Refusing Treatment — Who Shall Decide?

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The issue of consent in medical care, and its corollary — refusal of consent, has become more and more complex. Three major consent issues are: (1) the capacity of giving consent or obtaining consent when the individual involved is impaired or not competent to give consent; (2) the capacity to consent to or authorize non-treatment or withdrawal of treatment; and (3) the refusal to give consent where there is a question as to capacity to consent but where the patient is otherwise legally impaired and is under a legal disability such as involuntary commitment because of mental illness.

The first issue is exemplified by situations involving minors, unconscious patients, those with transitory mental impairments due to associated physical illness, and those found to be specifically incompetent to make rational decisions (e.g., certain retarded or mentally ill individuals). Rules dealing with emergency and primacy of religious belief have been particularly scrutinized in this group.

The second issue deals with brain-damaged individuals or those with hopeless physical conditions where further treatment is thought to be either fruitless or, at best, a temporary expedient to keep alive one set of organs without affecting the overall functional level of the person. The risk-benefit ratio is marked by minimal or no possibility of benefit, whatever the consideration of risk or worth of monetary cost.

The first two groups have been particularly applicable to general hospitals or nursing home situations. The third area is refusal of treatment or refusal of consent for treatment by a mentally impaired individual who has been involuntarily committed to an institution, public or private, in accord with the law of the state involved. At one time, the fact of commitment conferred with it the authority to treat. Sometimes this authority was specified in statutes that authorized the superintendent or medical director to authorize or delegate appropriate treatment. Sometimes, particularly when surgery unrelated to the mental condition was indicated, authority was granted to the nearest relative or in the case of emergency, to the superintendent. By inference, those working under the superintendent or medical director were authorized to proceed with procedures or treatments deemed necessary by the medical staff. Commitment was, in any case, generally assumed to carry with it the authority to treat. This authority has now been under attack for a number of years, and the rapidly evolving principle of the right to refuse treatment has rendered this earlier consensual system anachronistic. The evolution of legal cases dealing with consent issues in psychiatry and the practical effects of these decisions have been commented on by a number of authors.[1-11]

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Roots of Current Controversy

Numerous factors have entered into the current conflicts over treatment authority. One most important stimulus was concern over deprivation of civil rights and the numerous gaps in procedural protection (due process) proffered to the mentally ill. Initially, legal activism was directed at the commitment process itself and the rationality of deprivation of freedom for those classified as mentally ill. Obviously, if institutionalization in the first instance is to be scrutinized, then, too, the grounds for retention were appropriately to be reviewed as well as what in fact was being done to people deprived of liberty. The focus often was on the deprivation of liberty issue with some attention directed generally to quality and availability of care. Right to treatment itself has been an evolving principle, one not yet clear under the law. A major stimulus to this sociolegal review was the malignant environment provided to patients and the numerous institutional abuses — physical and otherwise. Compounding the issue was the early popularity of ideologists who declared there was no such entity as mental illness and hospitals were prisons, freedom being the only issue and abolition of hospitals the only reasonable course of action.

Like war or events of natural science, a declaration of non-existence does not mean that something does not exist, and so the popularity of the philosophers of abolition precipitously declined only to be replaced by the social model proponents who furthered another philosophy of denial by seeing mental illness only as problems in living with socioeconomic, political, and racial elements as the essence of all adjustment difficulties. The social model has also shown itself to be totally incapable of adapting to the rapid advances in biological medicine that are drastically altering the scientific perceptions of the significant psychotic disorders such as affective disorders, schizophrenia, and other forms of brain disease. This model, currently at its peak of influence, is increasingly recognized as insufficient to explain or manage mental illness — though it provided sufficient impetus for medical people, particularly psychiatrists, to be excluded from the management and administration process and from the corridors of government.

The institutional psychiatric practices were investigated and the numerous inadequacies involved. Specific procedures such as psychosurgery and electroshock therapy were bitterly attacked as symbolic of psychiatric procedure — despite the fact that psychosurgery is for practical purposes non-existent in government hospitals and electrotherapy rare — most such treatments being available in the private sector with public patients being deprived of such therapy — whatever its merits. However, excess and inappropriate medication regimens were common. Poorly supervised drug therapy, drug therapy as a behavior-control system, excess sedation, medication as punishment were all delineated as typical of government medicine. Recently, as metastatic litigation and governmental and administrative mismanagement have taken their toll, paralysis of therapy and problems of

insufficient medication are becoming manifest (although this is an issue in which the anti-medicine pressure groups have little interest). The quality of government physicians, their training, and even the ability to communicate in the language of the land have been bitterly attacked. But these matters had relatively little impact compared to two other relevant matters.

One was greater attention to the risk-benefit ratio analysis of psychiatric treatment. Generally it was assumed that treatment itself was beneficial and that the remarkable reduction in numbers of the institutionalized from roughly 550,000 to 150,000 in a twenty-five year period was one indication of remarkable therapeutic achievement (which to a degree it clearly was). Recently this was questioned in terms of utility to the individual patient, particularly as tardive dyskinesia was recognized as a significant side effect, mostly after prolonged treatment in older patients. The exact dimensions of the problem are still unclear, but this particular symptom complex became the focal point of those who would attack the psychiatric-medical model of mental illness and, more narrowly, schizophrenia. The risk factor now became a more significant concern in a way that the problems of psychosurgery or electroshock never did (one because the procedures were little used, and the other because significant problems were not adequately demonstrated by scientific verification). Thus, no longer could medication therapy simplistically be considered benign. This increasing recognition of risk is true of almost all significant medication systems in use, the difference here being that treatment was imposed rather than a result of a voluntary physician-patient interaction as is the case elsewhere in medicine.

Secondly, this recognition of the benefit-risk complexities supported a greater consideration of the right to autonomy, the right of the individual to determine his or her fate — one which has been subsumed legally (and perhaps inaccurately) under the right to privacy (the last Rennie decision emphasizes liberty rights). Thus the combination of physician autocracy and medical program inadequacy provided the spur for those questioning current procedures, particularly in position of treatment on the involuntary patient.

The issue of autonomy is a vexing one, for there is the interesting contradiction that those who are involuntarily hospitalized have already been judged by society to be impaired in their capacity for autonomy. Further, any talk of competency is directed at a part function — for one who might be considered competent to determine treatment has already been declared incompetent to make decisions as to need for treatment or hospitalization. This is further compounded by the artificiality, but occasional reality, of the use of the concept of dangerousness. The law often appears to say to the patient, "You are mentally ill, dangerous, and need to be locked up," but on the other hand, "You may exercise your own judgment as to treatment or to refuse treatment." The administrator, as well as the psychiatrist, may be confronted with the need to hold people who are judged treatable but without the means to alter events. The psychiatrist may view

with alarm the increasing chronicity of multitudes of patients imprisoned in hospitals, subjected to premature rotation from the community to hospital and back.

And a variety of parties are concerned by the small numbers of physicians, some trained psychiatrists, some not, some adequate, some not, providing care that is not in keeping with the standards of the profession. The issue to them is — "How do we raise the quality of psychiatric care in governmental programs?" Expanding a right to refuse treatment may or may not prevent an abuse or inappropriate treatment for a specific patient, but it is not really reasonable to expect that it will provide appropriate therapy.

Nonetheless, the issues described have pinpointed the question of consent to treatment and the protection of the individual. If consent is a right as well as a protection, who is to decide on a course of therapeutic action if the patient alone cannot? Who provides the consent (if it be a consent issue)? Or who makes the decision (if it is a decision issue)? In order to explore this aspect, I shall attempt to review possible modes of handling this problem with attention to the advantages and disadvantages of each.

The Spectrum of Decision Makers

Patient Ideally, patients should enter into their own treatment process in terms of decision making. The law is well established that people generally have the authority to decide what will or will not be done with their own bodies.[12] This right, however, is based on certain assumptions — that that right does not interfere with the rights of others, that the person is competent, and that the person is in an adequate position to make a judgment. Each element has apparent limitations.

Involuntary patients have been determined to be a threat in some way in most cases — either to self or others. Under parens patriae, the patient was considered to be unable to make a rational decision as to his or her need for hospitalization and treatment. If the person by virtue of mental illness is deemed to be dangerous to others, then by not treating the mental illness related to that dangerousness the likelihood of harmful behavior is greater, though this is not measurable or clearly predictable. To restrict treatment to those who are actively assaultive in the hospital under emergency provisions is to apply a very restrictive approach. Both patients and staff are at some increased risk when treatment is not given (or not allowed). Similarly, destructive behavior, property damage, milieu disruption, prolonged illness or chronicity, lowered staff morale, and so forth are all reasonable consequences to the option of untreated patients.

Secondly, the patient already has significant dysfunction in these important areas. The basis of that dysfunction, mental illness, may enter into the decision-making process, as might patient attitudes related to the basic condition. A depressed patient may well reject treatment with the hope that death may result (even when the likelihood is only prolonged depression). An anxious person may become excessively fearful of an intervention or its

side effects; a paranoid person may well include the treatment regimen into a delusional system. Any attempt to divide the person into competent and incompetent selves is a peculiar artifice of limited meaning. For example, the judge in the original Rennie decision,[13] in discussing Rennie's competency to make medication decisions, stated that John Rennie's problems were cyclical so that only on some days was he psychotic. The court believed his refusal to allow fluphenazine (Prolixin) was not a product of his mental disorder, although his capacity to participate in the refusal of medicine or choice of medicine was somewhat limited depending on the day. The court also endorsed the patient's view that the refusal of lithium without concomitant use of an antidepressant was well founded. On the other hand, Rennie's decision-making powers were considered to be "somewhat impaired" — a finding that would no doubt be quite common in circumstances such as these. After the court issued its opinion of November 9, 1978, Rennie's condition deteriorated — with abusive and assaultive behaviors, threats to patients and staff, insomnia, and hallucinations with the application of restraints. Chlorpromazine was given under emergency procedures. Yet the judge accepted the lawyer's representation that "in his current psychotic thrall Mr. Rennie has still knowingly refused to consent to injection of Thorazine." The court did find a lack of capacity, concluding "while his refusal of Thorazine is partly motivated by a rational desire to avoid harmful and unpleasant side effects, it is also prompted by an irrational desire to rebel against the hospital and its doctors."

In the Yetter case,[14] a 60-year-old woman hospitalized for two years for chronic undifferentiated schizophrenia refused biopsy and surgery for a possible breast carcinoma. She was fearful of an operation, stating that her aunt had died from such surgery, that it was her body, and that she did not desire the operation (apparently the aunt died fifteen years after surgery from unrelated causes). Mrs. Yetter said that surgery might hasten the spread of disease and do her further harm and that she would die from surgery. She also stated that the operation would interfere with her ability to have babies and would prohibit a movie career. The court queried: "Are we then to force her to submit to medical treatment because some of her present reasons for refusal are delusional and the result of mental illness?" The court concluded, "Upon reflection, balancing the risk involved in our refusal to act in favor of compulsory treatment against giving the greatest possible protection to the individual in furtherance of his own desires, we are unwilling now to overrule Mrs. Yetter's original irrational but competent decision."

The limits to autonomy are apparent. In the abortion case, the Supreme Court granted to women the absolute right to abortion in the first trimester but made permissible limitations in the last trimester if a state wished to provide restrictions based on the evolving rights of a fetus approaching viability — this in a situation where one is not concerned about the nuances of competency to decide on treatment and its meaning.

Ordinarily, consent issues are complex. Despite the mystique of consent, reliance on professionals is great, and true comprehension is often somewhat limited in degree. How many clearly competent people understand their lawyers or their accountants, much less their physicians? Limited recollection and understanding by patients is a phenomenon that has been periodically reviewed, but in these cases the effort had been made and current mental impairment not an issue.

Acknowledging the desirability of patient consent and its legal sanction, one can realistically note the limitations involved in allowing the involuntary patient to be the decision maker. At least one state, Utah, now clearly allows the incompetency issue to be determined at the time of involuntary hospitalization so that a patient can be both institutionalized and treated. A proposed New Jersey bill would do likewise.

Treating Doctor Traditionally, the treating doctor had authority to treat. Abuses in the system and the concern over individual rights have resulted in the current controversy over physician care. Therefore it would be naive to state that authority to treat should be that of the treating doctor alone, when that authority has been one of the causes of the current problems.

One aspect of the current concern is adequacy of care. Therefore, any change in the system that would provide for a high level of professional care (competent, well-trained psychiatrists) with manageable numbers of patients and intra-institutional therapy authority might lessen the need for social and judicial review. This would require other changes — higher salaries, more institutional psychiatrists, and drastic changes in institutional management and practices. This is a goal that psychiatrists clearly would support. In the long run, this may be the only approach that has meaning. One cannot improve the system by dabbling around the edges and focusing on global abuses and mistreatment of individual patients by providing a system that at great cost results in no treatment at all and a condemnation to chronicity in the name of due process.

The model of private practice, a direct doctor-patient responsibility with credentialing and peer review in a competitive market, seems increasingly inaccessible in the public sector. To apply the same rules as in the private sector can be time consuming, expensive, and inefficient in terms of utilization of resources.[15]

The conclusion, therefore, is that, at this time, there must be some review system above and beyond the individual treating doctor in the public hospital.

Medical Review Team One possibility is the creation of a supervising psychiatrist as the treatment review person, with or without an appeal process availability to a patient. To allow one institutional psychiatrist the formal role of decision maker would subject that person to charges of mechanical ratification of underling practices and would titillate the anxieties of those preoccupied with conspiracy theory. Thus a simple hierarchi-

cal treatment review therapist would not be sufficiently protective of individual patient concerns.

Another alternative is a treatment review team to which a patient could appeal. The composition of the team could be staff psychiatrists from other divisions or a combination of hospital staff and outside consultants. This system might have the benefit of more skilled, senior psychiatric input. Certainly a more pertinent psychopharmacologic treatment system could evolve under these circumstances. Whether such a program should be based on individual or group effort or be comprised only of psychiatrists, psychiatrists and other physicians, or psychiatrists and other professionals could be determined by experience. If the issue is psychopharmacology, then logic would dictate that this be a medical program. The concept of multidisciplinary approaches where other disciplines have no professional competence (as in one such administrative program in New Jersey) cannot be considered ethically responsible.

Such an institutional program would have to be subject to careful review, perhaps by a broad-based statewide study team to assure appropriate individual review and to avoid implications of an incestuous mutuality of interest. One possible positive attribute of such a system would be availability within the institution of prompt action and follow-up over time.

Independent Psychiatrist Although the latest Rennie decision[16] did not dictate the use of an independent psychiatrist as had been required by the district court, it did not preclude a state from adopting such a system if it wished. The advantage of such a system is that, if well run, well-qualified psychiatrists could be utilized to act as appeals review persons in case of patient refusal of treatment. This can be done by administrative directive and not by legislative fiat with its subsequent legal rigidity. Reportedly, this system is working well in New Jersey. The risk is that the participants will not be of acceptable quality, that there will be a ritualistic, superficial review, and that the process will be one of expenditure of cost and time without true meaning. However, the worth of any program will depend on the quality of its implementation, not on the wording of its structure. This is perhaps the best of the choices in terms of alternative decision making although its feasibility in isolated state hospitals might present difficulties.

Spouse, Parent, or Nearest of Kin Traditionally, the nearest of kin have provided consent when the involuntary patient was clearly incompetent to do so — particularly for surgical procedures. Where the patient refuses treatment and an alternative consent source is required, the use of such a person is probably no longer feasible.

First, the nearest of kin has been accused in numerous related matters (e.g., placement of minors in institutions for retarded or behaviorally disturbed) of having interests adverse to the party affected. Although many would question this reality in view of the numbers involved, abuses have occurred in individual cases. The Supreme Court in Parham[17] did question the institutionalization of minors hospitalized by their parents, deciding protection could be offered by the staff physicians who do the screening for

institutions and who would act as the independent parties without the requirement of formal due process.

To allow such relatives to be treatment arbiters would raise further problems in consent issues and possibly put them squarely in opposition to the patient who does not wish to have treatment — a situation not conducive to family harmony. Problems of availability and access would be compounded as many relatives do not live in close proximity to the institutions. Further, there is a likelihood of either ritualistic ratification of staff recommendation or the imposition of decision making on parties who not only have no particular competence but also who may themselves have limited sophistication. Using relatives might require an initial determination of "competence" by the patient.

Nonetheless, the use of nearest of kin does comport with traditions of family responsibility and allows for a type of substituted judgment that approximates that of the average person. It would also avoid "career" decision makers.

Guardian The interposition of a guardian as decision maker is another feasible approach.[18] The guardian group might consist of relatives, lawyers, or other parties. The use of relatives as guardians differs from the inherent authority of nearest of kin discussed in the prior section. It would require formal guardianship hearings and thus involve cost and delay, but it would sanctify authority.

The problem of others as guardians similarly has problems. The use of an attorney as a guardian is traditional in property matters inasmuch as lawyers are versed in property control, disbursements, estate management, payment for necessities, and so forth. The role of a guardian over property is an appropriate legal function. However, nothing in the training or experience of a lawyer makes that lawyer competent in medical decision making. The lawyer is likely to act on the basis of personal prejudices and extraneous experience. If the lawyer handles a number of cases, he or she is likely to handle them in accord with an attitudinal set in a mechanical fashion. Public advocate attorneys have been confronted with a number of dilemmas. Do they represent the wishes of a patient or the best interests of the patient? If the latter, what is the basis of the decision making? If a lawyer believes that personal autonomy is supreme, then that principle might rule. If the lawyer believes that medication is used to poison people, then he or she might act accordingly. If the lawyer defers to medical judgment, then another type of judgment will be forthcoming. In any of these cases, is the decision rational or necessary?

If a lawyer uses as authority adversarial literature from legal sources such as "Limiting the Therapeutic Orgy,"[19] then another type of inappropriate judgment will result.

The use of lawyers is likely to be time consuming, ill informed, and costly. The State of Massachusetts in the Rogers cases[20] has attempted to use attorneys as guardians in right to refuse treatment cases with final

authority in the hands of the judge. Massachusetts lawyers have not been enthusiastic in assuming such responsibilities, and guardians have been difficult to obtain. Ironically, the lawyers themselves have been concerned about the possibility of litigation against themselves because they might be vulnerable, whatever they recommend. If they recommend refusal of a specific treatment, could they then be sued for legal malpractice if the condition is not improved or improvement delayed? If they recommend treatment and problems result, could they then be sued in the same manner that physicians are, albeit a successful suit would not be likely?

And, overall, one may ask whether the multi-layering of decision makers accomplishes anything other than increasing costs and providing employment for the various participants.

These very same issues apply to public advocates, whether they be lawyers or not, if they are placed in the position of guardian.

If guardians are to be used, then the need for guardianship might well be demanded for all patients in public hospitals. This issue would not then be directed only to a paltry few in occasional state hospitals but would apply to tens of thousands of people across the country.

Lawyers and Legal Public Advocates Many of the problems in the use of lawyers and/or legal public advocates have already been presented. Not only has the record of attorneys been checkered in this regard, but also there are certain aspects of the legal background that make attorneys particularly unqualified. In addition to not having the appropriate professional background for pharmacologic judgments, lawyers by virtue of their adversarial orientation have both limited adaptability and ideologic conflicts of interest. The adversarial mentality leads to scientific distortion.

For example, many of those who have written on the topic of patient rights have focused quite appropriately on civil rights and human freedoms. They tend to bolster their arguments by selecting information from literature or "experts" and then prepare their briefs. If that brief is an element in a legal review, such behavior is quite appropriate as far as legal function, but it is not an adequate reflection of medical knowledge. More seriously, many attorneys are prone to write articles on behalf of causes they espouse. These articles are then printed in professional legal literature such as law reviews where they are used as references by other lawyers and judges. Ironically, few physicians write for law reviews, and their reports are buried in the medical literature where their style, content, and language either renders them not easily usable by the law or, conversely, renders them too easily usable by the law that relies on information taken out of context or not sufficiently relevant or verified. For example, various psychotropic drugs have been blamed for patient suicide, cancer, and so forth with minimal justification.

The area of litigation involving medication is replete with reference to articles written by lawyers (often not identified as such in the legal case reports).

Another problem for attorneys is that their comprehension is often limited by the biases of their medical "experts" who are used as knowledge resources and as witnesses in courtroom proceedings. Such witnesses are neither "good" nor "bad," "honorable" nor "dishonorable," but it is no secret that often certain experts will be used because their views and findings are predictable. Thus one may encounter an incestuous, ideologic value system where judgments are constantly reinforced. Such a system may be suitable for a fundamentalist church, but it certainly does not contribute to open-mindedness and flexibility.

Thus the use of lawyers as decision makers on appropriateness of treatment becomes a costly, time-consuming system not likely to be truly rational, in the sense of the reasonable application of evolving medical science. Numerous legal articles on psychosurgery, electroconvulsive (electroencephalotherapy) therapy, and psychopharmacology have dealt with reasonable issues in an unreasonable fashion so the totality is distorted and misinforming.

Other Professionals The use of psychologists, social workers, nurses, occupational therapists, vocational therapists as decision makers dealing with medical-pharmacologic treatment raises obvious problems. The inappropriateness of the use of such people as medical decision makers has been demonstrated in the administrative patterns of some social "scientists" who have gravitated to power positions in the mental health industry. The judge in the 1979 Rennie decision would have allowed a variety of people, including paralegals and others with "any equivalent experience," to be advocates in matters of drug treatment, urging they be given training in the effects of psychotropic medication and the principles of legal advocacy. Who is to give the training? How much? Who then is responsible? Can there be a decision maker without responsibility?

Judges Since judges are lawyers, many of the previous comments apply to the role of judge as medical decision maker, complicated perhaps by the almost absolute authority of the judge and his or her lack of responsibility (in the sense that a judge cannot be held personally responsible). Thus there would be no controls at all in what could otherwise be medical malpractice (if performed or decided by a physician). This is not to be construed as an attack on judicial immunity; I believe it is most important for judges to be able to make decisions without fear of personal attack.

The problem of judge as medical decision maker can be exemplified by a review of some judicial opinions dealing with these matters. When I presented examples of unusual decisions (such as the Yetter case above or those to follow), a lawyer criticized me for being selective and noted that most medical decisions made by judges are quite appropriate. I acknowledge there is merit in this contention. Nonetheless, the following examples are illustrative of the inadequacy of the judge as universal decision maker and of the process itself.

In particular, the judge in the Rennie case was involved in extensive review over a long time, referred to much literature, and was exposed to

numerous medical witnesses — both state hospital doctors and outside "experts." If ever a system were to have provided a reasonable base for a decision, this might have been such a case. Therefore it is meaningful to review some of the judicial comments.

In Rennie I, the judge was confronted with a refusal of treatment by a man who had had twelve hospitalizations in seven years with little social function or remission. At various times, Rennie was assaultive, paranoid, homicidal, suicidal, threatening to the President of the United States (at least on two occasions), depressed, delusional, manic, euphoric. At times he believed he was Christ or "Alpha Omega." Diagnosis at various times was either schizophrenia or manic-depressive illness. At the hearings at least four psychiatrists made a diagnosis of schizophrenia with one indicating that at times there were symptoms of manic-depressive illness. One made a diagnosis of manic-depressive illness with schizo-affective illness as an alternative, and two (apparently outside expert witnesses) a diagnosis only of manic-depressive illness. The judge concluded that aside from Rennie's reaction to psychotropics, the best course of treatment would be psychotropic medication combined with lithium and an antidepressant. However, he also added the proposition that Rennie had no fixed delusions, "thus making use of a psychotropic unnecessary," is reasonable, supporting a diagnosis of manic-depressive illness. Apparently his impression was that a fixed delusion meant schizophrenia requiring a psychotropic drug, and if a delusion was not fixed, the diagnosis would be manic-depressive illness.

The various witnesses discussed the concept of medication, and the judge referred to thirteen references, six from the legal literature, in his discussion of drugs.

The court rejected "any situation" that would allow treatment by "antipsychotropic drug alone" (apparently he meant either antipsychotic drug or psychotropic drug). He noted that both pharmacotherapy and psychotherapy were necessary, not one without the other, and concluded: "Only in the context of a trusting relationship achieved through psychotherapy can medicine be employed in a rational way." That last statement, so popular amongst some legal educators, is simply not accurate. He later noted that a trusting relationship or therapeutic alliance between psychiatrist and patient was essential for a drug regimen to succeed, again emphasizing this belief system. The court authorized the use of lithium and imipramine (Tofranil) and refused the use of other drugs in non-emergency situations (if the latter were refused by Rennie). When problems arose, the court allowed Thorazine to be continued as the least restrictive means to stabilize the patient so that lithium and psychotherapy could be used (the whole concept of least restrictive therapy as applied to a drug is nonsensical, but that will not be discussed here).

The court again reviewed the use of drugs in its last report, commenting that many patients can improve without drugs, that smaller doses often can be effective, and that in addition to dangerous side effects such as tardive

dyskinesia, drugs "inhibit a patient's ability to learn social skills needed to fully recover from psychosis and might even cause cancer [*sic!*]."

The merits of the particular case, the numerous legal issues, and the well-known problems of drugs in terms of benefits and risks need not be discussed here. What is of note is the arbitrariness and questionable conclusions incorporated into a legal judgment about narrow issues of medical knowledge after very extensive review. The problem is not so much the gross inaccuracy as the distortions that, if accepted, would present a picture significantly different from current medical practices as generally accepted by the profession. The fact is, despite all the court review, the education process of the court, using literature and experts, was not satisfactory and resulted in a highly biased picture of psychiatric practice, which other judges are apt to read and accept as medical gospel.

The Circuit Court decision on the Rennie matter on July 9, 1981 upheld the practice of an in-hospital medical review with the permissive use of an independent psychiatrist.

The Rogers v. Okin case still leaves the authority in the hands of a judge with the guardian to act as spokesperson to the judge who retains final authority in a right to refuse treatment case.

This authority was reaffirmed in the recent Massachusetts case of In the Matter of Guardianship of Richard Roe III.[21] The court refused to grant to a permanent guardian the right to authorize medication, retaining the substituted judgment doctrine in which the judge determines whether a patient or ward, if competent, would accept such medication. (Overriding state interests might include preservation of life, protection of third parties, prevention of suicide, and maintaing the ethical integrity of the profession and would constitute grounds for treatment, exclusive of the substituted judgment doctrine.)

The court allotted several pages of discussion to purported principles of psychopharmacology extracted from the Plotkin article on the "Therapeutic Orgy." Thus one encounters such verbalisms as references to drugs powerful enough to immobilize mind and body, cause a toxic psychosis, undermine the foundation of personality, and control behavior. The intended effects of antipsychotic drugs are described as "extreme." References to medical sources, such as an article by psychiatrists from Harvard in the *New England Journal of Medicine*, take a few lines.

The court would seem to accept deterioration and chronicity as a foregone conclusion with intervention justified only if there would be an *immediate*, *substantial*, and *irreversible* deterioration of a mental illness.

The view of the medications presented is indeed one of horror that does not quite coincide with the reality of the medical world. Sources such as "Limiting the Therapeutic Orgy" are highly determinative of judicial attitudes. Here the word "orgy" alone is sufficient to reflect its message. Plotkin himself was a staff attorney for the Mental Health Law Project at the time the article was written.

This phenomenon is indeed curious. Ordinarily in a trial court, an expert witness is one with specialized knowledge in a field, and in order to testify, he or she must be shown to have qualifications in the area at issue. Imagine the reaction of a court if an adversarial attorney were introduced to the court as an "expert" in clinical medicine and psychopharmacology. Yet courts do not seem averse to using the uncontradicted printed word, not subject to inquiry or cross-examination, by writers who have produced an argument, promulgated a cause, or reviewed in a law review a technical area outside their training. Appeals courts seem to be particularly susceptible to this type of influence. It is little wonder that medical people look with amazement and distress at some of the pronunciamentos emanating from august courts. (I wish to stress that my criticism here deals only with narrow medical issues, not the broad area of individual rights and their interpretation.) The point to be made is that courts, at high and low levels, have made grossly erroneous statements concerning medical practice and knowledge and then based their determinations on such beliefs.

Thus two significant problems face judges when they are confronted with medical decision making. Their sources of information, as currently used, are inherently unsatisfactory, and they do not have an adequate professional base to decide such issues. Additionally, treatment does not lend itself to such review because of the everchanging nature of illness and medical practices as well as the need for a system that acts promptly, flexibly, and periodically.

The court in the Rennie appeal noted the problem of judges "who have doffed their black robes and donned white coats." Similarly, the Supreme Court in the Parham case[6] did not accept "the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional rules of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decision-maker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."

Conclusions

Significant problems concerning appropriateness of treatment exist in the government-run system of managing the mentally ill who are subjected to involuntary hospitalization. In the long run, only good quality of service by appropriately trained physicians will provide an acceptable level of care.

The issue of the dimensions and limitations of the right by such a person to refuse treatment remains a perplexing one. Inasmuch as increasingly the courts have recognized such a right (whatever its dimensions), the problem of what to do becomes more complex. Somebody must decide — whether it be patient or someone else.

This article has discussed the nature of the problem and offered observations concerning the various parties who have been proposed as decision makers. Because of the complexities of the problem, no solution can be totally satisfactory. Nonetheless, the conclusion is offered that the essential party in a decision as to proffered medical treatment with consideration to possible benefit and risks is the medical person trained for such a task. A system of providing for a medical review by a person not directly involved with the care of the patient can be structured in a number of ways. The use of a review board within a hospital or supervision by a special staff person from within or without the hospital is now the practice in New Jersey — with the additional option of consultation by an outside independent psychiatrist (optional, not mandatory).

Of the various modalities discussed, this at this time would seem to be the most practical. In particular, the use of attorneys as decision makers is criticized in view of the professional inappropriateness, biases, and unwieldiness of procedure in terms of time, cost, and result.

Nonetheless, the question of "who shall decide?" remains a troubling one. If it is not answered well, the burden will fall ultimately not on the decision maker but on those patients who have been so grossly ignored and neglected while so many warriors joust as their champions.

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