

The Right to Refuse Treatment*

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The theme of our conference today is Legal Activism: Its Impact on Psychiatric Practice and Social Structure. I shall try to discuss the subject of the right to refuse treatment in this context and within this brief time limit, knowing full well that any one aspect of this subject could be, and indeed probably has been, itself the subject of a lengthy paper.

Controversy surrounding the right to refuse treatment is the result of the confluence and clash of conflicting interests as well as the result of conflicting trends and conflicting perspectives.

I shall begin my discussion by attempting to separate out some of these different trends and perspectives. Then, after touching upon certain legal issues, involuntary commitment and informed consent, I'll discuss in some detail a number of important decisions which have set forth the parameters of the right to refuse treatment. I'll then cite some of the attempts at solutions of the problems raised, to see where we stand at this moment, and then open for discussion the questions of what impact the development of the right to refuse treatment has had on our psychiatric practice and how we might better cope with the resulting difficulties.

Of the various modern social trends that are epitomized by the right to refuse treatment, the demand for clearer recognition of civil rights and civil liberties is perhaps the most dramatic. (That the American Civil Liberties Union is so active in this area is not a coincidence.) One by one, different groups have demanded genuine social, political and economic equality. A whole segment of the legal industry is devoted to such issues – the civil rights lawyers. When the clients themselves cannot articulate their dissatisfactions, as is often the case with psychiatric patients, the lawyer's role is particularly evident. This takes the form of a new style of legal practice – "advocacy."

A related trend, often surfacing under the banner of "the right of privacy," stresses the right to be left alone. As Justice Brandeis said, the makers of the constitution "conferred as against the government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men."¹ Our most basic rights are set forth in the Bill of Rights, but this document followed by eleven years the Declaration of Independence that listed "certain unalienable rights . . . life, liberty and the pursuit of

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happiness.” Thus, again and again, the emphasis is on rights.

And, parenthetically, it must be emphasized that in the context of our discussion here today, as regards the right to refuse treatment — indeed, whenever we are speaking of a right to refuse treatment — the right is asserted against the government. But who is “the government” in these issues? We are! Yes, keep that in mind — in these issues where treatment is refused, we psychiatrists represent the government. And, whether we see ourselves as psychiatrists, “care-givers” or just “good people,” we represent the government.

Another significant social trend that must be taken into account in understanding the issues related to the right to refuse treatment is the changing attitude of the public toward vested authority. On the campus, in the church, as well as in the professional’s office, we see the effects of this trend. The medical profession is not alone — clients of all professionals are demanding more say in regard to the service being delivered, and more accountability from the professional. You will sometimes hear these particular changes expressed in legal terms, the change from a “fiduciary” relationship to a more “contractual” or quasi-contractual relationship. What this means, in essence, is that there is a demand for equality between the parties, and, as a result, an increased emphasis on the patient’s right to know about the treatment proposed and his right to refuse treatment.

Turning to the refusal of psychiatric treatment, we must at the onset distinguish between the refusal to be hospitalized and the refusal of a particular treatment while in a psychiatric hospital. The former encompasses issues relating to involuntary commitment, the latter, the issues relating to informed consent. Let us first look at some problems in regard to right to refuse treatment and involuntary hospitalization.

The cases and statutes usually distinguish between voluntarily and involuntarily committed psychiatric patients, *i.e.*, a distinction involving the *status* of the patient. One would think that there would be little question that a voluntary patient clearly has the right to refuse treatment. However, the voluntary patient is often subject to the restriction of having to give notice before he leaves the hospital, and during this period of time the hospital director has the opportunity to convert the patient to involuntary status, so, in truth, he is not quite in the same position as an ordinary medical patient.

In any event, is the status of a hospitalized patient a truly valid distinction on which to base the difference of rights, *e.g.*, here, the right to refuse treatment? Some legal scholars have noted that the realities of why a particular patient is hospitalized under either status do *not* permit the conclusion to be drawn that there is an invariable relationship between the status of a patient (whether he is voluntary or involuntary) and the severity of his illness and therefore the denial of his right to refuse treatment.

On the other hand, the question is raised as to whether the involuntary commitment itself should be taken to imply that the patient cannot refuse treatment. Certainly a strong argument can be made that this was the intention of the statute, the intent of the legislature. And in my own experience it is certainly the intent of the judges who commit patients in our court at Bellevue, *i.e.*, that the patient is to be treated, even “involuntarily.”

But, putting the question differently: does the finding that a patient is not competent to remain at large (outside of a psychiatric hospital) imply an incompetency to participate in treatment decisions while within the hospital? Certainly this is not so in actual practice. Involuntary patients are often able to participate in treatment decisions. Furthermore, it should also be noted that this capacity may change during the course of a period of hospitalization without a change in status.

The psychiatric patient is entitled to be subject only to the "least restrictive alternative," the "least drastic means." As we shall see in our review of the cases, as particular types of treatment become "extra-ordinary or potentially hazardous" or more questionable in their efficacy, more restrictions are placed on their use.²

Restrictions on the use of certain treatments are usually raised in the context of informed consent. The many, many problems relating to informed consent cannot be detailed here. While it applies to ordinary medical and surgical patients, special issues are raised in relation to certain populations such as prisoners, minors, and, of course, psychiatric patients.

The basic principles of informed consent have been set forth by many authors. I like the way Stone³ formulates it: "Competent informed consent." For him, the threshold question is the competence of the patient to give consent.

Again, for our purposes, the issue arises in regard to the involuntarily committed patient. Is he competent to participate in treatment decisions? On the one hand we note that the trend has been to expand rather than to constrict the rights of the involuntarily hospitalized patient and therefore to hold him competent to exercise such rights as the right to vote, the right to make a contract, etc. But, on the other hand, the very purpose of involuntary hospitalization as contrasted to imprisonment is to administer treatment.

The next part of the formula, the "informed" part of "competent informed consent," *i.e.*, the knowledge to be imparted by the doctor to the patient, is complicated by the fact that it may be inappropriate in a particular case to list side effects and dangers to a particular psychiatric patient — even assuming we could predict these prior to treatment.

The last part of the formula, "consent," the actual agreement on the part of the patient to undergo treatment, is complicated, under the best of circumstances, by such questions as ambivalent communications, the doctor's influence over the patient — the transference if you will, both positive and negative — and the coerciveness of the hospital setting itself.

Having thus briefly reviewed some of the background issues that impinge upon the topic of the right to refuse treatment, I shall now turn to a number of illustrative cases.

First, as a link to our discussions this morning on the right to treatment, we note that in 1972, *Wyatt v. Stickney*⁴ set forth "minimum constitutional standards for the adequate treatment for the mentally ill," and under the heading "Humane Psychological and Physical Environment" stated that "Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, aversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express

and informed consent after consultation with counsel or an interested party of the patient's choice."⁵

In 1975, in essentially the same case, now known as *Wyatt v. Hardin*,⁶ in the Alabama United States District Court, Judge Johnson revised this court-ordered standard. It is interesting to note that at the onset of his order, Judge Johnson felt constrained to add a disclaimer that the Court is not determining which forms of treatment are appropriate.

It must be emphasized that . . . the court is not undertaking to determine which forms of treatment are appropriate in particular situations. Such a diagnostic decision is a medical judgment and is not within the province, jurisdiction or expertise of this court. But the determination of what procedural safeguards must accompany the use of extraordinary or potentially hazardous modes of treatment on patients in the state's mental institutions is a fundamentally legal question and one which the parties to this law suit have put at issue.⁷

He thus contrasts the determination of what is appropriate treatment to what he terms "procedural safeguards." Certainly on the face of it this seems an easy and neat distinction, but as clinicians know, not only do "procedural safeguards" of sufficient burdensomeness and complexity in essence prohibit a course of action and eliminate a particular choice of treatment, but also the mere existence of such "procedural safeguards" may have a "chilling effect" and inhibit the clinician in the exercise of his responsibilities to provide adequate care.

In any event, in this case Judge Johnson again orders standards to be applied in Bryce Hospital in regard to psychosurgery, aversive therapy, and shock treatment. First, psychosurgery is absolutely prohibited.

Is this a "procedural safeguard"?

Then, in regard to aversive therapy, he sets out strict conditions. Prior approval is required by a committee made up of a psychiatrist, a neurologist or internist, "and at least one member shall be an attorney."⁸ The patient must be represented by counsel throughout all the proceedings. Near the end of his list of conditions, Judge Johnson adds: "No patient shall be subjected to an aversive conditioning program which attempts to extinguish or alter socially appropriate behavior or to develop new behavior patterns for the sole or primary purpose of institutional convenience."⁹ Is this a "procedural safeguard"?

In regard to shock treatment, he now lists 14 conditions that must be met. The competency of the patient to give consent is to be determined by the attorney appointed to represent him and an "Extraordinary Treatment Committee." It is interesting to note that among these listed conditions is the prohibition of certain types of shock therapy. "Regressive, multiple or depatterning electro-convulsive techniques shall not be utilized."¹⁰ Is this a "procedural safeguard"?

Judge Johnson's order related to psychosurgery, ECT and aversive conditioning, and the few cases that have dealt with the right to refuse treatment are generally grouped according to the type of psychiatric treatment involved.

Let us start with the case of *Kaimowitz v. Department of Mental Hygiene*,¹¹ a 1973 County Circuit Court decision in Michigan, which I will discuss in detail to point out the Constitutional issues which are raised in cases related to the right to refuse treatment. Kaimowitz was an outside lawyer who brought this habeas corpus action on behalf of a patient, John Doe, who was a detainee under a sexual psychopath law, charged with rape and murder of a student nurse while he was a patient at a state hospital. The patient had been selected for experimental psychosurgery to “control his uncontrollable aggression.” He had signed consent and his parents had also signed. Two committees had reviewed the study and the validity of the consent. At that point Kaimowitz found out and notified the press. Considerable newspaper publicity ensued and this suit was filed. (Incidentally, funding for the research project was then stopped, as were plans to pursue the research.)

The Court held that informed consent for experimental psychosurgery cannot be given by a patient involuntarily detained. “It is obvious that there must be close scrutiny of the adequacy of the consent when an experiment, as in this case, is dangerous, intrusive, irreversible, and of uncertain benefit to the patient and society.”¹²

Addressing itself to the “consent” element of “competent, informed consent,” the court noted that the lawyers for the Department of Mental Hygiene and the doctors had argued that anyone who has ever been treated for any relatively serious illness is likely to acknowledge that a competent doctor can get almost any patient to consent to almost anything, because patients do not want to make decisions about complex medical matters and because there is the general problem of avoiding decision-making in stress situations. The lawyers for the doctors further argued that “a patient is always under duress when hospitalized and that in a hospital or institutional setting there is no such thing as a volunteer.”

The court retorted that it did not agree that a truly informed consent cannot be given for a regular surgical procedure by a patient, institutionalized or not. “The law has long recognized that such valid consent can be given. But we do hold that informed consent cannot be given by an involuntarily detained patient for experimental psychosurgery for the reasons set forth below.”¹³

After a long discussion of informed consent, reviewing the requirements of (1) capacity to consent, (2) the knowledge of the risks involved and the procedures to be undertaken, and finally, (3) the voluntariness of the consent, the court then turns to the “compelling constitutional considerations” that *preclude* the involuntarily detained mental patient from giving effective consent to this type of surgery.

The court cited the First Amendment as protecting the freedom to express ideas and to generate ideas. Then the court turned to the right of privacy, relying on the First, Fifth and Fourteenth Amendments, saying: “Intrusion into one’s intellect, when one is involuntarily detained and subject to the control of institutional authorities, is an intrusion into one’s constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless.”¹⁴

Finally the court also based its decision on the Eighth Amendment, stating that the psychosurgery proposed would constitute cruel and unusual punishment.

I have given you the details of this case to indicate the extent to which constitutional arguments have been utilized to hold as a matter of law that in this most extreme case not only is there a right to refuse treatment, but also informed consent cannot be given!

The case of *Knecht v. Gillman*,¹⁵ a 1973 case in the U.S. Circuit Court in Iowa, involved aversive conditioning or behavior modification. Here two prisoners in the custody of the State of Iowa alleged that the drug Apomorphin – a vomiting-inducing drug – was utilized as an aversion type therapy for various offenses such as not getting up, swearing, lying, etc.

Noting that the use of Apomorphin could be justified only as it was utilized as treatment, the court made it clear that the mere characterization of an act as “treatment” does not insulate it from the Eighth Amendment scrutiny (cruel and inhuman punishment). “Whether it is called ‘aversive stimuli’ or punishment, the act of forcing someone to vomit for a fifteen minute period for committing some minor breach of the rules can only be regarded as cruel and unusual unless the treatment is being administered to a patient who knowingly and intelligently has consented to it.”¹⁶ The court then listed specific conditions as to written and informed consent that would have to be met.

Recall that the court’s order in *Wyatt v. Hardin* related to psychosurgery, aversive conditioning therapy and ECT.

We turn now to ECT – shock treatment – and note that as contrasted to psychosurgery or aversive conditioning, this area is much more controversial within the subject of the right to refuse treatment, probably because there are differences of opinion within the profession, first as to whether ECT is “severe” or “hazardous,” and second, as to whether it is the treatment of choice for any psychiatric illness.

In 1966 – only ten years ago – in *Campbell v. Glenwood Hills Hospital Inc.*,¹⁷ which was a case for damages, claiming unauthorized treatment, the Supreme Court of Minnesota held there would be no recovery in tort (assault & battery) for ECT and medication administered during a hospitalization because there was a valid court order in which the patient – the plaintiff – was found to be “in need of care and treatment” and the statute provided for “institutional care and treatment.” The court said: “The course of treatment was determined and effected by competent institutional doctors who would have been at fault if they had not attempted to help the plaintiff (patient).”¹⁸ The court ended this part of its opinion by stating, “If defendants are to be held liable to plaintiff in this case, then every psychiatric hospital, state or private, and its superintendent would be liable in tort to patients in spite of full compliance with valid court orders and applicable statutory provisions.”¹⁹ In other words, a valid involuntary hospitalization was all that was required to administer ECT.

Six years later, however, in 1972, a New York court, in *Stein v. NYC Health and Hospitals Corporation*,²⁰ held that an involuntary patient (confined at Bellevue) could refuse ECT in spite of the valid involuntary hospitalization and despite the fact that her mother consented to this

treatment. The judge himself spoke to the patient and held that she was competent to decide that she did not want ECT. Her consent for ECT was required.

This case anticipated changes in the N.Y. Statute²¹ giving the patient the right to object to ECT — *i.e.*, requiring the consent of the patient for ECT — which we shall review later.

Thus, having discussed cases involving psychosurgery, aversion therapy and ECT, let us now turn to the issue of the right of an involuntarily committed patient to refuse medication.

Recall the 1966 *Campbell* case, mentioned above, where the court said the doctors would have been at fault if they had not treated the patient despite his refusal. In 1965, in a N.Y. case, *Whitree v. State*,²² damages were awarded to a patient because he was confined without treatment.

Why? Because the patient *should* have been given certain medication *despite* his refusals, because he was “entitled to it.” The court noted with disapproval that the patient, Mr. Whitree, had not been “treated with any of the modern tranquilizing drugs . . . during his entire stay at the hospital.” And it found “that the reason for not using such drugs was that Whitree refused them.” The Court said, “We consider such a reason to be illogical, unprofessional, and not consonant with prevailing medical standards.”²³ Thus, this court not only did not recognize the right to refuse treatment, but also cited a “duty to treat” and raised the specter of a malpractice suit if a patient’s refusal should be improperly honored.

Within six years the pendulum had swung to the opposite side. It was in 1971 that the U.S. Court of Appeals in N.Y. decided the leading case of *Winters v. Miller*.²⁴ (Incidentally, this is another Bellevue case.) A 59-year-old spinster on welfare had been transferred after ten years in one hotel to another hotel where she created a problem for the manager by refusing to move to a different room. The police were called and she was taken to Bellevue, where she was committed on a two-physician certificate for 60 days. She refused to have her blood pressure taken and refused to take medication on the grounds that she was a practicing Christian Scientist. She was given medication orally and intra-muscularly over her protests.

The issue was whether she was entitled to relief under the Federal Civil Rights Statutes. The trial court said no, but the Appellate Court reversed and remanded the case for trial, noting that the finding of mental illness of New York State does not relate a presumption of incompetence.

Absent a specific finding of incompetence, the mental patient retains the right to sue or defend in his own name, to sell or dispose of his property, to marry, draft a will, and in general to manage his own affairs It is clear, and appellees concede, that if we were dealing here with an ordinary patient suffering from a physical ailment, the hospital authorities would have no right to impose compulsory medical treatment against the patient’s will and indeed, that to do so would constitute a common-law assault and battery. The question then becomes at what point, if at all, does the patient suffering from a mental illness lose the rights he would otherwise enjoy in this regard.”²⁵

The answer: when there is a judicial finding of incapacity. The court clearly distinguished between the involuntary hospitalization issue and the competency to consent to treatment issue. "Appellant (the patient), however, is not suggesting in this case that the authorities could not legally retain her in the hospital, but rather only that her First Amendment rights were violated as a result of compulsory medication."²⁶ Again, involuntary treatment – here the administration of medication.

But the dissenting judge in this case took the opposite view. His opinion was that an involuntary admission "constitutes a quasi-judicial determination under State law authorizing medical care of an individual notwithstanding her lack of consent thereto,"²⁷ and that the doctors "should be entitled to rely on such quasi-judicial authorization."²⁸

To bring us up to date, the most recent case relating to the administration of medication without consent is *Scott v. Plante*,²⁹ a 1976 Federal case in New Jersey. The District Court concluded that the involuntary administration of psychotherapeutic substances was not the basis of a claim of constitutional deprivation, but the Court of Appeals disagreed, holding that "case law points to at least three conceivable constitutional deprivations that may accompany the involuntary administration of such substances by state officers acting under color of state law to inmates confined in a state institution."³⁰ These constitutional deprivations included the First, Fifth, and Eighth Amendments and a possible Fourth Amendment constitutional deprivation, the invasion of the patient's right to bodily privacy. The court also noted that the patient, "though perhaps properly committable, has never been adjudicated an incompetent who is incapable of giving an informed consent to medical treatment."³¹

Some other relevant cases in regard to the right to refuse medication include the famous *Lessard* case³² (a leading case in regard to the due process safeguards required in the civil commitment process), where the court held that a patient should be able to appeal at an initial commitment hearing without being incapacitated "by medication."

Alan Stone, discussing this determination, points to the difficulties faced by an administering psychiatrist under these circumstances, noting that

A violently disturbed patient can disrupt not only an entire ward, but an entire hospital, if staff have to be brought to subdue him and struggles ensue. Without medication, mental hospitals would be back to straightjackets, padded cells, and the 19th century. What such struggles do to the staff in terms of physical injury, morale and therapeutic attitude are critical costs which affect other patients as well. The uneasy compromise allowed [by one of the judges] was to permit drugs to be used at dosages or of a kind which would 'restrain' but not 'treat.' Is it possible to translate this legal distinction into pharmacology? One might administer sodium amytal intramuscularly rather than phenothiazines. But query, which drug would permit a more effective hearing? Clearly, this is one of those human situations where human judgment rather than rigid rules is the sensible alternative. Even if this solution [the judge's] were to be found legally unacceptable, then mentally ill patients who are violent should be taken to jails rather than

hospitals until their probable cause hearing. Bad as that would be, it surely would be more sensible than transforming hospitals into jails.³³

Another case relevant to the right to refuse medication is *Bell v. Wayne County General Hospital at Eloise*.³⁴ In this case, the Eastern District Federal Court in Michigan in 1974 declared unconstitutional a number of sections of Michigan's civil commitment statute, and prohibited chemo-therapy before a final commitment order, stating that both due process and the right to privacy forbid the administration of "physically intrusive forms of treatment designed to alter or modify a person's behavior"³⁵ – among which the court included surgery, electroshock and chemotherapy – before there has been a final commitment order. The only exception was where the patient was "in immediate need of treatment in order to prevent him from physically harming himself or others, provided such treatment is necessary to maintain physical health."³⁶ However, as contrasted to the cases mentioned earlier, the court did not deal with the right to refuse treatment after final commitment.

We have thus gone from the most hazardous intrusive types of therapy such as psychosurgery to aversive therapy to shock treatment, all the way to medication. What about "milieu" therapy?

While there are no cases directly on point, some legal activists and patient advocates are citing articles³⁷ which indicate that this form of therapy may be harmful to certain patients, and I am certain that some lawyers are considering litigation to enforce a right to refuse treatment by milieu therapy. I shall not comment at this point except to note that milieu therapy was formerly called "moral therapy," which if eliminated might leave only "immoral therapy."

Let us now look briefly at some attempts to solve the problem of decision-making in the right to refuse treatment. In other words, assuming that a question has been raised as to whether a patient is competent to participate in a treatment decision, how is this question decided?

First let us look at the notorious fourth draft (1975) of the report of the APA task force on the right to treatment,³⁸ which contained a section titled "The Right to Refuse Treatment."

The American Psychiatric Association is aware of the possibility that the right to adequate care and treatment may be misunderstood and even be used in some cases in a coercive manner. We, therefore, wish to clearly indicate that our concern is that adequate care and treatment be available. If a patient declines to accept or participate in one or more forms of treatment, we support that patient's right to refuse. We recommend that the courts be the final arbiters of such a disagreement, should the hospital staff feel that such treatment is essential. In cases where the patient refuses treatment which is deemed essential by the medical staff, and where this refusal is supported by the judiciary, the medical staff should review whether this patient should remain in an active treatment setting, or whether his right to care should be implemented in another facility. Appropriate facilities should be available for alternative placement of selected individuals, who because

of their refusal of treatment, may not belong in a hospital devoted to active treatment.³⁹

Dr. Rachlin and others, in a series of trenchant articles⁴⁰ and letters,⁴¹ appropriately raised serious questions in regard to these principles and questioned the feasibility of such "appropriate facilities."

Recently the sixth draft of the APA task force report was published. The title has now been changed to "Authorization for Treatment."⁴² This new draft states:

The American Psychiatric Association is aware of the possibility that the right to adequate care and treatment may be misunderstood and even be used in some cases in a coercive manner. We, therefore, wish to clearly indicate that our concern is that adequate care and treatment be available. As is the practice generally in medicine, the patient's informed consent for treatment is required except for emergent situations.

No patient should be treated against his will unless some procedural safeguards are instituted. Since a patient's refusal of necessary treatment may not be in his best interest, some means of allowing him to receive proper medical care with the least amount of time consuming procedures must be developed. Depending on the circumstances, any of the following may be appropriate:

1. Court-authorized treatment at the time of commitment.
2. Court evaluation for competency to consent to or to refuse treatment.
3. In-hospital patient rights review committees (with outside representatives).
4. Administrative-judicial hearings.

These alternatives may represent a new departure from usual past procedures and therefore will require further study and trial.⁴³

Here in New York State the attempt to solve the problem of decision making took the form of a N.Y. State Department of Mental Hygiene regulation⁴⁴ promulgated in September 1975, titled "Care and Treatment: Right To Object and Appeal." It begins with the statement that "Patients may object to any form of care and treatment and may appeal decisions with which they disagree."

A general provision is first made for emergency treatment. Next it is stated that patients on voluntary or informal status may not be given treatment over their objection but must be discharged or converted to involuntary status. Involuntary patients may be given treatment over their objection only under certain circumstances. Four categories are set forth:

1. Emergencies.
2. Those who object on the basis of religious belief — in which case a court order must be obtained.
3. Those for whom the treatment recommended is surgery, ECT, a major medical treatment, experimental drugs, or aversive stimuli — in such cases a separate set of regulations require consent of a relative or court order.

4. Finally, the fourth category – for all others – establishes a special review procedure.

The review procedure is in two steps. First, the objection is reviewed by the head of service, and his decision is communicated to the patient or his representative. Then, if any object, an appeal can be taken to the director of the facility. The director's decision is apparently final for the purpose of this regulation, though it is clear that an appeal to the court is available.

A year after this regulation was put into effect, I undertook some research. Exploratory questionnaires were sent to the thirteen in-patient psychiatric facilities in Manhattan (New York County), and replies were varied. Some facilities responded that they had "no problems." Others related "problems" including concerns that treatment had been delayed, claims that the lawyers assigned to particular facilities were encouraging patients to refuse medication, and stories of patients discharged who committed suicide.

To obtain more detailed, quantifiable data, a pilot study was carried out on the five adult units in Bellevue Psychiatric Hospital, with a total capacity of 250 patients. The period covered was the year from October 1, 1975, through September 30, 1976. Bellevue is a short-term hospital, and during this time there were approximately 4,000 admissions to these units (including readmissions). At any time about 30 per cent of the patients were on involuntary status.

Because the study was retrospective, details as to the handling of objections to treatment that did not come to appeal could not be reliably determined or quantified. During this period only five cases were appealed to the director, or .125 per cent. In all cases the director supported the doctor's wish to medicate the patient even after refusal.

This fact led a senior member of the faculty to comment that the regulation seems not to have profoundly affected practice in the hospital. Most psychiatrists and lawyers agree that its impact has been minimal.

Another attempt at decision-making was set forth in Dr. Alan Stone's book, *Mental Health and the Law: A System in Transition*, 1975.⁴⁵ He concludes that the practical legal solutions in the area of the right to refuse treatment will have to be linked to the development of PSRO's and effective psychiatric utilization procedures.

For the moment, Dr. Stone further suggests the appointment of a third party as decision-maker.⁴⁶ However, he notes that unless the decision-maker is a judge, questions will be raised as to whether the patient's civil liberties have been protected. He therefore goes on to suggest a two-step procedure involving a preliminary judicial hearing as to whether the patient requires commitment and then a second judicial hearing, of a more formal type, which would deal with a number of questions including patient's competency to object to some part of the treatment plan. He notes, however, the tremendous cost in terms of medical time, etc., as well as the dangers of delaying treatment. He suggests that the full procedural safeguards be made mandatory only for "the more severe therapies." These include psycho-surgery, any convulsive or coma therapy, aversive therapy, inhalation therapy and medically prescribed high-addictive substances (e.g., Methadone).⁴⁷

I began this talk by briefly reviewing some of the larger issues that impinge on the question of the right to refuse treatment, including such matters as the social changes of recent years and the implications of these changes, the rise of the advocacy movement in the mental health area, and the changes in the perception of and the status of the professions. Then I remarked upon some of the intertwined issues of involuntary commitment and informed consent. All of these, in turn, have had an impact on the cases I have just reviewed, and I would like now to turn more specifically to what I believe to be the impact such changes have had on psychiatric practice.

I believe that the law suits, both individual and class actions, and the changes in statutes have permanently altered the nature of the doctor-patient relationship. Patients will expect a greater role in decision-making.

Furthermore, I believe we are seeing only the beginning of the questioning of psychiatric expertise, and if I am right, judges and lawyers will preside over a greater narrowing of our authority and autonomy.

Finally, the changes have "raised our consciousness" about patient autonomy.

Can anyone truly object to the requirements of informed consent? Yes, I have noted considerable resentment, even resistance, if you will.

Some speak of siege mentality. The theme of a recent AAPL meeting was "Psychiatry Under Siege."⁴⁸ We must ask ourselves how much of our reaction is concern for the patient and how much is the result of our perception of these changes as assaults on our prerogatives, as a narcissistic injury if you will, as our roles are narrowed and restricted. Certainly there are better ways to cope than to become defensive, negativistic.

One way we can cope is to demonstrate the scientific basis of our practice and treatments. A recent article in the *Archives*⁴⁹ distinguished between two groups of schizophrenic out-patients on medication: those who stopped taking their medication and those who did not. Those who *did* stop were found to develop an "ego-syntonic grandiose psychosis." They wanted to experience the feelings of grandiosity that resulted from their illness. The others – the ones who did *not* stop taking their medication – would, if they stopped, experience dysphoric affects – depression, anxiety. They would get depressed if they stopped – so they did not.

This kind of research will clarify for us some of the clinical issues relating to a patient's refusal so that we can argue our points more strongly and thereby affect the legal decisions.

The law is a very coarse instrument. It cannot undertake the fine regulation of our work. It cannot properly take into account the subtleties of the psychiatric relationship, or communications made in the context of the psychiatric relationship. We can, however, at least insist that the lawyers who intrude themselves into issues of patient care be *well trained* and appreciate the complex issues of psychiatric treatment.

Lastly, we must regain our role as advocates for the patient. To do this we must ally ourselves with the "consumers" – our patients (and their families) – to assure them, in these days of budget cuts, of the best care that can be provided.

It must be unmistakably clear that our primary concern is the well-being

of our patients, especially the poor and helpless. We must unite with them — our clients, if you will; the consumers, if you will; but most of all “our patients” — to demand from the State, and then assure, *adequate* care and treatment, and not allow the lawyers to monopolize the role of advocate.

Finally, as patient advocates, we must become legal activists and alter our statutes as well as our practices.

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4. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 1341 (M.D. Ala. 1971); enforced by 344 F. Supp. 373, 344 F. Supp. 387, appeal docketed *sub nom. Wyatt v. Aderholt*, No. 72-2634, 5th Cir. filed Aug. 2, 1973
5. *Id.*
6. *Wyatt v. Hardin*, No. 3195-N (1975) (U.S. District Ct., Middle District, Ala., Feb. 28, 1975, modified July 1, 1975). Reprinted in Miller F: *The Mental Health Process*, p. 556 (2nd ed., 1976)
7. *Id.*
8. *Id.* at 557
9. *Id.* at 558
10. *Id.* at 560
11. *Kaimowitz v. Dept. of Mental Health, C.v. # 73 - 1943* (Cir. Ct. for City of Wayne, Michigan July 10, 1973). Unreported. Reprinted in Miller F: *The Mental Health Process*, p. 567 (2nd ed., 1976)
12. *Id.* at 593
13. *Id.*
14. *Id.* at 577
15. *Knecht v. Gillman*, 488 F. 2d 1136 (8th Cir. 1973)
16. *Id.* at 1139
17. *Campbell v. Glenwood Hills Hospital, Inc.* 142 N.W. 2d 255 (1966)
18. *Id.* at 262
19. *Id.*
20. *New York City Health and Hospitals Corporation v. Stein*, 70 Misc. 2d 944, 335 N.Y. 2d. 461 (Sup. Ct. 1972)
21. N.Y. Mental Hygiene Law, Sec. 15.03 (McKinney, 1976)
22. *Whitree v. State*, 290 N.Y.S. 2d 486 (Ct. of Claims, 1968)
23. *Id.* at 501
24. *Winters v. Miller*, 446 F. 2d 65 (2nd Cir. 1971). Cert. denied 404 U.S. 985 (1972)
25. *Id.* at 68
26. *Id.* at 70
27. *Id.* at 74
28. *Id.*
29. *Scott v. Plante*, 530 F. 2d 939 (1976)
30. *Id.* at 946
31. *Id.*
32. *Lessard v. Schmidt*, 349, F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded 414, U.S. 473 (1974)
33. *Supra*, n. 3, at 53
34. *Bell v. Wayne County General Hospital at Eloise*, 384 F. Supp. 1085 (E.D. 1974)
35. *Id.* at 1099
36. *Id.* at 1102
37. See, e.g., Van Potten: Milieu therapy: Contraindications? 29 Archives of General Psychiatry 640 (1973). See also Pardes *et al.*: 46 Psychiatric Quarterly 29 (1972).
38. Proposed Position Paper: The Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded. Prepared by the Task Force on the Right to Treatment, Jonas R. Rappeport, M.D., Chairman. Oct. 19, 1974, Fourth Draft (unpublished)
39. *Id.* at 6
40. See, e.g., Rachlin S: One right too many, presented at the Seventh Annual Meeting of the American Academy of Psychiatry and the Law, Boston, Oct. 23, 1975.
41. Unpublished letters: Aug. 1, 1975 (J. Talbott), Aug. 12, 1975 (J. Rappeport)
42. See note 38, Sixth Draft, May, 1975.
43. *Id.* at 6
44. 14 N.Y.C.R.R. Sec. 278 (1975), Care and treatment: Right to object and appeal
45. *Supra*, n. 3
46. *Id.* at 104
47. *Id.* at 105
48. This was the theme of the Annual Meeting of the American Academy of Psychiatry and the Law, San Francisco, Oct. 21, 1976.
49. VanPutten T, Crumpton E, Yale C: Drug refusal in schizophrenia and the wish to be crazy. 33 Arch Gen Psychiatry 1443 (Dec. 1976)