

The Health Care Proxy for Mental Illness: Can It Work and Should We Want It To?

Gary N. Sales, JD, MD

The living will was first proposed more than 20 years ago,¹ and for almost that long commentators have suggested that it and other types of advance directives* could be used in the treatment of individuals with mental illness.² The uses offered for advance directives vary considerably depending on the philosophy and goals of the commentator. Psychiatrists and families of mentally ill individuals propose advance directives as a means to facilitate hospitalization or pharmacological treatment of mentally ill patients or family members.³⁻⁸ Health care consumers and their advocates take a more cautious approach but still envision advance directives as a

method of effectuating their right to make health care decisions and their right to privacy.^{9, 10} The actual validity, utility, and enforceability of instructional advance directives for mental health care, however, is far from clear.¹¹⁻¹³

The health care proxy is the most recent advance directive alternative.¹⁴ New York's new law provides for the broadest use of proxies.¹⁵ The New York statutory scheme specifically envisions use of the proxy by individuals with diagnosed mental illnesses and/or in mental health facilities.

As psychiatrists, patients, and the families of mentally ill individuals continue to search for ways to provide psychiatric care to those who need it, the health care proxy at first blush appears to be useful. Many times the desire and need to help, care for, and treat those with acute and chronic mental illness is frustrated by confusing and conflicting state laws and court decisions in such areas as: confidentiality versus involuntary commitment;¹⁶ involuntary commitment versus least restrictive treat-

Dr. Sales obtained his B.S. in 1977 from the University of Cincinnati; J.D. with honors in 1980 from The Ohio State University College of Law; M.D. in 1988 from Wright State University School of Medicine; Residency in Psychiatry; University of Cincinnati; Fellowship in Forensic Psychiatry, State University of New York at Syracuse. Reprint requests to Dr. Sales at 3300 Providence Drive, Suite 107, Anchorage AK 99508.

* Advance directives for health care are of two general types: 1) instructional directives, such as living wills; and 2) proxy directives, such as durable powers of attorney for health care and health care proxies. With the former type, the individual provides written directives concerning future care and treatment. In the latter type, the person generally names an agent or proxy who, under certain conditions, can exercise substituted judgment on the principal's behalf.

ment environment; confidentiality versus *Tarasoff* duty¹⁷ to warn or protect; informed consent versus assent;¹⁸ right to refuse medication versus right to treatment; and *Tarasoff* duty versus liberty interests and the difficulty of predicting dangerousness.

To determine the extent to which health care proxies can and should be of use in treating mental illness, it is necessary first to look at the utility of proxies in medicine generally. This will require a review of the history of and philosophical reasons for advance directives and a review of studies of the use of proxies in medical settings. Second, it will be necessary to address factual differences and legal differences between patient care in the ordinary medical setting and in the mental health setting. Of particular importance is the long history of statutory and case law distinctions in the treatment of medical and mental illnesses. Finally, predictions will be made about the validity, utility, and enforceability of health care proxies in the mental health arena.

Advance Directives in Medicine

Advance Directives, Generally The Patient Self-Determination Act was signed by President Bush on November 5, 1990 and became effective on December 1, 1991.¹⁹ This federal law requires medical facilities that receive Medicare or Medicaid to inform all patients of their rights under state statutory law or case law to execute advance directives.^{20, 21} This law was passed in response to the significant national public interest in the avoidance of unwanted

medical care, especially in instances of patients in permanent neurovegetative states, that was generated by the case of *Cruzan v. Director, Missouri Department of Health*.²²

Living will statutes have been around for greater than 15 years and probably received their original impetus from another landmark case, *In re Quinlan*.²³ California enacted the first living will statute in 1976²⁴ and the first separate Durable Power of Attorney Law for Health Care.²⁵† At this point in time all states have some type of law recognizing the use of designated types of advance directives under certain conditions.^{26, 27} There is, however, significant variation by the individual states concerning the specific details of their advance directives.

The legal foundation for advance directives is twofold. Common law has long recognized the individual's right to autonomy and self-determination. Justice Cardozo, while a justice on the New York Court of Appeals, is generally credited with first enunciating this common law right in the medical area when he wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . .,"²⁸ which is the basis for a common law requirement for informed consent. More recently, courts have also found the constitutional rights to privacy²⁹ and liberty²² provide a basis for treatment refusal. These rights,

† Of note, the California law specifically prohibits a principal from authorizing attorney-in-fact to consent to, among other things, convulsive treatments or mental health commitment.

moreover, are not lost when one becomes incompetent. Instead, by means of advance directive or other probative evidence of a person's treatment choices, a court,²⁹ guardian,³⁰ proxy,¹⁵ or family member³¹ may make treatment decisions for the incompetent individual. Because the decision for the incompetent is a substituted judgment, i.e., the decision maker attempts to make the decision his/her principal would have made, advance directives do not, as a rule, involve the state's *parens patriae* power. *Parens patriae* involves a "best interests" standard of decision making and, as such, requires a different analysis by a court, as will be discussed below.

Although there is no requirement that designated proxies be relatives, the health care proxy can generally be seen as the outgrowth of the common medical practice of physicians turning to relatives to make treatment decisions for incompetent family members.³²⁻³⁴ Although the legality of informally turning to family members to make treatment decisions has always varied among jurisdictions,³⁵⁻³⁷ the practice has generally been universal in medicine outside of psychiatry.^{14, 35, 38, 39} *Cruzan*, however, was perceived as an attack on using family members to make substituted judgment treatment decisions,⁴⁰ and this was a further impetus to establishment of formal proxy laws.

Although there has been much scholarly writing on advance directives in medicine⁴¹⁻⁴⁵ and the medical profession has taken steps to encourage physician familiarity with advance directives,⁴⁶⁻⁴⁸ advance directives are still not utilized

by most individuals. Studies suggest that only eight percent to 15 percent of American adults have prepared a living will.^{20, 41, 49} This figure, however, should increase as a result of the recent state legislative action providing for some type of advance directives in all states and federal law requiring many care facilities to provide advance directive information to their patients.¹⁹

Physician Attitudes About Advance Directives Although 78 percent of the U.S. physicians in one study favored withdrawing life-sustaining treatments from irreversibly comatose patients if the patient or family requested such action, another study showed that 74 percent of physicians generally do not discuss advance directives with their patients.⁴³ Another study found that 87 percent of persons 65 or older believed that physicians should routinely discuss issues concerning cardiopulmonary resuscitation with patients, but only three percent had ever had such a discussion.⁵⁰ Thus, there appears to be a significant gap between the generally high level of acceptance of advance directives philosophically by both physicians^{21, 45} and patients and the low occurrence of practical physician-patient discussions in this area.

In his study of physician responses to advance directives, Zinberg⁵¹ concluded that most physicians' "lack of knowledge about directives, like their lack of experience with them, suggests that advance directives are infrequently used and perforce have little effect on medical decision-making." Moreover, despite the high level of physician approval of the

concept of advance directives (84 to 85%) that he found, Zinberg found that physician actions belied their enthusiasm for the concept. He found that "the most important determinants of treatment decisions for incompetent patients are the physician-family consensus as to the proposed treatment and the physician's perception of potential civil or criminal liability."⁵² This physician-family consensus was so important that physicians would delay implementing a clear directive to withhold care until the family agreed. Zinberg points out that physicians are acutely aware that surviving relatives are potential plaintiffs. He determined that the most useful function of instructional advance directives might be to better help the physician and family reach a consensus.

In contrast, Davidson and colleagues⁵³ found that a majority of the physicians in their study had actual experience with advance directives in their practice (55.9%), and a significant majority of physicians (83.5%) said their attitude had become more positive toward advance directives as a result of their experience.

Thus, while most physicians support the concept of advance directives, studies indicate most physicians do not discuss advance directives with their patients or follow the directives unless they comport with family wishes. Moreover, there is some concern among physicians that advance directives may cause them to be required to provide medically unacceptable minimal or extraordinary care.^{14, 54-58}

Patient Attitudes About Advance Direc-

tives Gamble *et al.*⁵⁹ studied elderly, nonhospitalized individuals in North Carolina to determine their knowledge and attitudes regarding the state's Right to Natural Death Act, which had been in effect for about 10 years. While they concluded that the living will legislation was congruent with the desire of many elderly to limit terminal medical care, they found elderly North Carolinians were not making use of living wills. They identified three potential barriers to signing a living will, including lack of knowledge, lack of communication between physicians and patients, and a preference for proxy decision-making by family members.

In a very revealing study, Sehgal *et al.*⁶⁰ investigated just how closely dialysis patients wanted their advance directives followed. Only 39 percent of the study subjects would give their surrogates "no leeway" to override their advance directives, 19 percent would give "a little leeway," 11 percent would give "a lot of leeway," and 31 percent would give "complete leeway." The majority of subjects (54%) thought that written statements should carry more weight than oral statements. Nonetheless, even among only those study subjects with prior written advance directives, 40 percent did not want advance directives followed strictly.

Thus, the current literature suggests that despite the clear preference of adult Americans for the concept of advance directives, relatively few have executed such directives and many, if not most, of these individuals still would like their family to be able to deviate from strict

Health Care Proxy for Mental Illness

enforcement of written or oral directives.^{37, 61} Therefore, although the patient's autonomy and self-determination rights are the basis for advance directives, it appears that most individuals would choose to exercise these rights by giving their proxies or relatives significant leeway to ignore their previously communicated wishes.

Effectiveness of Advance Directives Advance directives are premised on the fact that the individual's right to privacy and right to autonomy and self-determination allow him/her to direct his/her own care even when incompetent by means of either a written advance directive or surrogate decision making by a proxy. Thus, theoretically, the individual's rights would be effectuated if either his/her written advance directive were followed or the surrogate made a correct substituted decision.³⁸

A literature review found only one prospective study evaluating the effectiveness of written advance directives. In that study, Danis *et al.*⁶² evaluated "the effectiveness of the written advance directives. . . in terms of how frequently the directives were available at the time of an outcome event and how frequently the patient's care was consistent with the previously expressed wishes." The authors found that advanced directives were in the nursing home chart for 74 percent of the outcome events of the patients while in the nursing home. The advance directives, however, were delivered to the hospital and incorporated into the hospital chart for only 25 of the 71 hospitalizations. Clearly, written advance directives have limited effective-

ness when they do not make it into the chart in most of the hospitalizations.²⁰

Danis *et al.*⁶³ found that medical treatment was consistent with the advance directives in 75 percent of outcome events. Paradoxically, "[c]onsistency between previous wishes and patient care occurred less often when the advance directive was present in the medical record than when it was absent." Several reasons existed for not following the written advance directive, including: the preference in the advance directive was too restrictive to allow care that was strongly believed by the health care providers to be appropriate at the time of this outcome event;^{62, 64} treatment chosen in the advance directive was not administered because it was not likely to afford benefit; the patient changed his/her mind; families made choices that contradicted the patients' previously expressed wishes;^{21, 38, 56, 64} and the health care providers were unaware of the advance directives.

Zweibel and Cassel⁶⁵ studied the treatment choices of elderly patients and their physician-selected proxies in several hypothetical care situations and concluded that "[w]ithout advance statements of treatment preferences, it appears that physician-selected proxies of decisionally incapacitated widowed elderly often would choose care for their older relations that goes against what the patients would choose for themselves." Not surprisingly, the authors found that the vast majority of these proxies would treat their older relatives in the same way the proxies would want to be treated themselves. This suggests that when a

physician chooses a proxy, which is often the way a substituted decision maker would be chosen in the absence of a patient chosen proxy appointed by an advance directive, the proxy lacks information on which to form a substituted judgment. In such cases the proxy falls back on what he/she would want in making the proxy decisions. Certainly, this failure to implement a substituted judgment is likely also to occur in patient-selected proxies when the patient and proxy do not discuss the patient's health care philosophy and wishes.⁶⁶

Uhlmann *et al.*⁶⁷ studied the accuracy of spouse and physician prediction of elderly patient's resuscitation preferences in several hypothetical situations. They found that "the proportion of correct predictions did not exceed that expected due to chance alone in most decisions for physicians and in half of the decisions for spouses."⁶⁸ Therefore, they concluded that there was little to support using spouses for substituted judgment decisions and that physicians often do not know the wishes of their patients even when they think they do.

Thus, while there is little scientific literature evaluating the effectiveness and accuracy of advance directives, the literature that exists suggests written directives are often ignored or not followed and substituted decision makers often do not make accurate substituted judgments.

Summary of Advance Directives for Medical Care In the minds of physicians, patients, and legislators, advance directives conjure up images of terminally ill elderly individuals or young

adults in persistent neurovegetative states, who but for the presence of the advance directive, would be forced to undergo unwanted treatment used to prolong their dying. State and federal action to encourage and facilitate advance directives also is clearly financially based in part. Because advance directives are most often envisioned to limit terminal care, they necessarily will lead to health care financial savings.

Certainly, as evidenced by the flurry of state and federal legislation in this area, advance directives have caught public attention and interest. Despite this interest and legislation, however, most individuals do not opt to exercise their right to execute an advance directive.

Moreover, despite the nearly universal belief that advance directives are important to preserve and protect the individual's autonomy, self-determination, and privacy rights, there is ambiguous evidence at best that this is the case. Nevertheless, the long history of family decision making for incompetent family members, both formally and informally, makes the use of advance directives, especially proxies, a universally accepted and thus enforceable concept.

Differences in Medical Care and Mental Health Care That Would Affect Proxy Use

***Parens Patriae* and the Police Power** The two justifications for civil involuntary commitment to a mental health care facility are the state's *parens patriae* and police powers.^{69, 70}

Parens patriae originated in the power

Health Care Proxy for Mental Illness

of the King to act as the guardian of incompetent subjects and, as such, to promote their interests and welfare. "The *parens patriae* function can thus be viewed as a power which the members of the community have granted the state for the protection of their future well-being."⁷¹ Generally, *parens patriae* is an evaluation of what is in the best interests of the incompetent and not a substituted judgment determination.^{2, 18, 69} Therefore, once a determination is made that the individual is incompetent, and therefore in need of the state to protect his/her interests and welfare, the state can act on the incompetent's behalf to commit him/her.¹⁸

Unfortunately, the rationale and justification for invoking the *parens patriae* function of the state has been excluded from almost all state commitment statutes: i.e., most states do not require that an individual be found incompetent as a prerequisite for involuntary commitment. The result is that individuals have their liberty curtailed by involuntary hospitalization, but can refuse the very treatment that will alleviate their mental illness so that they could be discharged from the hospital.⁶⁹

To a significant measure this subversion of *parens patriae* is due to its confusion with and subordination to the state's police power as a justification for involuntary commitment.^{2, 69} Unlike *parens patriae*, in which the state commits to further the best interests of the mentally ill individual, police power commitment is used solely to vindicate the state's interest in preventing harm to members of society, whether it is self-

harm or harm to others. Under a police power commitment rationale, competency is not seen as relevant. Instead, the *sine qua non* is a finding of dangerousness. Thus, while mental health care providers and families of the mentally ill advocate for a "medical model," which is essentially synonymous with *parens patriae*, the courts often look at commitment from a "legal model," which is essentially a police power approach. The police power "conceives of commitment as a deprivation of liberty in order to protect society from dangerous persons: accordingly, all of the criminal justice legal procedures should apply."^{70, 72}

Fortunately, *parens patriae* and police power play a small role in medical decision making outside of psychiatry. Family members traditionally have made medical decisions for incompetent relatives. Furthermore, even when courts have become involved, they have generally made their decision using a substituted judgment analysis pursuant to the patient's common law autonomy and self-determination rights and the constitutional rights to privacy and liberty.²² Although the police power has been used to order medical care, such as ordering blood transfusions to competent, objecting Jehovah Witnesses,⁷³ this occurs relatively rarely.²

Because medical hospitalization and care are generally not premised on police power or *parens patriae*, courts will be much more likely to honor proxy decision making in the medical setting than in mental health setting care. Contrarily, courts that are accustomed to looking at involuntary hospitalization under this

confused *parens patriae*-police power approach may find it difficult to give effect to a proxy's attempt to psychiatrically hospitalize his/her principal.

Commitment Statutes As indicated in the previous section, civil commitment to mental institutions is an area of law that is heavily regulated by statute in all jurisdictions.⁷⁴ Moreover, these statutes have been subject to countless instances of construction and misconstruction by state and federal courts.

Therefore, a court, in deciding what, if any, effect to give to an individual's health care proxy as it relates to psychiatric hospitalization and treatment, will need to interpret a state's proxy law in light of its longstanding mental illness and disability laws. Because general medical care is not so highly regulated by statutes, it will be much simpler for a court to interpret and give effect to medical care proxy decisions under a state's proxy law. Moreover, inasmuch as advance directive statutes were written primarily for use in decision making for terminally ill individuals, their application in such instances should proceed more easily than in the mental health care area. In terminal care patients, advance directives will most often be used to prohibit clinical interventions for patients who cannot be expected to regain decision making capacity. Contrarily, in mental health care, the issue will be whether to endorse clinical intervention, which can be expected to restore the patient's decision making capacity.⁸

Family Role in Mental Health Care Although the law speaks in terms of the state committing an individual,

usually an individual is committed at the behest of family members and "the state's judiciary machinery merely formalizes and sanctions a decision arrived at by the family and the family doctor."⁷⁵ Nonetheless, it is generally only in the mental health area that states and courts uniformly require such judicial formalization and sanctioning.³⁵ In fact, the United States Supreme Court's 1979 decision in *Parham v. J.R.*,⁷⁶ upholding the rights of parents to psychiatrically hospitalize their minor children without requiring an adversarial-type hearing before an impartial tribunal, stands out as the sole exception to the eradication of the family's role in mental health decision making by courts. The court's logic and reasoning in reaching this decision bear repeating:

Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. . . . The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.

. . . That some parents "may at times be acting against the interests of their children" as was stated in *Bartley v. Kremens*, 402 F. Supp. 1039, 1047-1048 (ED Pa. 1975), vacated and remanded, 431 U.S. 119 (1977), creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests. [cite omitted] The statist notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition.⁷⁶ (Emphasis in original.)

Clearly, the tendency of states and courts to ignore or degrade family decision making and instead to apply such

Health Care Proxy for Mental Illness

“procedural safeguards” as court determination by clear and convincing evidence of terminally ill or chronically neurovegetative patients’ wishes about cessation of life-prolonging treatment, as exemplified by the *Cruzan* case,²² has been the impetus for advance directive legislation. As the impetus for the legislation has been primarily issues concerning care in terminal life events,^{36, 41, 44, 58} much of the legislation is directed at, and sometimes limited to, such situations.⁵¹ Thus, the acceptance by courts of advance directive use in such instances may have little precedential value in mental health treatment care. Historically, families have, as a practical matter, had much decision making authority in the care of their incapacitated, terminally ill relatives. Advance directives often merely statutorily empower families to do what they always did anyway. Families long ago lost whatever authority they had to informally make mental health care decisions on behalf of their incapacitated adult relatives.^{77, 78} Therefore, it is highly questionable whether a proxy law or other advance directive law that was drafted primarily to deal with cases of terminal health care can be used to give families authority they long ago lost. California’s proxy law, for example, specifically prohibits individuals from granting their proxies the power to consent, on their behalf, to placement in a mental-health facility, electroconvulsive therapy, or psychosurgery.²⁵

Differing Issues of Decision Making Capacity Often the issue of incapacity of a patient for whom substituted judg-

ment is sought for medical treatment is not open to question. Either the patient is temporarily unconscious and needs emergent treatment to prevent death or significant morbidity, or the patient is chronically comatose due to terminal illness or neurologic damage. As discussed above, it is these types of patients that advance directives were enacted to cover.

Most other medical patients, however, who are not comatose, do not present especially difficult questions as to their decision making capacity.‡ If an individual’s rejection of the physician’s proposed treatment causes the treating physician to question capacity, the physician will often request a consultation from a psychiatrist to rule out mental illness, but this occurs relatively infrequently.^{45, 79}

Although incapacity usually is not required by courts and commitment statutes, it is very relevant to psychiatric treatment. Most types of psychotherapies require a patient who knowingly engages in therapy for the treatment of a self-perceived problem and understands that there are certain rules and expectations of that patient in order for psychotherapy to be helpful. Furthermore, although psychiatric patients, like their counterparts receiving regular medical care, overwhelmingly do not object to their medications,^{80, 81} significant ethical, medical, and legal issues

‡ The term “decision making capacity” is used to describe the analysis physicians and others use to determine an individual’s ability to give an informed consent or refusal of proffered treatment. The term “competency” describes a court’s decision that an individual has capacity.^{14, 18, 69, 82, 83}

arise when they do refuse. In medicine if a patient refuses the proposed treatment, that usually resolves the issue. If the patient is hospitalized, he/she is discharged since there is no reason to maintain the person in the hospital and anyone competent to refuse treatment generally is capable of leaving the hospital against medical advice.

In psychiatry, however, the courts and legislatures have created a dichotomy: hospitalization and treatment are legally two entirely separate matters. Thus, courts have no problem committing individuals who are mentally ill and perceived as dangerous to a psychiatric hospital and then deciding that the person does not need to take the medication which is the only therapy that can be offered to him/her in the hospital with any expectation of treating the mental illness so that he/she can meet criteria for discharge. Courts and legislatures apparently are unconcerned with or unable to resolve this ethical dilemma. Psychiatrists, of course, are acutely aware of their obligation to respect patient autonomy. Most would likely opt in this type of situation not to involuntarily hospitalize such a person to begin with⁶⁹ or to discharge the patient—an approach they can take only with voluntarily admitted patients, however. The Hippocratic Oath requires of all physicians, psychiatrists included, to “first do no harm.” Hospitalization without treatment violates this principle. Psychiatrists, however, are forced by society, through its commitment statutes, to act as custodians of the public safety by being obligated to commit those who are mentally

ill and dangerous. Significant professional and financial ramifications can result from a violation of this duty to society.^{17, 84, 85}

Apparent Double Standard as to Informed Consent Clinical decision making capacity is essentially the ability to give informed consent.^{18, 86} Evaluating clinical decision making capacity requires an examination of at least five factors: (1) the patient’s understanding of the reason for the proposed treatment and how to apply it to the patient’s circumstances; (2) the patient’s ability to understand the risks, benefits, and alternatives to the proposed treatment; (3) the patient’s ability to rationally weigh these considerations; (4) the patient’s ability to communicate his/her decisions and the basis for the decisions; and (5) whether the decision is voluntary.⁸⁷ Any one of these can be compromised as a result of severe mental illness or physical illness. In medicine, however, the presumption that a person may merely assent to the taking of medication, without being truly capable of giving informed consent to the taking of the medication, remains fairly well accepted by the medical and legal communities.¹⁸ Generally, it is only if the patient suffers adverse consequences from the medication that questions of informed consent arise.⁶⁴

Significant inroads into this commonly accepted practice, however, are occurring in psychiatry. For example, California requires written informed consent from all voluntary mental patients treated with neuroleptics, antidepressants, or lithium.⁸⁸ Courts and leg-

islatures, which apparently have few problems enacting laws to involuntarily hospitalize competent mentally ill individuals and enforcing these laws, balk at actually treating these involuntarily committed patients. Repeatedly, courts speak of these “mind altering drugs” and the need to ever be on guard to protect patients from their (mis)use.⁷⁸ Courts often appear to lose their normal sense of equilibrium and proportionality when discussing psychiatric medications and regurgitate the Physician’s Desk Reference list of possible adverse effects for these medications without appreciating their relative safety compared with many other commonly used medications.⁸⁹

It has been suggested that courts and legislatures require a different standard for mentally ill individuals because they believe psychiatrists have extraordinary power over their patients¹² or are drugging their patients into submission.⁹⁰ Moreover, courts ignore the literature that suggests that medication treatment refusal is much more likely a symptom of the mental illness than a knowing assertion of the patient’s rights.⁹¹⁻⁹³

Nor is the double standard of requiring informed consent limited to the pharmacologic treatment of mental illness. Some states require informed consent for voluntary psychiatric hospitalization.⁹⁴ The requirement can only result in people who need psychiatric hospitalization being denied treatment or else unfairly being traumatized and stigmatized by being processed through the courts in involuntary civil commitment proceedings.⁹⁵

Into the Crystal Ball: Proxy Use in Mental Health Care

As Compared with Instructional Advance Directives Two types of instructional advance directives have been offered by commentators for use by individuals with mental illness in the treatment of mental illness.

The first type of instructional advance directive is the “Ulysses Contract.”[§] It is a written document whereby the patient instructs and authorizes his/her psychiatrist to hospitalize and treat him/her in the event of an episode of exacerbation of his/her mental illness even if the patient should object to the treatment at that future time. The enforceability of such a contract is very unlikely for myriad policy and constitutional reasons,¹² although there are no published court opinions specifically ruling on the validity or enforceability of such a contract.

The second type of instructional advance directive is the “living will” or, a variation of this, the “psychiatric will.” Such contracts provide, in the event of a relapse of a mental illness, that the writer of the “living will” would request or refuse certain proposed treatments or hospitalization.⁹ A literature review revealed only one court case involving a psychiatric living will’s use in determining the present treatment wishes of an incompetent involuntarily hospitalized patient. In this case, *In re Rosa M.*,⁹⁶ a

[§] The name comes from the story of Ulysses in Homer’s *Odyssey* in which Ulysses instructs his crew to put wax in their ears, to tie him to the mast of his ship, and not to release him no matter how much he requests it so that he may hear the song of the sirens but will not be free to wreck his ship as the sirens will try to make him do with their beautiful but deadly song.¹¹

patient revoked consent for electroconvulsive therapy (ECT) and at the same time executed a form stating she did not want to be approached about ECT unless her legal services attorney was present. Subsequently, the hospital applied for an order authorizing it to administer ECT against the patient's wishes. The court refused, concluding that the patient's informed refusal of a specific medical treatment must be honored even if she becomes incompetent. Such a decision is consistent with established case law in substituted judgment cases wherein the courts attempt to deduce the patient's wishes from past oral statements and conduct.⁹⁷ It can be anticipated that courts will be much more likely to refuse treatment over objection when the patient can produce past written statements made while competent that are consistent with his/her current objections.

The real question remains, however, whether the court will order treatment over objection of an incompetent patient currently refusing medication who in the past indicated in an instructional advance directive that he/she wanted treatment in such circumstances. The Supreme Judicial Court of Massachusetts has stated that an incompetent's current treatment refusal should be entitled to serious consideration as a factor in the substituted judgment determination.⁷⁸ "Informed consent is often considered a continuing process in which consent must be renewed with respect to specific steps during a course of treatment."⁹⁸ Whereas psychiatrists often understand these treatment refusals during

acute exacerbations of mental illness as being a result of the mental illness, courts may be quite leery of this argument and find it self-serving as well as circular.

Proxy Use for Psychiatric Hospitalization The reasoning behind proxy use for psychiatric hospitalization is as follows: As a result of mental illness, the principal lacks decision making capacity; as a result he/she cannot make an informed decision to either accept or refuse hospitalization. Therefore, if the principal is dangerous he/she would be subject to involuntary hospitalization under the state's commitment statute and if not dangerous, likely would not qualify for admission. However, having executed an advance directive naming a proxy to make psychiatric health care decisions, if not explicitly proscribed by the state's proxy law, the proxy theoretically may make a substituted judgment for the principal. In the above situation the proxy can make one of four choices: 1) proxy can reject voluntary admission on behalf of a nondangerous incapacitated principal; 2) proxy can decide to seek voluntary admission on behalf of nondangerous incapacitated principal; 3) proxy can reject voluntary admission on behalf of dangerous incapacitated principal; and 4) proxy can seek voluntary admission on behalf of dangerous incapacitated principal. Ultimately, the perceived advantage of proxy use by treatment advocates is the ability of the proxy to get treatment for his/her nondangerous incapacitated principal who now "falls through the cracks" and often does not receive care that family mem-

Health Care Proxy for Mental Illness

bers feel he/she should. Also, for the dangerous patient, health care advocates would like to see voluntary proxy admission to avoid the stigma of court involvement.

It is unlikely, however, that advance directive proxies will be successfully used to allow voluntary admissions of principals or to make an involuntary commitment voluntary. There are several reasons for this.

First, courts are very distrustful of the ability of anyone but themselves to make substituted judgment for incompetent mentally ill individuals.⁷⁸ This can be seen by the fact that courts have traditionally made commitment decisions and courts are the holders of *parens patriae* power in this country to make this type of decision. No informal family substituted decision making exists in this area except for children.

Second, courts view allowing someone other than themselves to make hospitalization decisions for an individual as a waiver¹² of and diminution of the many statutory rights, constitutional equal protection, and procedural and substantive due process protection otherwise applicable to persons in civil commitment proceedings.^{12, 99, 100}

Third, courts have held that someone cannot do on behalf of the incapacitated person what he/she could not do him/herself. Thus, in *Pima County Public Fiduciary v. Superior Court*,¹⁰¹ the court refused to allow a guardian to commit his ward to a mental health institution without the ward's consent because it believed this would violate due process. The guardian under applicable state law

was empowered to authorize medical or other professional care or treatment. Nevertheless, the court felt that because an incapacitated person could not consent to treatment, the guardian could not consent for her.

Fourth, many involuntary admissions are done over the objection of competent individuals on the basis of the state's police power. Consequently, there is no reason for courts to honor a proxy's refusal of hospitalization on behalf of an incompetent dangerous patient. Moreover, a court may be unlikely to accept a voluntary admission for a dangerous principal since a voluntary patient may be allowed to leave the hospital at will.

Finally, all states have intricate, involved, often confusing, and sometimes conflicting statutes, rules, regulations, and court decisions in the area of psychiatric hospitalization, whether voluntary or involuntary. It is very unlikely that an advance directive proxy law can be made to comport with the existing law in this area. In this event, it is likely that the proxy law, as less clearly applicable, will be found inapplicable. It is a common rule of statutory construction that courts will try to read statutes so as to be consistent; but if they cannot, the more specific law will apply.^{102, 103} Moreover, New York's prototype model proxy law specifically provides: "Nothing in this article creates, expands, diminishes, impairs or supersedes any authority that a principal may have under law to make or express decisions, wishes or instructions regarding health care. . . ."¹⁰⁴ This provision could be read as severely limiting the application

of the proxy law in the highly regulated mental health area, including hospitalization.

Proxy Use for Psychiatric Treatment

Proxy substituted judgment for mental health treatment decisions raises many of the same concerns and implementation problems as proxy consent for psychiatric hospitalization. States already have in place internal administrative review procedures,¹⁰⁵ court mechanisms for substituted judgment,⁷⁸ court mechanisms for best interests judgments,¹⁰⁶ or specific mental health statutes providing for appointment of treatment guardians.¹⁰⁷ Courts are unlikely to interpret the authority of a proxy under a nonspecific proxy statute to take precedence over the already established treatment decision process for incapacitated mentally ill individuals.

Allowing an individual while competent to name a proxy to make mental health decisions for him/her in the event of future incapacity should serve arguably to further the individual's autonomy, self-determination, and privacy rights. Courts, however, are likely to feel these rights are better served and protected by established laws and procedures. They are likely to see attempted proxy use as a waiver of these rights and safeguards.¹¹ This would be especially true in cases in which the principal was objecting to the proxy's treatment decision. Under New York's model proxy law, such cases would require court adjudication of the principal's incapacity.¹⁰⁸ Furthermore, the proxy agent only has "the authority to make any and all health care decisions on the principal's behalf that the prin-

cipal could make."¹⁰⁹ Such a provision could put the proxy into the Catch-22 position that, because an incapacitated principal cannot make certain treatment decisions, his/her agent also cannot make them.

Often nonobjecting mentally ill patients may assent to treatment without a finding of informed consent just as medical patients may. Arguably, the presence of a proxy statute could be interpreted to proscribe assent to treatment by all patients and require use of proxy decision making any time that the principal's current capacity to consent to treatment was not clear. If courts interpreted proxy laws this way, the proxy laws could have the paradoxical result of decreasing patient autonomy and self-determination. Similarly, difficulties may arise because capacity is in a frequently shifting status during hospitalization.¹¹⁰ The practical difficulties of reassessing capacity for every treatment decision, determining whether or not proxy consent is needed, notifying and informing the proxy of the need for his/her decisional input, notifying the principal of his/her incapacity, and the need for proxy decision making, all of which are required by New York's Proxy Law, could be very time consuming and unnecessarily interfere with treatment and the physician-patient alliance.

Proxy Use and Confidentiality Issues

Families with mentally ill relatives often perceive that mental health professionals do not give them adequate information about their ill relative such as diagnosis, treatment modalities, medication and side effects, community resources, etc.¹¹¹

Health Care Proxy for Mental Illness

Consequently, commentators have encouraged mental health providers to rethink the issue of confidentiality and its application to families acting as caregivers.³⁹ In fact, the APA Model Code proposes utilizing family decision making for patients who do not have the capacity to make informed treatment decisions.⁶⁹

New York's Proxy Law specifically provides for health care provider immunity for actions taken in good faith pursuant to the Proxy Law.¹¹² This appears to be broad enough to cover providing otherwise potentially confidential information if given to the proxy agent to enable the agent to make informed substituted judgments.

Therefore, to the extent that proxy use encourages greater communication between principal and proxy agent and good faith communications between health care providers and proxy agents, the proxy law will serve a valuable function. Nevertheless, such communication could and should already be occurring in the absence of a proxy law.

Proxy Use Liability Issues Proxy laws generally provide criminal law immunity and civil liability immunity for good faith acts undertaken by health care providers and decisions of proxy agents made pursuant to the proxy law.

Liability issues for psychiatrists likely will not be markedly affected as proxy laws likely will have minimal use in the mental health area. Some increased liability might occur if a psychiatrist ignores proxy law requirements in a bad faith manner such as refusing to discuss treatment decisions with the proxy be-

cause of a clearly unjustified concern about confidentiality.

A potentially greater question of liability would occur for proxy agents if, in their role of exercising substituted judgment, they refused treatment or hospitalization for a principal who later committed suicide or severely injured or killed a third party; i.e., will proxy law immunity act to protect proxy agents from a potential *Tarasoff*-type¹⁷ duty to protect?

If proxy laws were found to be applicable to psychiatric hospitalization and medication treatment, however, significant liability issues would arise. The psychiatrist would find her/himself owing potentially conflicting duties to the patient, the proxy, and third parties. In instances in which the proxy and patient disagreed, resolution by the court would be necessary. Court resolution would also be indicated if the physician felt the proxy's decision was made in bad faith or not in the best interests of the principal. Any time the state's commitment laws or treatment over objection laws would otherwise be applicable, failure to follow these procedures would raise liability issues, but conflicting liability issues would result if the proxy or patient sued because the psychiatrist refused to follow the proxy law dictates. Issues of suicidality, homicidality, and medication side effects would become even more legally complex and untenable.

Conclusion

Health care advance directives laws, including proxy laws, have been enacted with great public and physician support

to protect the individual's right to determine health care choices even during periods of incapacity. Although these laws further the important common law rights of autonomy and self-determination as well as the constitutional rights to privacy and liberty,^{38,64} these laws and the rights they protect are not absolute. In the mental health care arena "proxy rights" come face to face with society's rights in the areas of *parens patriae* and police power. These "proxy rights" also can be seen as waiving or diminishing many procedural and substantive due process rights that have been recognized by the courts over the past few decades. As a result, it is unlikely that a health care proxy for mental health will have much effect. The proxy's substituted judgment would likely be one of many factors a court would consider in making its own best interest or substituted judgment decision, but it would be unlikely to be controlling. If the proxy's treatment decision was in accordance with the incompetent principal's choices, there would, of course, be more likelihood that the court would give it substantial weight. When the proxy's treatment decision is being objected to by the principal, real doubt exists whether the court will be likely to give the proxy's decision much, if any, weight, separate from the court's own independent judgment.

Moreover, as the proxy embodies another set of rights, i.e., autonomy rights for terminally ill patients to refuse further treatment through their proxy agents, applying proxy policies in the already overly rights-complex mental

health area could lead to untoward and unintended complications. For example, proxy laws could have the unintended effect of limiting autonomy rights by decreasing the right of mentally ill patients to assent to treatment just as the medically ill can. Certainly the proxy concept embodies important rights, but these rights could best be effectuated by a reanalysis of the existing statutory and court-made mental health law, and a reasoned incorporation of these rights into a comprehensive new statutory framework.⁶⁹

Meanwhile, the concept of health care proxy arguably does appear to be workable in the area in which it was really intended to apply—terminally ill incapacitated patients and the chronic neurovegetative comatose patient. As mentally ill individuals can potentially fit into one of these categories one day, psychiatrists should assist their patients who wish to execute health care proxies to cover such situations. This is especially true because courts and other physicians may be less likely to honor the advance directives of individuals with mental illness because they may incorrectly see the advance directive health care choices as the product of mental illness. A contemporaneous evaluation by the psychiatrist of the patient's decision making capacity with the execution of his/her advance directive would be of great assistance if questions later arise.

Although the proxy laws likely will not be the mechanism by which decision making in psychiatry can be de-legalized, they offer a good opportunity for psychiatrist, patient, and often times the

Health Care Proxy for Mental Illness

patient's family, to discuss the patient's illness and treatment needs. Because of the many potentially significant pitfalls in trying to use advance directives, particularly proxies, in the mental health care area, psychiatrists would be ill-advised to vigorously advocate use of advance directives in this area.

References

1. Kutner L: Due process of euthanasia: the living will, a proposal. 44 *Ind L J* 539-54, 1969
2. Development; Civil commitment of the mentally ill. 87 *Harv L Rev* 1190-406, 1218, 1974
3. Reinert RE: A Living Will for a Commitment Hearing. *Hosp Community Psychiatry* 31:857-8, 1980
4. Rosenson MK, Kasten AM: Another view of autonomy: arranging for consent in advance. *Schizophr Bull* 17:1-7, 1991
5. Applebaum PS: Advance directives for psychiatric treatment. *Hosp Community Psychiatry* 42:983-4, 1991
6. Advance Directive Could Give Mentally Ill More Treatment Control. *Am Med News*, p 3 (Dec. 16, 1991)
7. Psychiatric "living will" gaining popularity as Alternative to Involuntary Commitment. *Psych News*, 26(20):9 (Nov. 15, 1991)
8. Developing living wills for the seriously mentally ill: an important aid when addressing psychiatric emergencies. *Psych Times*, 9(5):7 (May 1992)
9. Rogers JA, Centifanti JB: Beyond "self-paternalism": response to Rosenson and Kaster. *Schizophr Bull* 17:9-14, 1991
10. Szasz, TS: The psychiatric will: a new mechanism for protecting persons against "psychosis" and psychiatry. *Am Psychologist* 37:762-70, 1982
11. Dresser R: Bound to treatment: the Ulysses Contract. *Hastings Cent Rep* 14(3):13-6, 1984
12. Dresser RS: Ulysses and the psychiatrists: a legal and policy analysis of the voluntary commitment contract. *Harv CRCL L Rev* 16:777-854, 1982-3
13. Winston ME, Winston SM: Can a subject consent to a "Ulysses Contract"? *Hastings Cent Rep* 12:26-8, 1982
14. High DM: Planning for decisional incapacity, a neglected area in ethics and aging. *J Gerontol* 35:814-20, 1987
15. N.Y. Pub. Health Law, Art 29-C (Health Care Agents and Proxies) (McKinney 1991)
16. *In re Miller*, 63 Ohio St. 3d 99 (1992)
17. *Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal. 1976)
18. Winick BJ: Competency to consent to treatment: the distinction between assent and objection. *Hous L Rev* 28:15-61, 1991
19. Omnibus Budget Reconciliation Act of 1990. Public Law No. 101-508. §§ 4206 (Medicare Provider Agreements Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient). 42 U.S.C. 1395 cc
20. Greco PJ, Schulman KA, Lavizzo-Mourey R, *et al*: The Patient Self-Determination Act and the future of advance directives. *Ann Int Med* 115:639-643, 1991
21. LaPuma J, Orentlicher D, Moss RJ: Advance directives on admission—clinical implications and analysis of the Patient Self-Determination Act of 1990. *JAMA* 266:402-5, 1991
22. *Cruzan v. Director, Missouri Department of Health*, 110 S.Ct. 2841 (1990)
23. *In re Quinlan*. 355 A.2d 647 (NJ 1976)
24. Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1992)
25. Cal. Civ. Code §§ 2430-2444 (West Supp. 1992)
26. States Move to Get Advance Directives. *Am Med News* p 3 (Nov. 11, 1991)
27. Stanley JM: The Appleton Consensus: suggested international guidelines for decisions to forego medical treatment. *J Med Ethics* 15:129-36, 1989
28. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914)
29. *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977)
30. *In re Guardianship of Browning*, 568 So.2d 4 (Fla. 1990)
31. *In re Guardianship of McInnis*, 61 Ohio Misc. 2d 790 (1991)
32. Solnick PB: Proxy consent for incompetent non-terminally ill adult patients. *J Leg Med* 6(1):1-49, 1985
33. Capron AM: Informed consent in catastrophic disease research and treatment. *U Pa L Rev* 123:340-438, 1974
34. President's Commission For the Study of Ethical Problems in Medicine and Biomedical Research: Making Health Care Decisions (1982)
35. Krasik EB: The role of the family in medical

- decision making for incompetent adult patients: a historical perspective and case analysis. *U Pitt L Rev* 48:539-618, 1987
36. Areen J: The legal status of consent obtained from families of adult patients to withdraw treatment. *JAMA* 258:229-35, 1987
 37. High DM: All in the family: extended autonomy and expectations in surrogate health care decisionmaking. *Gerontologist* 28 (Suppl.):46-7, 1988
 38. Emanuel EJ, Emanuel LL: Proxy decision making for incompetent patients—an ethical and empirical analysis. *JAMA* 267:2067-71, 1992
 39. Petrila JP, Sadoff R: Confidentiality and the family as caregiver. *Hosp Community Psychiatry* 43:136-44, 1992
 40. Lo B, Rouse F, Dornbrand L: Family decision making on trial. *N Engl J Med* 322:1228-32, 1990
 41. Emanuel LL, Barry MJ, Stoeckle JD, *et al*: Advance directives for medical care—a case for greater use. *N Engl J Med* 324:889-95, 1991
 42. Emanuel LL, Emanuel EJ: The medical directive—a new comprehensive advance care document. *JAMA* 261:3288-93, 1989
 43. Davidson KW, Moseley R: Advance directives in family practice. *J Fam Practice* 22:439-42, 1986
 44. Editorial: Who should decide your death? *J Am Med Assoc* 267:103-4, 1992
 45. Eisendrath SJ, Jonsen AR: The living will—help or hindrance? *JAMA* 249:2054-8, 1983
 46. AMA Offers Tips on Advance Patient Directives. *Am Med News*, p 8 (December 16, 1991)
 47. AMA Guidelines for Advance Directives, Member Matters. *Am Med Assoc Newsletter* (Feb. 1992)
 48. Hospitals Must Inform Patients About Advance Directives. *Resident Staff Physician* 38(2):70, 1992
 49. McCrary SV, Botkin JR: Hospital policy on advance directives—do institutions ask patients about living wills? *JAMA* 262:2411-4, 1989
 50. Schmerling: Discussing cardiopulmonary resuscitation: a study of elderly outpatients. *J Gen Int Med* 3:317-21, 1988
 51. Zinberg JM: Decisions for the dying: an empirical study of physicians' responses to advance directives. *Vt L Rev* 13:445-91, 473, 1989
 52. *Id.*, at 476
 53. Davidson KW, Hackler C, Caradine DR, *et al*: Physicians' attitudes on advance directives. *JAMA* 262:2415-9, 1989
 54. Schneiderman LJ, Arras JD: Counseling patients to counsel physicians on future care in the event of patient incompetence. *Ann Int Med* 102:693, 694, 1985
 55. Letters for the editor re advance directives. *JAMA* 267:1920-1, 1992
 56. Miles SH: Informed demand for "non-beneficial" medical treatment. *N Engl J Med* 325:512-5, 1991
 57. Virginia Bill Would Let Doctors Refuse to Treat. *Am Med News* p 9 (March 16, 1992)
 58. Kapp MB: Response to the living will furor: directives for maximum care. *Am J Med* 72:855-9, 1982
 59. Gamble ER, McDonald PJ, Lichstein PR: Knowledge, attitude and behavior of elderly persons regarding living wills. *Arch Int Med* 151:277-80, 1991
 60. Sehgal A, Galbraith A, Chesney M, *et al*: How strictly do dialysis patients want their advance directives followed? *JAMA* 276:59-63, 1992
 61. Lynn J: Procedures for making decisions for incompetent adults. *JAMA* 267:2082-4, 1992
 62. Danis M, Southerland LI, Garret JM, *et al*: A prospective study of advance directives for life-sustaining care. *N Engl J Med* 324:882-8, 1991
 63. Danis M, Southerland LI, Garret JM, *et al*: A prospective study of advance directives for life-sustaining care. *N Engl J Med* 324:882-8, 885, 1991
 64. Orentlicher D: The illusion of patient choice in end-of-life decisions. *JAMA* 267:2101-4, 2101, 1992
 65. Zweibel NR, Cassel CK: Treatment choices at the end of life: a comparison of decisions by older patients and their physician-selected proxies. *Gerontologist* 29:615-21, 620, 1989
 66. Diamond EL, Jernigan JA, Moseley RA, *et al*: Decision-making ability and advance directive preferences in nursing home patients and proxies. *Gerontologist* 29:622-6, 625, 1989
 67. Uhlmann RF, Pearlman RA, Cain KC: Physicians' and spouses' predictions of elderly patients' resuscitation preferences. *J Gerontol* 43:M115-21, 1988
 68. Uhlmann RF, Pearlman RA, Cain KC: Physicians' and spouses' predictions of elderly patients' resuscitation preferences. *J Gerontol* 43:M115-21, M120, 1988
 69. Stromberg CD, Stone AA: A model state law

Health Care Proxy for Mental Illness

- on civil commitment of the mentally ill. *Harv J on Legis* 20:275-396, 1983
70. Dershowitz AM: Dangerousness as a criterion for confinement. *Bull Am Acad Psychiatry Law* 2:172, 1974
 71. Civil commitment of the mentally ill. *Harv L Rev* 87:1190, 1204, 1974
 72. Stromberg, *supra* at 282
 73. Application of President & Directors of Georgetown Col., 331 F.2d 1000 (D.C. Ct. App. 1964)
 74. Brakel SJ, Parry J, Weiner BA: The mentally disabled and the law. Chicago, American Bar Foundation, 1985, pp 76-176
 75. *Id* at 32
 76. *Parham v. J.R.*, 442 U.S. 584, 602-603 (1979)
 77. *Price v. Sheppard*, 239 N.W.2d 905, 913 (Minn. 1976)
 78. *Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981)
 79. Mahler JC, Perry S, Miller F: Psychiatric evaluation of competency in physically ill patients who refuse treatment. *Hosp Community Psychiatry* 41:1440-1, 1990
 80. Zito JM, Craig TJ, Wanderling J: New York under the *Rivers* decisions: an epidemiologic study of drug treatment refusal. *Am J Psychiatry* 148:904-9, 1991
 81. *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 308 (Mass. 1983)
 82. Lo B: Assessing decision-making capacity. *Law Med Health Care* 18:193, 1990
 83. McKinnon K, Cournos F, Stanley B: *Rivers* in practice: clinicians' assessment of patient's decision making capacity. *Hosp Community Psychiatry* 40:1159, 1989
 84. *Lipari v. Sears, Roebuck*, 497 F. Supp. 185 (D. Neb. 1980)
 85. *Petersen v. State*, 671 P.2d 230 (Wash. 1983)
 86. Sprung CL, Winick BJ: Informed consent in theory and practice: legal and medical perspectives on the informed consent doctrine and a proposed reconceptualization. *Crit Care Med* 17:1346-54, 1989
 87. Applebaum PS: Assessing patients' capacities to consent to treatment. *N Engl J Med* 319:1635-8, 1988
 88. Cal. Welf. & Inst. Code §§ 5326.2, 5325.3, and 6006 (West 1992)
 89. Gutheil TG, Applebaum PS: Substituted judgment: best interests in disguise. *Hastings Cent Rep* 13:8-11, 1983
 90. Rhoden NK: Can a subject consent to a "Ulysses Contract"? *Hastings Cent Rep* 12:28, 1982
 91. Marder SR, Mebane A, Chien C. *et al*: A comparison of patients who refuse and consent to neuroleptic treatment. *Am J Psychiatry* 140:470-2, 1983
 92. Schwartz HI, Vingiano, Perez CB: Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication. *Hosp Community Psychiatry* 39:1049-54, 1988
 93. Grossman L, Summers F: A study of the capacity of schizophrenic patients to give informed consent. *Hosp Community Psychiatry* 40:205, 1980
 94. *Zinermon v. Burch*, 110 S.Ct. 975 (1990)
 95. Winick BJ: Voluntary hospitalization after *Zinermon v. Burch*. *Psychiatr Ann* 21:584-9, 1991
 96. Unpublished Opinion, No. 95-965-89 (N.Y. Sup. Ct. Nov. 27, 1991)
 97. *In re Boyd*, 403 A.2d 744 (D.C. 1979)
 98. Dresser RS: Ulysses and the psychiatrists: a legal and policy analysis of the voluntary commitment contract. *Harv CR—CL L Rev* 16:777, 830, 1982
 99. *Von Luce v. Rankin*, 588 S.W.2d 445 (Ark. 1979)
 100. *Lippmann v. Johnson*, 429 N.E.2d 167 (Ohio Ct. App. 1980)
 101. *Pima County Public Fiduciary v. Superior Court*, 546 P.2d 354 (Ariz. Ct. App. 1976)
 102. Singer. NJ, Sutherland Statutory Construction, § 53.01 Deerfield, IL, Clark, Boardman, 1992 (5th ed.)
 103. *Anderson v. Federal Deposit Insurance Corp.*, 918 F.2d 1139, 1143 (4th Cir. 1990)
 104. N.Y. Pub. Health Law § 2989(2) (McKinney 1991)
 105. *Washington v. Harper*, 110 S.Ct. 1038 (1990)
 106. *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986)
 107. NM Stat. Ann § 43-1-15
 108. N.Y. Pub. Health Law § 2983(d)(5) (McKinney 1991)
 109. N.Y. Pub. Health Law § 2982 (McKinney 1991)
 110. Schwartz HI, Blank K: Shifting competency during hospitalization: a model for informed consent decisions. *Hosp Community Psychiatry* 37:1256-60, 1986
 111. Francell: Families' Perception of Burden of Care for Chronic Mentally Ill Relatives. *Hosp Community Psychiatry* 39:1296-1300, 1988
 112. N.Y. Pub. Health Law § 2986(1) (McKinney 1991)