a leading authority states:

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*Dr. Tanay is Clinical Professor of Psychiatry, Wayne State University, Detroit, Michigan.

> . . . In an emergency which threatens death or serious bodily harm, as where the patient is bleeding to death and it is necessary to amputate his foot to save his life, it is generally recognized that these requirements (of consent) must be waived, and the surgeon must be free to operate without delaying to obtain consent. It is said in these cases that the consent is "implied" under the circumstances. This is obviously a fiction, since consent does not exist, and there is no act which indicates it. It is probably more accurate here . . . to say that the defendant is privileged because he is reasonably entitled to assume that, *if the patient were competent and understood the situation, he would consent, and therefore to act as if it has been given.* (Emphasis supplied.)

It is not unusual for the law to utilize legal fictions; the principle of "implied consent" represents an example of it. The doctrine is merely a shorthand way of saying that there are some overriding policy considerations that dispense with the need for actual consent, or that the law will presume consent where it should have been given by a reasonable man. "Informed consent" is a legal doctrine which plays an ever-increasing significance in the practice of medicine. The current meaning of "informed consent" begins with *Natanson v. Kline* (186 Kan. 393, 350 p.2d 1093) which was decided by the Kansas Supreme Court in 1960. In the absence of "informed consent" to medical care, treatment or surgery, medical intervention may be a civil wrong and in extreme cases even a criminal offense. Without consent medical intervention may constitute an assault and battery or malpractice.

It is important for the medical profession to understand that medical intervention may be a tort even if the intrusion was for the patient's welfare and actually accomplished some good. The issue is not the physician's professional competence or skill, but rather the patient's right to control medical intervention and to make informed decisions as a matter of self-determination. The patient has an interest in bodily (and psychic) integrity, and his person is inviolate except for unusual circumstances.

The doctrine of "informed consent" presents numerous difficulties, especially with regard to what and how much must be divulged by the physician to the patient so that his consent is an "informed" one. Generally, it is agreed that there should be a communication for the so-called "risk-benefit ratio" in order for the patient's decision to be an informed one. Just how specific and detailed this must be is not certain, except that the physician should communicate that information which would be given by a reasonable physician under the circumstances. Some decisions also recognize that a reasonable physician would take into account the mental and emotional state of the patient and need not disclose matters which would upset the patient and interfere with care and treatment.

II. The Right to Refuse Treatment

The legal arguments in favor of the right to refuse treatment are many. One commentator writes:

> . . . physicians and judges usually honor a patient's refusal of treatment, no matter how trivial the reason for refusal. There is no good reason to deviate from this position when we are dealing with the mentally ill. In a recent case, for example, a court refused to override a mental patient's "irrational but competent" refusal to undergo breast surgery for cancer; that the reasons for the refusal were unsound was considered immaterial . . . (citation omitted) . . . . If the law requires consent out of respect for the dignity and autonomy of the individual, that interest can be no less significant when the individual is a mental patient; if the interest does not diminish, then we are saying that the mental patient is less a human being than others. Consent is not simply a question of who knows better what will happen, or what the risks are; the doctor is generally a better judge of that than the patient is. But, since the patient will suffer the consequences, since he bears the risks in mischances, he should have the power to make the decision.[3]

The author then proceeds to show on legal grounds that the wishes of the mentally ill person should be overridden only when the state can show compelling interest in providing the treatment. One element of such a showing in support of involuntary treatment has to be proof of the value of proposed treatment. He states that psychiatric opinion on the effectiveness of treatment cannot be relied upon. "The psychiatrist's opinion of whether his patient is better cannot be an unbiased judgment; it may be highly colored by what he thinks the patient ought to be." (p. 1161) DuBose writes: "Unless we wish merely to perpetuate the errors of the psychiatric profession, we must ask for something sounder than subjective clinical experience to justify a treatment method." (p. 1161) He then goes into a critical evaluation of various studies and experimental designs of drug treatment of schizophrenia:

> If there is a flaw in experimental design, we cannot be sure that the experimental result is due to the hypothesized cause . . . . My own preference is that there is an unconscious bias in the researcher, who knows the greater glory belongs to the discoverer than to the debunker, and that this bias appears in the experimental results because of the lack of proper controls. But whatever the reason, we should be suspicious of the positive results of poorly designed research . . . . In the past the courts have been retrettably reluctant to examine carefully the efficacy of treatment provided the involuntary patient. (p. 1162)

This is a logical conclusion of the efforts of the law to become involved in details of the practice of the psychiatric profession. First, the clinical decisions became the subject of scrutiny, now the research, design, and results will also have to pass legal muster.

DuBose, after careful scrutiny of psychiatric literature, concludes that there is no sufficient proof that drug treatment of schizophrenia is effective, therefore, it cannot be legally imposed upon the unwilling patient.

DuBose makes a persuasive argument that treatment is not a sufficient justification for depriving a citizen of liberty. It is his view that there is a constitutional right to being psychotic. As a basis for his assertion, he uses the U.S. Supreme Court decision in *Stanley v. Georgia* (394, U.S. 557 (1969)). In that case, there was an argument presented to affirm Mr. Stanley's conviction for possession of pornographic movies in his home. The State of Georgia argued that since: "the state can protect the body of a citizen, may it not . . . protect his mind?" The Supreme Court answered in the negative. It was their conclusion that the only possible explanation for Georgia's action was a desire to control Mr. Stanley's "intellectual and emotional needs." The court found this to be an impermissible state purpose; the state ". . . cannot constitutionally premise legislation on the desirability of controlling a person's private thoughts." (Quoted by DuBose) Then DuBose goes on to conclude: "In terms of what is important to one's personal integrity, who is to say whether Mr. Stanley's pornography is any more or less essential than our patient's suspicions? I have occasionally heard psychiatrists assert that 'there is no right to be psychotic.' It may be that not only is there such a right, but that it is a constitutional one." I have no difficulty in accepting his conclusion that neither dangerousness nor treatment provide justification for involuntary hospitalization. DuBose writes:

> Since psychiatrists have not proved any form of treatment other than drugs to be effective in treating mental illness, my analysis would suggest that, if the burden of proving effectiveness is, as it should be, placed on the state, no other form of treatment may be forced on refusing patients. This conclusion is fortified by the fact that the literature on schizophrenia and the psychotropic drugs is far more complete than the literature on any form of treatment for any other mental illness. Thus, the case for forced treatment of other mental illness is likely to be even weaker than the case that I have set up in this article, and if that is so, then confinement and treatment of an objecting mental patient, no matter what his disorder, should be impermissible. This would seem to leave "dangerousness" the sole reason for confining the mentally ill, for treatment or otherwise . . . . Presently, there is no known method of predicting serious dangerous behavior with any degree of accuracy; all attempts over-predict dangerousness so that confinements based on these predictions will

inevitably result in the confinement of large numbers of persons who never would have committed any dangerous act. If we eliminate from "police power" commitments those cases where the danger is predicted for the distant future, we reduce "police power" commitments to the traditional power of the police to arrest, confine, and restrain someone who is presently dangerous to himself or others: for example, someone who is presently attacking other people or is presently unconscious. Once the person is calm or conscious, as the case may be, the reason for confinement (assuming there is no pending criminal charge arising out of the behavior) ceases, so ought the confinement to cease. (p. 1215) . . . . Let us, for the purposes of argument, separate the issues of confinement and treatment and examine some of the problems that arise with the right-to-treatment if we also accept a right-to-refuse-treatment. If, for example, an involuntary patient refuses to take the drugs that the hospital offers him, can the hospital honor that refusal and continue to hold him against his will? If it cannot, is he really held involuntarily, since by the act of refusing he gets out? And if he is not held involuntarily, then the key element in all right-to-treatment cases, confinement, is missing. If the hospital can keep him although he refuses treatment, then is that any different, in actual effect, from keeping him without treatment? Would it not be cruel and unusual to punish someone for his failure to consent to treatment by keeping him locked up? Is it less cruel and unusual to require the doctors to make significant efforts to convince the patient to consent to treatment? The trial judge in *Donaldson,* 493 F. 2d at 531, apparently feeling that a patient's refusal of treatment that others felt was good for him was not enough to excuse the others from personal liability for confining him without treatment, instructed the jury that Mr. Donaldson could not recover damages for those periods when he refused proffered treatment. The plaintiff did not appeal this instruction so the issue was not before the Supreme Court.

This line of reasoning leads to the inevitable conclusion that there is no justification in the law to differentiate between civil and criminal commitment; therefore, abolition of involuntary hospitalization becomes a legal necessity based upon due process.

III. Due Process and Mental Illness

Due process has been defined as involving fairness, impartiality and orderliness (see in *Ray Gault,* 387, U.S. 1, (1966)). These procedural safeguards have been long observed in commitment proceedings. What has been happening in the last ten years is not provision of procedural safeguards but a drastic change in criteria of commitment itself.

The recent developments do not change the methods of commitment, they drastically revise the basis of commitment. It could be argued that

we have witnessed partial abolition of civil commitment as it has been known a decade ago. It is, therefore, not possible to discuss the concept of right to refuse treatment without placing it in its proper historical context, as a device to abolish commitment.

It is my view that the concept of right to refuse treatment by a committed patient is a contradiction in itself. The commitment proceeding might not deprive the individual of various legal rights, but it addresses itself first and foremost to the capacity of the individual to provide for the care of his mental illness. Any person able to consent or withhold consent for treatment of his mental illness should not be committed in the first place.

The recent trend in the law has been to criminalize commitment for mental illness based upon the fact that criminal and civil commitments lead to deprivation of liberty.[4] Given procedural safeguards, it is considered justifiable to deprive citizens of liberty only if they committed a crime. In the past, it has been considered justifiable to deprive an individual of liberty when he suffered from mental illness and was in need of care and treatment.

Courts and legal commentators have focused upon the deprivation of liberty as the cardinal aspect of involuntary hospitalization of the mentally ill. There is significant similarity in regard to deprivation of liberty both in civil and criminal commitment. This similarity, however, does not make both procedures identical; there are also significant differences. In this connection, I would like to quote from the dissenting opinion of Mr. Justice Harlan in *Gault* (387, U.S. 1, (1966)):

> Among the first premises of our constitutional system is the obligation to conduct a proceeding in which an individual may be deprived of liberty or property in a fashion consistent with the "traditions and conscience of our people," (*Snider v. Massachusetts,* 291, U.S. 97, 105) . . . . It must at the outset be emphasized that the protection necessary here cannot be determined by resort to any classification of juvenile proceedings either as criminal or as civil, whether made by the state or by this court. Both formulae are simply too imprecise to permit recent analyses of these difficult consitutional issues. The court should instead measure the requirements of due process by a reference both to the problems which confront the state and to the actual character of the procedural system which the state has created . . . .

In other words, Justice Harlan called attention to the subject matter. Contrast this with the 1972 statement of the Lessard Court: "It would thus appear that the interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses. The resulting burden on the state to justify civil commitment must be correspondingly high."[5] The Lessard Court ignored the differences between civil and criminal commitment and showed disregard of the subject matter when

they provided protection for the patient from having to speak to a psychiatrist.

> Wisconsin may not, consistent with basic concept of due process, commit individuals on the basis of their statements to psychiatrists in the absence of a showing that their statements were made with knowledge that the individual was not obliged to speak.

A footnote comments about the concept "knowledge." The Court said:

> We use the term "knowledge" advisedly. The presumption in the civil commitment proceeding must be that the individual is indeed competent. If his rights are explained to him in simple terms, it may be presumed that he has the requisite knowledge. If the individual, in fact, does not have this knowledge because of mental illness, the subsequent finding of mental illness or mental incapacity on the basis of his statements cannot be said to violate due process.

In real life, if a patient describes hallucinations or delusions, is one to presume that he has spoken with knowledge? If the same psychotic individual were charged with a felony and would sign a waiver, the courts would generally consider such a waiver not valid.

The logical conclusion seems to be that prior to the examination of a psychiatrist, a hearing should be held on the competency of the individual to undergo psychiatric examination for the purpose of being declared incompetent.

A major premise underlying the commitment process of the mentally ill is the capacity of legal fact finders, the Probate judges, or jury to make the determination that someone is indeed mentally ill. In evaluating the capacity of the judge to make such a determination, one has to first of all examine the setting in which the judge functions. In the recent past, there has been particular attention paid to the provision of all of the traditional due process rights to a person who faces commitment proceedings. The adversary nature of these proceedings has been assumed to be a natural quality. There is, however, no empirical evidence to support the view that the majority of commitment proceedings are adversary. Very often the adversary appearance is merely the product of legal fiction.

Insofar as those seeking and promoting commitment of an individual are acting in his best interest, there is an identity of interests between the alleged adversary parties. The courts have become incapable of recognizing the identity of interests between the parties. The adversary fiction has been extended to include relations between parents and children.[6]

In criminal proceedings there are two natural adversaries: the criminally accused and the State. The courts have attempted to apply the same principles to child-parent relationships and doctor-patient relationships when it comes to treatment of mental illness.

The traditional role of a judge facing two adversaries and assisting in a resolution of a dispute rarely prevails in commitment proceedings. Thus, the judge functions less often as an arbiter between competing parties and more often as a gatekeeper to an institutional setting. The judge's perception of his role and reality often clash.

A second major concept underlying the commitment process is the assumption that there is a high incidence of abuse. Once again, there is no empirical evidence to support this particular view. The law and the individual judges are committed to the proposition that abuse of the commitment process is widespread in the direction of admitting people to the hospitals who do not require institutional care.

Due process proponents emphasize that the criminally accused person is innocent until proven guilty. At the same time, they presume that there is abuse of certain trust relationships unless it is proven that there is no abuse. The courts have injected themselves in a variety of trust relationships on the theoretical assumption that abuse is not only possible but very likely. In these areas the courts operate on a presumption of abuse. "While the model of deference (to parental judgment) is built on trust, the model of due process is built on distrust."[7]

This view is not based upon empirical evidence, but derives from ideological commitment and professional identity of the legal profession. Thus, the lawyer is burdened with a built-in blind spot which interferes with his ability to function in an objective, realistic manner. The structure of the setting sends him in search of adversaries. His professional training and identity direct him to find abuses. It is, therefore, not surprising that often the lawyers appear to be battling windmills. The appellate decisions, the law review articles, and the activities of the so-called "Mental Health Bar" are in marked contrast to the day-to-day realities of commitment proceedings.

Friday, August 12, 1977, I visited the Probate Court for Wayne County in Detroit. I observed six commitments within an hour; all followed the requirements of the new law, but essentially did not differ from the old process. The State was represented by a prosecuting attorney; each "respondent" was represented by a defense attorney. The participants referred to the patient as "defendant" and often corrected themselves by substituting the word "respondent." On a number of occasions, the "respondent" did take the witness stand. Direct examination by the defense counsel sounded more like cross-examination.

A woman who was found wandering the streets appeared clearly psychotic. She gave history of traveling all over the country. She was questioned by her defense counsel after she requested to take the witness stand against her wishes. He asked whether she had a job, to which she gave very evasive answers. He finally elicited that she had not worked in the last seven years. He asked if she had relatives, to which she responded in the affirmative; but upon further questioning it turned out she had not been in contact with them in many years. The defense counsel

made a perfect case "against" his client. The so-called psychiatrists who testified on behalf of Northville State Hospital and the Detroit Psychiatric Institute (a state hospital located in Detroit) were both Far Eastern physicians whose command of English was poor; no one asked their qualifications. Their testimony was stereotype; so were the questions by the prosecuting attorney and defense counsel. Throughout the proceeding not a single question was asked by the judge.

A young man who took an overdose in a suicidal attempt was brought in by ambulance. He was stuporous and on a stretcher. He never took the witness stand. I overheard the conversation between the ambulance driver and the relatives. The ambulance driver expressed disgust that the young man was subjected to the ordeal of being brought to the court without having been asked a single question or having been even looked at by the judge. The clerk determined that it was not proper for him to be brought into the courtroom.

The attorney for one respondent, a woman acquitted by virtue of insanity for the killing of her two children, was one hour late. This was remedied easily. A defense attorney who represented four or five just-heard cases assumed the responsibility for the defense of Ms. X. He conversed with her for about one minute in the hall and assumed her representation.

Not having had the opportunity to witness commitment proceedings in about ten years, I anticipated major changes. Michigan has a new commitment law which had been debated intensely by proponents and opponents. As far as I could tell, at the practical level not much had changed. True enough, more lawyers secure assignments. I would assume the cost of committing an individual has increased significantly.

The essence of mental illness of psychotic proportions is the loss of structure in behavior and communication. In schizophrenia, the speech breakdown is due to disorder of thought processes. In chronic brain syndrome, the breakdown of verbal communication is due to the damage to the brain cortex.

The impairment of capacity to structure inner processes leads to chaos in the environment of the psychotic. Treatment and care efforts are designed to restore and compensate for the loss in the capacity to structure. In psychosis, autonomous functioning is impaired or even absent.

Both technical treatment considerations and humanitarian concern require imposition of structure from outside. The imposition of external control is perceived by uninformed observers as deprivation of freedom. These critics fail to recognize that freedom is available only to those who have some degree of autonomous function. As Justice Cardozo pointed out: "We are free only if we know and so in proportion to our knowledge. There is no freedom without choice, and there is no choice without knowledge — or none that is illusory. Implicit, therefore, in the very notion of liberty is the liberty of the mind to absorb and to beget. . . ."[8]

IV. The Right to Refuse Treatment and Clinical Reality

In the discussion of the right to refuse treatment, there has to be a definition of terms. What is treatment? A person admitted to a hospital for psychiatric reasons is exposed to treatment from the moment he enters the institution. It is impossible to separate evaluation from treatment. The mere entrance into a hospital and interactions with its personnel constitute treatment. Courts could, however, specify that by treatment they mean merely administration of medication and any other forms of treatment which have been called by some pejoratively "intrusive." There are obviously those who will argue, with some justification, that psychotherapy is more intrusive than Valium. I emphasize that my concern in this context is merely with accepted forms of treatment and has no reference to any experimental approaches. It has been well established in law and medicine that experimental treatment methods require informed consent from a person capable of giving such consent.[9]

To argue that commitment merely justifies confinement and not treatment is an effort to reduce involuntary hospitalization to a form of incarceration. It is not surprising that those who label involuntary hospitalization a form of incarceration at the same time engage in efforts to convert psychiatric hospitalization into a form of quasi-criminal detention by the use of the right to refuse treatment doctrine.

How can one argue for the right to refuse treatment by a committed patient if the very basis for commitment in many jurisdictions is the incapacity to recognize the need for treatment? For example, the Michigan Mental Health Code of 1974 provides three justifications for commitment. The first one deals with dangerousness; the second with the incapacity to attend to basic physical needs; and the third reads as follows:

> A person who is mentally ill, whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant harm to himself or others.[10]

The right to refuse treatment is related to the capability to give consent for treatment. Logical and practical considerations lead to the conclusion that a person who has no capacity to give consent has no ability to refuse treatment when in need of it.

The existence of severe psychosis does create the practical presumption of incapacity to give consent for treatment. A physician who obtains consent from such a patient does so at the risk of being sued for malpractice or even violation of criminal statutes. The law in a given jurisdiction might be that the patient has the right to refuse treatment even though he is civilly committed. It is unlikely that the law would state that

such a patient has at the same time the capacity to give informed consent for treatment. Thus, the physician is caught between the patient's right to refuse treatment and his incapacity to give consent for treatment. Unless the physician is willing to take great legal risks, he should in such a situation secure a judicial decision in each and every case requiring administration of treatment. The social and therapeutic implications of such an approach are far-reaching.

The Massachusetts case of Joseph Saikewicz, a sixty-seven year old, severely retarded man, illustrates the legal dilemmas associated with consent for treatment. Saikewicz developed myeloblastic monocytic leukemia. He was incapable of giving consent for treatment of his illness. The Belcertown State School, where Saikewicz was a lifelong patient, petitioned for appointment of a guardian on April 26, 1976. Nine days later on May 5, a guardian was appointed. On May 13 a hearing was held in Probate Court where the guardian recommended that no treatment should be given since the discomfort of chemotherapy would outweigh the potential benefits. The Probate judge applied to the Supreme Court for Appellate review, asking essentially two questions:

1. Is it appropriate to withhold treatment even though such decision might shorten the life of the individual?
2. The judge wanted to know if under the facts of the case the court was correct in ordering that no further treatment be administered for this condition without court order.

On July 9, 1976, the Massachusetts Supreme Judicial Court replied in the affirmative without giving an opinion. Such an opinion was issued on November 28, 1977, however, Mr. Saikewicz died on September 4, 1976.

The Saikewicz case does not represent an exercise of the right to refuse treatment, it is an assertion of the right to withhold treatment. Throughout his 67 years Mr. Saikewicz did not have the opportunity to make independent decisions. I presume that prior to April 26, 1976, he had been sick on a number of occasions and required a variety of intrusive treatments including even surgery. I assume that in the past his medical caretakers made these decisions on behalf of Mr. Saikewicz. In 1976 the power of vicarious consent was transferred to the court. As Vaccarino points out: "In Massachusetts, physicians may choke the legal system with applications to withhold life-prolonging treatment if they do what a recent ruling apparently says they should."[11]

It is unlikely that doctors will, at first, overwhelm the judicial system by complying with the mandate of the court. At one point or another, however, a physician or an institution will be sued for malpractice which might lead to an intolerable compliance with this principle. Judicial management of prospective medical decisions is, as a practical matter, not feasible and possibly not even desirable.

It could be argued that such decisions as required in the Saikewicz case involve moral values which are properly the domain of the courts. I fully

subscribe to this proposition. At the same time, I believe that medical practice involves a variety of moral decisions which cannot be prospectively monitored by the judiciary. I have deliberately avoided commenting upon the issue of the merits of the Saikewicz decision. I am fully aware of the fact that there is no absolute answer to the question posed by the circumstances of the Saikewicz case. Aside from the philosophical implications, there are certain practical aspects which should be considered. Obviously, the doctors entrusted with the care of Mr. Saikewicz avoided not only an ethical dilemma but also a medical-legal complication. The fact is that neither the guardian, the probate judge, nor the Supreme Court of Massachusetts can be sued for malpractice as the result of this decision; whereas the doctors could have been sued for giving or withholding treatment. We are thus witnessing the progressive development of a conditioned reflex within the medical profession which can be summed up under the slogan, "When in doubt, call the judge." One cannot leave the Saikewicz case without making some reference about the length of time involved in the legal decision-making process. It took the law seven months and two days to give a definitive answer to the question raised by the Belcertown State School about the treatment of Mr. Saikewicz.

Although legal philosophers and idealogues emphasize the ethical aspects of consent issues involved in medical treatment, it should not be overlooked that this whole area is a hatching ground of profitable litigation. Let us take a look at the treatment decisions facing a physician.

If the patient is a competent adult he may give or withhold consent. This appears to be deceptively simple. With increasing frequency, litigation arises in regard to the issue whether the giving or withholding of consent was informed. Inasmuch as fully informed consent is a legal fiction, the determination in a given case becomes "an issue of fact," to use a legal phrase, which paves the road to the courtroom.

If the physician faces an emotionally disturbed or outright mentally ill patient, the situation is even more complex inasmuch as the question can be raised whether or not the patient had the capacity to give consent. The only safe course of action for the physician is to take the Saikewicz route, namely, have the court give or withhold consent for treatment.

When the courts tell physicians that they should obtain consent, they do not mean agreement; they mean consent. Most people know what is meant by agreement, but even lawyers will be reluctant to admit that they know what is meant by consent. They will tell you that it has to be voluntary (Nurenberg Code), that it should be informed. Furthermore, if there are some experimental aspects to the treatment, then consent has to be "proper informed consent" to satisfy the National Institute of Health, and has to be "knowledgeable informed consent" to please the Federal Food and Drug Administration. Informed consent, be it proper or knowledgeable, will not satisfy the Health, Education and Welfare Commission, which requires a "legally effective" informed consent.[12]

Assuming that a physician would find a lawyer who could tell him what these various forms of consent mean, he would still face the problem of what he should disclose to his patient to obtain his consent. Should he be guided by the "majority rule," *i.e.,* tell the patient what other physicians in his locality disclose. Should he follow the "full disclosure" principle which requires that the physician discuss with his patient all the risks he knows or should have known? If the physician practices in Rhode Island, he would have to comply with the doctrine of individuality which states: "What is reasonable disclosure in one instance may not be reasonable in another."[12]

As recently as 1976, an authority informed physicians in the pages of the Journal of the American Medical Association: ". . . even the most ardent advocate of informed consent has no choice but to exclude from this requirement, those who are actually legally incapable of giving such consent. This group includes infants, children, legal minors and mental incompetents."[13]

The right to refuse treatment implies the right to consent to treatment. The severely psychotic individual is not capable of either. An individual who suffers mental impairment of sufficient severity to lose his right to be free in the community is not likely to have the capacity to give or withhold informed consent.

This by no means implies that a physician should not make every effort to secure his patient's agreement and cooperation regardless of how psychotic the patient. One can tube feed a catatonic patient with his agreement. It would be, however, ill-advised to consider it a valid consent. A physician who relies upon the consent of a psychotic patient for a treatment procedure is in a very precarious position. The doctrine of right to refuse treatment and the presumption of the capacity to give consent for treatment by a committed, psychotic patient is unrealistic, and the lawyers who advocate it know it or should know it. The true purpose of these efforts is to come a few steps closer to the abolition of involuntary hospitalization of the mentally ill. The right to refuse treatment is another valiant effort to gain pseudo-liberation of the mentally ill.

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