# The Rights of Involuntary Patients to Refuse Pharmacotherapy: What is Reasonable?†

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> [H]ow real is the promise of individual autonomy for a confused person set adrift in a hostile world?[1]
>
> Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds.[2]

## Introduction

A number of prominent and often well-reasoned cases have increasingly defined a limited right, on the part of involuntarily detained psychiatric patients, to refuse treatment.[3-12] Historically, most of these cases dealt with prisoners,[6] or with patients who had religious objections to the treatments being imposed.[3] However, as the mental health bar expanded and as scholarly critiques proliferated,[13-20] the courts have been called upon to extend this right. That is, to extend it to nonprisoners on constitutional grounds other than religion.

Over the last year, three federal district courts have reached different conclusions as to how this right should be extended. First, in *Rennie v. Klein*[11] the court developed the least-restrictive-alternative reasoning of earlier cases[21-23] and commentaries[24,25] in finding that the plaintiff-patient had a qualified right to refuse treatment. That case, initially decided after detailed scrutiny of that one patient's treatment needs, was subsequently broadened into a class-action suit.[26] The second opinion in the case, besides continuing to hold that a right to refuse treatment exists, created an elaborate review process. That process is extra-judicial, an independent psychiatrist is established to review treatment decisions; and quasi-judicial, the patient must be provided with an advocate, often a lawyer, to protect this new right. The second court found, in *Rogers v. Okin,* a constitutionally-rationalized absolute right-to-refuse treatment.[27] Treatment could proceed over the patient's objections in only two circumstances: either in a narrowly defined emergency; or, where the patient had previously been adjudicated incompetent and a guardian had consented to the treatment. This second class-action suit significantly widened the right-to-refuse doctrine in comparison with *Rennie.* The third court, in *A. E. and R. R. v. Mitchell,*

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held that a Utah civil commitment statute was sufficiently specific so that no right-to-refuse treatment existed.[28] However, that ruling is less *contra* the right-to-refuse movement than it appears. Utah had recently revised its civil commitment process so that commitment could only occur when it constituted the least-restrictive treatment and where the patient was not functionally competent. In effect, the Utah statute assumed away most of the issue.

As if these cases did not adequately demonstrate the need for some comprehensive coherent determination (ideally done at the Supreme Court level), new right-to-refuse decisions are being reported almost monthly.[29,30] Major federal district court suits are pending in California, New York, Pennsylvania, and Ohio. Not surprisingly, both *Rennie* and *Rogers* have been appealed.(1)

The point in recounting this is to highlight the historic complexity of the right-to-refuse-treatment issue, an issue that continues at the cutting edge of the law. For mental patients and mental health professionals it is profoundly important: if a broad constitutional right is upheld at the appellate level, psychiatric care will be significantly altered.

This paper, by examining some problems suggested by the conflicting cases, discusses the issue of the right to refuse "psychotropic" medication.(2) The primary concern is on how much of that right, both from the psychiatric and the legal perspective, is reasonable. Earlier treatises have discussed the issue in considerable detail, generally from either the psychiatric perspective (largely patient treatment),[13,31,23] or from the legal one (largely constitutional rights).[16,33-37] What now appears necessary is an attempt to describe a sensible framework for balancing the competing equities of patients' rights and needs.(3)

An important *caveat* is in order at the outset: these issues are complex; no single solution is adequate or comprehensive.[38] As patients' rights evolve, as therapies change, and as involuntary commitments become more precisely defined, the question of the right to refuse treatment will warrant reconsideration.

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(1) As this paper was being revised, the First Circuit handed down its decision in *Rogers v. Okin* (No. 79-1648, 79-1649). That decision vacated the District Court's judgment holding that objected-to treatment could proceed in police power commitments on a broader basis than the lower court had held, but upholding much of the earlier decision in pure *parens patriae* commitments.

(2) The term "psychotropic" is not an ideal one since literally included are a variety of drugs which affect the central nervous system (hallucinogens, stimulants, anti-cholinergics, inhalants, *etc.*) and which are rarely used therapeutically. "Anti-psychotic" is an appropriate appellation, though "neuroleptic" is perhaps preferable in describing more precisely the effects of current anti-schizophrenic medications. As currently construed, anti-psychotic generally means anti-schizophrenic; yet, if used denotatively, it would be an ideal term to cover those pharmacologic agents used to treat schizophrenia, mania, and depression (of psychotic proportion).

(3) One could argue that *Rennie* is an adequate balance. My concern is that its review procedure is cumbersome, expensive,and probably not sufficiently responsive to clinical reality.

## Preliminaries

At the beginning it seems appropriate to articulate certain perspectives and premises. First, abuses have occurred and sometimes continue. By abuses, I refer to the fact that some patients have been badly and even capriciously treated by mental health professionals; and that some patients have had their illnesses exacerbated by zealous advocacy which elevated patients' rights over their welfare. In short, patients have been and can be dehumanized both by inappropriate treatment and inappropriate lack of treatment. Neither the psychiatric nor the legal profession should be solely blamed for these excesses. Second, competent persons should have an unambiguous[4] right to determine their own treatment, and this right should be vigorously protected. Third, the presence of mental illness should not be confused with the incapacity to make informed-consent treatment decisions. Fourth, ongoing legal remedies exist to protect individuals from careless practitioners. Typically, the legal mechanism for doing this has been via the doctrine of informed consent. Like many abstract doctrines, this one tends to break down in extreme cases; hence the legal aphorism: hard cases make bad law. Traditionally, incompetence and involuntary status have posed vexing challenges to this doctrine. Thus, while civil law remedies, suits in tort, exist to protect all patients, both the courts and the legislatures have specifically banned certain treatments (*e.g.,* psychosurgery or behavior modification with succinyl choline) for certain classes of patients (*e.g.,* prisoners, or involuntarily-detained psychiatric patients, or retarded children).[38] Fifth, treatment emergencies do exist (*e.g.,* homicidal outbursts, suicidal or self-mutilatory rages, extreme agitations to the point of an irreversible inanition or electrolyte imbalance, or refusal to take even minimal nourishment) which require rapid therapeutic intervention if the patient is to be prevented from harming others or self.[40,41] In some cases, seclusion and/or restraint will not suffice to abate the emergency unless used for unconscionably long periods. Sixth, the ultimate aim of rethinking the right-of-involuntary-patient-to-refuse-treatment issue is to reduce and ideally eliminate abuses; that is, to enhance patient welfare. In general, increasing patient access both to treatment and to legal counsel should further this aim. Seventh and last, it is important to remind oneself that much of what is wrong with mental health care has little to do with the right to refuse treatment. Inequities in funding, inadequacies in training, misallocation of resources, and deficiencies in knowledge (about mental illness) all make present treatment less than ideal.

Next, it is important to note the legal underpinnings of the right-to-refuse-treatment doctrine. As many commentators have noted, that

(4) It would be tempting to write about an "absolute right" in this regard but the courts have determined that certain treatment decisions, typically those which potentially affect others such as vaccination against contagious diseases, cannot be made absolutely.[40]

right can be rationalized via a variety of legal theories.[16-20,23,24,33-37] A comprehensive review of those theories cannot be considered here. Yet it is important to observe that most of these theories have been well reviewed, and that each tends to be considered under a formal legal appellation. Thus, the right to refuse treatment is often discussed from the perspective of explicit constitutional guarantees,(5) freedom of religion,(6) dangerous to others,(7) dangerousness to self,(8) grave disability,(9) the right to privacy,(10) the right to mentation,(11) freedom from cruel and unusual punishment,(12) procedural due process,(13) the

(5) A logical place to begin a constitutional analysis of the right to refuse treatment is with those rights explicitly guaranteed in the Constitution (*i.e.,* freedom of speech, freedom of religion, *etc.*).[42] Whenever the state infringes on one of these rights, the courts scrutinize the state action according to the standards set down in *United States v. O'Brien.*[43] The action must be within the power of the government; it must further an important or substantial government interest unrelated to the suppression of the affected right; and incidental restriction on the affected right must be no greater than is essential to the furtherance of that interest.

(6) Freedom of religion is a First Amendment right that a patient could assert as a reason for refusing treatment. There are two threshold issues here. The first is: what types of beliefs are religious? The second is: what types of religious beliefs are protected? These questions are obviously relevant to the psychiatrist whose patient refuses treatment on the basis of some idiosyncratic belief. The classic definition of religion is in *Davis* where religion is defined in terms of man's relationship to his maker.[44] This definition is somewhat dated and a definition today would probably be broader. This is suggested by the court's analysis in *Ballard.*[45] In this case defendants tried to start a new religion, the "I am," movement, through the mail (and were later indicted for mail fraud). The Supreme Court upheld the trial court's refusal to submit the issue of the truth of the defendant's belief to the jury. The court held that the only relevant issue in determining First Amendment rights was the good faith of the party claiming the right. This was the case in *Winters.*[3] In order to override a patient's right to freedom of religion the state must first show an important or substantial interest. The trial court in *Winters* suggested the State's interests. The first interest was expense: the untreated mental patient was a burden on the state. This interest was rejected completely by the Court of Appeals as not being important enough.[46] The second was the state's interest in helping mental patients who might not be able to make decisions for themselves. The trial court came close to finding a compelling interest here, but stated it so broadly that it too was rejected by the Court of Appeals.

Potential interests for treating a patient can be found in the state's allegations in commitment proceedings. For example, under California's Lanterman-Petris-Short Act a patient may be committed if he presents a danger to others, a danger to himself, or is gravely disabled (as a result of a mental disorder).[47] A brief analysis may suggest the extent to which each of these reasons can be asserted as state interests in overriding a patient's refusal to accept treatment in the case of freedom of religion.

(7) Certainly the state should be able to assert this as an important interest. The *Rennie* court recognized this. Some courts have found that all committed patients have a constitutional right to be protected from the violent patient.[48] The major issue is the extent of danger that must be present in order to override the patient's rights. Given the importance of the patient's right, there should be a real danger. Probably, only assaults, attempted assaults, or at the least threats under circumstances when there is a high probability that the patient will carry out the threat in the very near future, would give the state the right to administer drugs in spite of a patient's refusal on religious grounds.

The state must do more than demonstrate an important interest. The means used must be necessary to achieve that interest. This means that as soon as the patient no longer presents a high degree of danger, the right to refuse treatment revives. Furthermore, the means of treatment chosen must be the least restrictive alternative. Given current realities of care, neuroleptics will often be the only effective means of treatment, especially in emergency situations. However, as the extent of the danger to others decreases, the Constitution may require the use of means, such as confinement or isolation, which impinge less on the patient's First Amendment rights.

(8) The state's interest in protecting individuals from self-harm is evidenced in various federal

and state anti-suicide statutes. In the past, the court has constrained the practice of deeply held religious beliefs by forbidding exposure to death from handling dangerous snakes or ingesting poison. This was in spite of deep conviction and the fact that large numbers of persons engaged in such acts.[49]

The patient's interest should be viewed in light of whether or not the religious belief is due to mental illness. An issue which must be considered is to what degree a patient will be protected from harm. Is a ritualistic thumb-prick the same as an attempted suicide? Obviously, it is not. Will suicidal threats without actual attempts be used as a reason for initiating involuntary treatment? Again, the treatment itself must be shown to be the "less drastic means for achieving the same basic purpose" required under *O'Connor.*[50] As with the category of danger to other patients, what intrusiveness of treatment is justified to protect the patient? In *Quinlan,* a hospital ethics committee decided to continue the life-support treatment of a comatose patient, and thus raised this issue.[51]

(9) The extent of the state's *parens patriae* power is one of the least clear issues in mental health law. Current U.S. Supreme Court definitions are somewhat vague: the power extends to "providing care to its citizens who are unable because of emotional disorders to care for themselves."[52] At the least this probably extends to providing for the patient's basic personal needs of food and clothing and shelter. This was recognized implicitly in *O'Connor.*[50] Under LPS this is the limit of the state's power to commit under the gravely disabled category.[53] If this is the limit of the state's power, the non-dangerous patient would appear to have an absolute right to refuse treatment on religious grounds.

Some courts have recognized another facet of *parens patriae* commitments, commitment for the purpose of treatment. This position was expanded by the Court of Appeals opinion in the *O'Connor* case.[54] The Supreme Court's decision in *O'Connor* vacated the lower court opinion. The court saw no reason to reach the issue of the extent of *parens patriae,* deciding only that the state could not confine, without treatment, a non-dangerous individual, capable of providing for himself. The courts have thus been inconsistent as to whether the state may confine an individual for treatment.

Can treatment ever be asserted as an important state interest in order to override the refusal of a non-dangerous patient to accept treatment? Clearly, if the state asserts its *parens patriae* power to care for and treat the individual, it also must assert or show that the individual is incapable of making the relevant decisions for himself. Thus, some of the reasoning by the *Winters* court may be correct: before the state can assert *parens patriae* to override an individual's refusal of drugs, the individual should first be adjudicated incompetent (with the attendant procedural safeguards required by the due process clauses of the Constitution).[3] That is, in circumstances other than emergencies. It is an important question whether for brief hospitalization actual adjudication rather than allegation is necessary. At present the answer is unclear. In *Winters* the treatment was non-emergent and long-term.

A still more difficult problem is posed by the incompetent patient (in *Winters* and *O'Connor* the patients were not incompetent). Here the legitimate state interest (caring for the patient) and the patient's interest (right to refuse treatment on religious grounds) may be diametrically opposed. Sometimes the courts have decided this issue in favor of the state's interest. In the appropriate situation, in psychiatry and in medicine more generally, the state is able to order treatment for those unable or unwilling to give consent.[9,12] This result is justified on the grounds that the individual would act differently if competent and thus needs someone to help him make competent decisions. Often, since the chance for error is great and the patient's affected rights are important, the courts require the state to go through a hearing (with the attendant requirements of procedural due process). An in-depth discussion of procedure is beyond the scope of this note but the requirements are discussed thoroughly in some commitment cases[4] as well as in *Price*[9] and *Rennie.*[12] Some of the requirements listed include right to counsel, appointment of a guardian, right to an adversary hearing, and right to call outside experts.[55]

What standard should the court use in determining that the state can treat an individual in spite of his refusal to accept treatment? Some commentators have advocated a reasonable-person test.[56] This rule would seem to ignore the deference the Constitution gives to even irrational religious beliefs. Other commentators have suggested an alternative starting point: ignoring the patient's wishes should be the exception and not the rule.[57] Such a starting point would suggest that the state should be able to overrule the patient's wishes only if it can show a high probability that the treatment will be successful and desirable. Factors to be considered should include the nature and extent of the patient's illness, the probable effect(s) of the proposed medication(s), the possibility of adverse side effects, and the (potential) psychological damage of overriding the patient's objections. A further factor might well be the patient's religious beliefs. Such a test may be impractically severe.

(10) The right to privacy, unlike the right to religious freedom, will be found in every case and

hence is the most frequently discussed in relevant case law and commentary. It formed the basis for the decisions in *Price* and *Rennie.*

The right to privacy is not explicitly guaranteed by the Constitution. It was recognized in *Griswold v. Connecticut*[58] and was the basis of the decision in the abortion case of *Roe v. Wade.*[59] The justices came up with three theories in *Griswold* to explain the right. Justice Douglas' majority found "penumbras" around the explicit guarantees of the various amendments which gave them "life and substance." The "zone of privacy" penumbra was created by the First, Third (quartering of soldiers), and Fourth (right against self-incrimination) Amendments and this was protected by the Constitution just as much as the rights explicitly guaranteed by those amendments. Justices Brennan, Goldberg and Chief Justice Warren found that the right to privacy was protected by the catch-all reservation of all rights to the people found in the Ninth Amendment. Justice Harlan found the right "implicit in the concept of ordered liberty" and this part of the liberty protected by the Due Process clauses of the Fifth and Fourteenth Amendments.

The right to privacy cases have generally involved family, marriage and birth control issues. To extend this right to cover a mental patient's refusal of treatment is a step that some courts have been willing to take: "the Constitution reserves the individual free of government intrusion, certain fundamental decisions about how he or she will conduct his or her life."[9]

Case law on the right to privacy is not fully developed. One of the unclear areas is the proper standard of review for a state action that infringes on the right. The standards adopted by the majority in *Roe v. Wade* sounds very much like that used in *United States v. O'Brien;* the state can override the individual's right only by showing a compelling interest and the action must be designed narrowly to express or accomplish only those compelling interests.[43] Moreover, later cases have demonstrated that some infringements on the individual's right to privacy will be subjected to a much less strict scrutiny.[60] Apparently, the right to privacy can be infringed upon incidentally almost as a matter of course. However, once the state goes beyond some degree of intrusiveness, the higher level of scrutiny is triggered and the state must show a compelling interest to justify the intrusion.[61]

An analysis of the competing interests would proceed much the same as it did for the right to religious freedom. Moreover with the sliding scale approach the psychiatrist may be able to use some milder drugs in situations where he would not be able to use them if the patient asserted religious freedom as an interest. Those points beyond which the state's interests are so strong that the individual cannot refuse treatment, should remain the same.

For the non-dangerous, incompetent patient the assertion of this right changes the nature of the hearing required before drugs can be forcibly administered. Perhaps, the state should have to show a high degree of desirability for the proposed therapy and a "least restrictive degree of intrusiveness."

(11) Both the *Kaimowitz* and the *Rennie* decisions recognize that a proposed therapy may infringe on a patient's right to mentate or generate ideas. The origin of this right and its extent are even less clear than the right to privacy. It is possible that it is part of the right to privacy, or even another penumbral right as defined in *Griswold.* It is more likely however, that the right should be identified with the First Amendment free speech guarantee.[62] Using such an analysis, the appropriate standard of review for a state action would be the same as it was for an infringement of religious freedom.

The crucial issue is when is this right infringed. The degree of permanence of any changes in mental activity caused by the proposed therapy are the most important factors. *Kaimowitz* was probably correct in finding that psychosurgery infringed on this right (given the involuntary status of the prisoner/proposed patient). The *Rennie* court dealt with this issue in finding that some chemotherapies did not infringe on the right.

(12) Several cases: *Knect,*[5] *Scott,*[8] *Nelson,*[63] and *Mackey,*[6] have recognized that forced administration of drugs to prisoners and mental patients may violate the Eighth Amendment's ban on cruel and unusual punishment. The key issue in these cases has been whether the medication constitutes treatment or punishment.[63] In making this determination the court may look directly "at the situation" if the harm of the side effects far outweighs the possible benefits.[5]

There is obviously a large gray area where the Eighth Amendment status of a treatment may be questionable (especially with drugs whose possible efficacy and side effects for a particular patient may be unknown). However, the patient charging cruel and unusual punishment must do more than question the efficacy of the drug. The courts have expressed the standard in a number of ways: the treatment must not offend "attitude(s) which our society has traditionally taken" or "traditional ideas of fair procedure:"[64] it must not be "shocking to the conscience"[63] and any side effects must not be "unnecessarily harsh in light of the potential benefits."[12] Under this standard any psychiatrist who in good faith administers a medication of proven efficacy according to established practice should not be subjected to an Eighth Amendment claim.

(13) The Due Process clauses of the Fifth and Fourteenth Amendments require fair procedures whenever an individual is to be deprived of life, liberty or property by the state. In general, for example, when the state seeks to infringe on an individual's right to privacy or religious freedom because of its *parens patriae* power, the Due Process clause requires a hearing to make sure that the individual really cannot make the relevant decision for himself and that the state can assert that interest and infringe on individual rights (although for obvious reasons such a hearing is not appropriate in emergency situations).[12]

The *Rennie* court found infringement of another, more basic liberty interest. Any time a state seeks to confine a person, depriving him of the most basic of all liberty interests, it must provide a fair procedure. This requirement applies to civil commitments as well as criminal detentions.[52] The *Rennie* court extended this argument: since the forced administration of drugs "involves a major change in the condition of confinement,"[12] additional proceedings are required. This analysis however, misses the point of the U.S. Supreme Court in *Meachum v. Farro.*[65] Under *Meachum,* once the state has confined a person and met the due process requirement in the original commitment or conviction, the state may make changes in the conditions of the individuals, even if they have a "substantial adverse impact" upon the individual, and not have to meet additional procedural Due Process requirements. It is only when the change in condition infringes upon a new property or liberty right that the state must give the individual an additional hearing. Such a property or liberty interest may be one found in the Constitution or may be one promised by a state statute.[66] The correct analysis of the procedural Due Process right for a patient who refuses drugs is probably as follows: the state must meet fair procedure requirements because the forced administration of drugs works a new (and potentially greater) infringement on various constitutional rights (*i.e.,* right to privacy, right to religious freedom) and not because the conditions of confinement have changed.

least restrictive alternative,[24,25] and informed consent.[67-70] Because it is not explicitly dealt with in the Constitution, no single rubric is sufficient to establish an absolute right to refuse treatment. Yet, as *Rogers* has demonstrated, a broad right to refuse treatment can be constitutionally rationalized.[27] Such a right is founded primarily on the Bill of Rights prohibitions regarding intrusions into privacy and mentation and the Due Process Clause of the Fourteenth Amendment. Still, at least normatively, what is of interest is not whether such a right can be rationalized, but whether (and how) it should be.

Finally, certain principles, though too broad to compel scientific solutions, provide a context in which a right-to-refuse-treatment discussion can be formulated. That is, they suggest approaches to specific solutions and are thus useful.

The grounds of the civil commitment make a difference. At one extreme is the person whose mental illness makes it more likely that he will be violent to others. Contrast this with the person whose illness is expressed as extreme passivity and who is likely, at most, to harm himself. For the former, the state's interest (rationalized under the rubric of police power, the power of the state to decrease one person's freedom when it directly infringes upon others) is clear; while for the latter, the state's interest is much less clear. So much so in fact, that some scholars (*e.g.,* Szasz) would argue that all such *parens patriae* commitments are, *per force,* inappropriate.[71] Somewhere between these two extremes falls the interest of the state in those mentally ill patients whose illness makes direct self-destructive acts more likely. To confound these issues further, there are some unfortunate individuals whose

illness may simultaneously create an increased likelihood of several kinds of risk-creating behavior. The point is that the state's interest in an individual varies depending upon the nature of the illness and the rubric under which involuntary commitment is rationalized.

The length of the proposed involuntary commitment also makes a difference. In California for example, most commitments expire within 31 days and many within 72 hours.[47] The longer the commitment, the greater are the procedural guarantees. Most states recognize this principle explicitly by detailing more elaborate requirements for initiating longer civil commitments, while allowing shorter ones to be initiated by a larger number of agents (police, psychiatric technicians, psychologists, social workers, physicians, and psychiatrists). Thus, when Loren Roth proposes that civil commitments, whether stemming from police power or *parens patriae,* be six weeks (or longer), the right to refuse treatment is called more directly into focus than if the maximum possible commitment were 72 hours.[72]

The efficacy of the available treatments should affect the right to refuse treatment. The example of a schizophrenic patient illustrates this.(14) Currently, neuroleptic therapy is about ninety percent effective in reducing hallucinations, decreasing agitation, eliminating thought disorders, and lysing delusions.[75] Alternative therapies, whether talk therapy, milieu therapy, or occupational therapy, are less effective.[76] Thus, for a patient to decline neuroleptic treatment would statistically reduce his chances of recovery from around ninety percent to some much smaller figure. As pharmacotherapies become more effective, this difference will be increased. If current pharmacotherapies were only as effective as other therapies (even if less costly to administer) the interest of the state in compelling pharmacologic treatment would have to be much more delicately rationalized. In this context "delicate" is a euphemism to indicate that such cost-benefit or alternative-resource use reasoning might well not meet constitutional requirements.[46] Thus, the efficacy of the imposed therapy affects the right to refuse treatment.

An intimately related concern is the risk/benefit ratio of the proposed therapy.[77] In the case of the neuroleptic therapy of schizophrenia, side effects and risks are well known.(15) And though the literature presents a continuing debate about the prevalence and irreversibility of tardive dyskinesia, it does not appear to be as catastrophic as it did five years ago.[78,79] Further, the majority of psychiatrists believe that for schizophrenia the risk/benefit ratio of

(14) The vast majority of involuntarily committed patients are diagnosed as having schizophrenia, though several important recent articles question the general validity of such diagnoses.[73,74]

(15) Side-effects (generally non-idiosyncratic are reversible) include most commonly the extrapyramidal reactions of rigidity, tremor and akisthesia, though a variety of less frequent side-effects have been reported as well. Risks (generally idiosyncratic and irreversible) principally include tardive dyskinesia though a few cases of sudden death have been reported.[75]

neuroleptic therapy favors the benefit.[75] Viewed more broadly though, this is an important issue. Hypothesize a treatment for schizophrenia that is 100% effective, and yet has an associated mortality. Even if this treatment were only one percent lethal, how far should the state's interest to compel treatment extend?(16)

The diagnosis of the patient should affect the right to refuse treatment. Some commentators have argued that involuntary commitment for psychiatric illness is or should be predicated on a diagnosis of psychosis.[80] In many cases this happens in fact, but not by legal requirement. Civil commitment statutes generally permit involuntary hospitalization for evaluation and treatment if there is a mental disorder or alcoholism. Typically, such statutes define a mental disorder as anything included in DSM II.[81] Of course, DSM II not only includes many organic conditions (*e.g.,* delerium tremens, senile dementia), but also neuroses, personality disorders, situational reactions, and marital and social maladjustments. Most involuntary commitment statutes include implicitly the perspective that the patient's illness be of such magnitude as to render informed treatment decisions impossible. As such, they assume that mental illness, *per se,* carries with it a likelihood of incompetence. Though individuals vary, this assumption is accurate for the psychoses where gross impairments of judgment are often part of the diagnosis, but this is not true for many neurotic, psychophysiological conditions, personality disorders and situation reactions. Thus, if one envisages a civil commitment system where dangerous nonpsychotic individuals can be hospitalized, the issue of the competence of the specific patient must be addressed. In those rare jurisdictions where only psychoses constitute a proper rationale for hospitalization, the issue of the patient's competence is less urgent.

Obviously then, no matter how it is raised, the matter of competence is vital to the issue of the right to refuse treatment. For at least two centuries the common law has required consent on the part of patients, lest the physicians be liable in court.[70,82] To overcome this consent requirement there must be a compelling reason or a strong (albeit rebuttable) presumption of incompetence. Clearly some psychiatric patients (irrespective of diagnosis) will be competent, and their treatment decisions should be not only heeded but protected. Clearly too, some psychiatrically ill patients are manifestly incompetent and these patients need their access to treatments protected. Unfortunately, specific

(16) Fortunately, this issue is more academic than real. Given the risk/benefit of presently available neuroleptics it seems inconceivable that any court would permit the hypothesized neuroleptic with its associated mortality to be involuntarily administered. See the discussion regarding the forced administration of ECT and psychosurgery.[38] Further, given the reasoning of the *Kaimowitz* court, it is even questionable if such a treatment could be given to an involuntary patient who had established his competence.[7] Voluntary patients could choose such an extreme therapy as some conventional medical and surgical procedures carry mortalities significantly in excess of even 10%.

diagnoses do not linearly imply competence (or its lack). It is important to note that a clear, decade-old trend is to separate determinations of illness from that of competence.[83]

The court in *Winters* found that it was inappropriate to treat the patient over her religiously-based objections unless the situation was emergent.[3] Roth, too, speaks of emergencies in proposing a civil commitment statute which permits treatment on an emergent basis, and only the treatment necessary to control the emergency.[72] Clearly then, the emergent nature of the patient's condition needs to be considered in evaluating the right to refuse treatment. Psychiatric emergencies should be defined as they are in the rest of medicine as those special circumstances involving grave and urgent threat to the patient's well-being. These are the circumstances in which the doctrine of implied consent has arisen. Such emergencies are rare in psychiatry.[40,41]

The issue of the patient's dangerousness should affect the right to refuse treatment. A concrete example will illustrate this. Imagine two schizophrenic patients, each with a different delusional system, each with a history of responding to neuroleptics. One believes that "UFO beings" are controlling his actions and rendering employment difficult and sexual expression impossible, while the other believes that all men over 6'3" demand sexual relations with him. The first experiences much subjective dysphoria, rarely takes medication, and spends most of his time attempting to alert the press to the danger of the "UFO beings." He has sought voluntary hospitalization twice. The second has attempted to knife three different men, all over 6'3", each of whom he encountered in bars, and has attempted to strangle male staff on two occasions while involuntarily hospitalized (he has never sought voluntary hospitalization). When treated with neuroleptics his delusions have remitted and his violence abated. Granted the hypothetical nature of these patient histories, one might well conclude that these two patients should be treated differently.(17)

Finally, there are three issues which merit mention, if not detailed discussion, as each could affect the right-to-refuse-treatment decisions. First, since the vast majority of involuntary psychiatric hospitalization is in publicly-financed institutions, and government is under increasing political pressure to curtail spending, there is arguably some fiduciary obligation to do things in a reasonably cost-efficient fashion; and since the maintenance of institutions is expensive, one wonders whether publicly-financed treatment, at least for dangerous patients, can include

(17) Some commentators would argue that patients such as the latter belong in, or would be better processed by, the criminal justice system.[84,85]

primary treatments other than medication.[18] The second issue is prognosis. If involuntary psychiatric hospitalization is permitted for acutely disturbed, transiently ill persons, should they be treated differently than patients whose symptoms are no more severe (*e.g.,* chronic schizophrenics) but for whom the prognosis is poor? That is, should prognosis directly affect the right to refuse therapy? Third, does it matter what happens to the patient if he refuses medication? In most jurisdictions involuntary patients are retained until: 1) the involuntary commitment expires, 2) the patient recovers sufficiently to check out against medical advice or to sign into the hospital voluntarily, or, 3) the commitment is terminated judicially. Suppose, however, that physicians treating involuntary patients were vested with the "right" to sign patients "out against medical advice" if treatment were refused.[19] In such a system a dangerous patient could short circuit hospitalization unless the system permitted the patient's competence to be examined. Presumably, those patients found incompetent to refuse treatment would have treatment imposed until one of the above three conditions occurred. Further, one wonders whether the Constitution requires treatment, if involuntary confinement is to be permitted for dangerous but noncriminal patients. Anything less could be considered preventive detention, regardless that the locale of detention is the hospital.

The foregoing discussion should underscore two cardinal points: first, that the right to refuse treatment can be meaningfully considered only from the patient's clinical and legal needs; and second, that the issues are enormously complex.

## Proposals

Stone and Roth have separately proposed that if treatment is to be compelled (if the patient's right to refuse treatment is to be overridden), four conditions must be met: without treatment the prognosis is for major distress;[20] treatment is available;[21] the illness impairs judgment

(18) It is assumed *arguendo,* that a meaningful proportion of dangerous patients are schizophrenic and that chemotherapy continues to be by a wide margin the most cost-effective therapeutic modality.

(19) Such a proposal has been made by a group of psychiatrists at Napa State Hospital (California) in response to the *Jamison* litigation. In effect these physicians argue that if patients are going to be treated as "voluntary" (in the sense of having the usual right to refuse therapy), then they as physicians ought to enjoy the full prerogatives of treating voluntary patients. Thus, they have proposed that treating psychiatrists be able to discharge such patients, "against medical advice," for failing to accept the proposed treatment. One wonders how reasonable such a response is, no matter how heart-felt or provoked the psychiatrists believe themselves to be.

(20) Such a notion however, would not deal effectively with concerns about transient situational disturbances, where the prognosis is quite good.

(21) Probably this should be restated as the presence of efficacious treatment is available. For all conditions, treatments are "available," though many do not work well, others have been supplanted, and still others are considered too risky. What matters more than the presence of a treatment is its adequacy or effectiveness.

(competence); and the risk/benefit ratio of the proposed therapy is such that a "reasonable person" would consent to a therapeutic trial.[72,87] These are guidelines which point the way toward practical, if tentative, solutions to the right-to-refuse-treatment dilemma. What follows here is an attempt to apply these specific notions, as well as those broader principles generated above.

Concretely, I propose that for brief civil commitments (on the order of a week), psychiatrists be empowered to formally declare involuntary patients incapable of making an informed consent to treatment, and then be allowed to treat such a patient for the duration of the commitment, or until the patient regains the capacity to make an informed consent and requests the discontinuation of the treatment. Such a declaration should be formalized via a document as that modeled in Figure 1.

FIGURE 1
MODEL DECLARATION

PSYCHIATRIST'S DECLARATION OF AN INVOLUNTARY PATIENT'S INCAPACITY TO CONSENT TO TREATMENT

(1) This patient (fill in patient's name) _____ has been examined by (fill in physician's name) _____ on (fill in date of examination) _____.

(2) The ground(s) for involuntary hospitalization continue(s). Such ground(s) is/are: (check which one(s) apply) ____danger to others; ____danger to self; and ____grave disability.

(3) I believe the following to be true regarding this patient:
  (a) he/she is presently incapable of making an informed-consent decision regarding his/her own therapy;
  (b) this disability will probably last a significant portion of this involuntary commitment;
  (c) psychotropic medications may be indicated (to control this patient's behavior and/or to facilitate his/her recovery); and
  (d) the risk/benefit ratio of the medications (c) is such that a "reasonable person" would consent to a therapeutic trial.

(4) The patient will be treated over his/her objection(s) only during that period that he/she is incapable of making an informed consent, and in no case longer than the involuntary commitment.

(5) Once the patient's capacity to make an informed consent is restored, even if prior to the expiration time of the involuntary commitment, his/her treatment decisions will be heeded.

(6) This patient has been informed of this declaration, the reasons for it, and the nature and risks of those pharmacologic agents which may be employed. If it is not clinically indicated to inform the patient check here ____.

_____
Psychiatrist's Signature

_____
Date

(One copy of this Declaration is to be filed in the patient's chart and one copy, unless clinically contraindicated, is to be given to the patient.)

At the expiration of the initial period of involuntary treatment, continuing treatment over the patient's objection would depend upon the ground(s) of commitment. For those patients committed on the basis of being gravely disabled (pure *parens patriae* commitments), no

further involuntary treatment would be permitted until the patient had been adjudged gravely disabled and incapable of making informed-consent decisions (and some individual had been appointed to make vicarious treatment decisions).[22] This would be true except for emergencies. Patients hospitalized involuntarily as being a danger to others (pure police power commitments), danger to self (a commitment which draws upon both legal rubrics of *parens patriae* and police power), or any combination of grounds, would be handled differently. For these patients, treatment over objection could continue briefly (another week or so) upon the psychiatrist's again alleging the points in paragraph 3 of the model declaration. Thus, the psychiatrist would need to allege four things if treatment were to continue involuntarily beyond a week: that the patient continues to be incapable of making an informed-consent decision regarding his/her own treatment; that this disability will probably last a significant portion of the duration of the commitment; that medication(s) is/are indicated to control the patient or to facilitate his/her recovery; and, that the risk/benefit ratio of the medication(s) is such that a "reasonable person" would consent to therapy.

These allegations, though similar to those required initially, are slightly different. By changing the wording from "therapeutic trial" to "therapy" in the second document, one is acknowledging that treatment of several weeks' duration is more than a trial. Since a "reasonable person" might accept a "trial" but not "therapy," this distinction is aimed (again) at sensitizing psychiatrists to the importance of carefully considering all involuntary treatments.

These allegations would allow treatment to continue until the commitment expired, the patient regained competence, the patient was declared legally competent, the commitment was disallowed at review, or the second week ran out. More explicitly, the state would have to prevail in three allegations in order to continue involuntary treatment. First, it would have to demonstrate that the patient had a mental disorder. Second, it would have to establish that there remain ground(s) for the extended commitment (that is, that the patient continues to be a danger to self, others, both, *etc.*, as a result of a mental disorder). Third, it would have to establish that the patient lacks the capacity to make an informed consent to treatment choice as a result of the mental disorder. This third allegation is a new one required by this proposal. Where the state prevailed in the first and second allegations only, confinement could continue, but treatment would be limited to the use of those

(22) The informed consent literature continues debating over whether the person appointed (often designated as a guardian or conservator) should try to follow the patient's pre-illness wishes, or should attempt to do what a "reasonable man" would want to do.[88,89] Often, the two would be similar or identical. Yet, such distinctions are of great moment when the treatment is drastic (*e.g.*, major surgery followed by morbidity-inducing chemotherapy to arrest the spread of cancer).[90]

pharmacologic agents to which the patient consented.

All long-term involuntary treatment would be predicated on a judicial finding that that patient was incompetent to make treatment decisions.[23]

This leaves the issue of emergency treatment. As mentioned previously, there is a common-law heritage of decisions involving emergencies. Thus, the term does not need, *de novo,* definition. Judged clinically, there is little doubt that in emergencies physicians need to act in a manner unencumbered from the formal requirements of informed consent. This is what I would propose. Irrespective of a patient's legal status, his/her actual state of competence, his/her judicially determined (hence legal) state of competence, or his/her ground(s) for commitment, treatment should proceed as clinically indicated during emergencies. As is presently the case, sound clinical practice requires thorough documentation whenever emergency care is given. Also, as is presently the case, such treatment is relatively uncommon. For psychotic patients, emergency care could include seclusion, restraint, or pharmacotherapy (it should not include electroconvulsive therapy, adversive conditioning, or psychosurgery).[38,87] Where the patient believes that he has (inappropriately) been treated under the rubric of emergency care, when an actual emergency did not exist, he would be free to bring a civil suit.

## Discussion

The foregoing proposals are complex and thus require some commentary.

For treatment during short civil commitments, the central issue is whether it is sensible to treat patients over their objection(s) prior to a judicial hearing (or some other kind of external review process). I believe such treatment is legally and psychiatrically reasonable when appropriately restricted.

The proposed declaration and the type of civil commitment statute that it contemplates contain a number of such restrictions. To begin with, it is strongly implied by the declaration that the mental disorder being treated is a serious one. Some commentators have suggested only a psychotic diagnosis should qualify one for involuntary treatment.[80]

23. Explicitly then, this proposal would allow non-emergent involuntary treatment under clearly defined and limited circumstances for up to two weeks, the rationale being that such treatment is clinically indicated and that the patient lacks the capacity to meaningfully consent, assent, or refuse because of his/her illness. During that period, the treating psychiatrist would decide the appropriate therapeutic modalities (subject to the usual constraints about ECT and psychosurgery). Specifically unresolved is the question of who should decide on long-term treatment, and how the decision should be made, when a patient is found incompetent of making informed-consent decisions. Appointment of a guardian is the traditional solution. It is, however, a time-consuming and expensive process which often lends the appearance of protection but little protection in fact. That is, many guardians "rubber-stamp" the treatment recommendations of the treating psychiatrist. However, allowing psychiatrists to treat without some kind of review or external affirmation would not appear to be sound.

Further consideration suggests such a view is unreasonably narrow. Where civil commitment statutes couple specific grounds (such as dangerousness to self or others, or grave disability) with the requirement of a mental disorder, a serious condition is required.[24] Nevertheless, some nonpsychotic conditions (drawn from DSM II), including depressive neurosis, depersonalization neurosis, explosive personality, nonpsychotic OBS with alcohol (drunkenness) and adjustment reaction of adult life, can be severe. Further, for the model declaration to become operative, the mental disorders would have rendered the patient incapable of making informed-consent decisions. Sometimes the above disorders would support commitment; yet involuntary treatment would rarely be allowed (*e.g.,* a neurotically depressed, impulsive individual might require involuntary hospitalization to avert suicide and yet be able to make informed-consent decisions regarding treatment with (if vegetative signs were present) tricyclic anti-depressants).

The incapacity to make informed-consent decisions would, in the opinion of the examining psychiatrist, have to last a significant portion of the commitment. This is another manner of limiting the imposed treatment of those patients who have serious disorders.

By limiting the period of involuntary treatment to one or two weeks (depending upon the grounds for the commitment) one carefully circumscribes involuntary treatment. Yet, such periods allow time for judicial determination of incompetence, and (potentially) the appointment of a guardian or the ratification of the treatment plan by an external consultant. Involuntary treatment in general is, however, proscribed.

The fact that certain intrusive modes of therapy would not be covered by the model declaration further delimits the potentially imposed treatments. Excluded would be convulsive therapies, insulin therapy, behavior modifications with aversive techniques, and psychosurgery. These limitations could be enumerated in an additional paragraph in the declaration if one wished.

Several other assurances are evident in the proposed declaration. First, the risk/benefit ratio of the imposed medication has to pass (or more precisely, the psychiatrist has to allege that it would pass) a "reasonable person" test. This is a nontrivial obligation in that the imposed pharmacotherapy must receive scrutiny (in this case by the

(24) Some future court might do well to adopt a portion of the ALI insanity defense definition regarding "mental disease or defect" to the notion of mental disorder.[91] That is, the definition of mental disorder should explicitly exclude psychiatric conditions manifested solely by dangerousness to self or to others, or grave disability.

treating psychiatrist) which meets an external standard. Second, the model document (in paragraphs 4, 5, and 6) contains language to remind both the patient and the psychiatrist that the imposed treatment is time-limited, confined to the period of the patient's incapacity, and that the patient should know of the declaration and about the imposed therapy unless clinically contraindicated. Third, the proposed declaration could be initiated only by a psychiatrist. This may not appear to be as important a safeguard as it is in fact. In many jurisdictions, the initial, short civil commitment can be initiated by a wide variety of persons (*e.g.,* police officers, psychiatric-technicians, nurses, social-workers, psychologists, physicians (generally) and psychiatrists). Many such persons have little formal training in psychiatric assessment and treatment. Thus, the documentary procedure would increase the likelihood of careful, deliberate, and professional evaluation before nonemergent treatment is imposed by guaranteeing the patient a psychiatric evaluation.

Each of the individual limitations discussed above has an important circumscribing effect; yet conventional psychiatric treatments can still be administered (for brief periods) so that therapeutic access is best preserved.

Two largely legal issues remain: how does a patient claiming injury under such a system obtain relief; and, what about those patients who allege religious objections to treatment. Under the proposed system, patients claiming relief would be free to pursue a civil suit. In such a suit they would need to claim that the psychiatrist negligently formed his beliefs (as set forth in paragraph 3 of the model), and/or that the patient recovered his capacity and that the treatment staff negligently failed to recognize this, and/or that they did recognize the patient's renewed capacity and negligently continued the refused treatment. Such a system places the burden of proof on the patient-litigant. I believe this to be a proper weighing of the right-to-treatment-and-right-to-refuse-treatment equities: psychiatrists have to make specific allegations which limit the imposed treatment; patients claiming injury have to demonstrate that the allegations were misapplied.

Detailed discussion of religious objections to treatment are beyond the scope of this paper. However, the reasoning of *Winters* is sufficiently compelling that the problem deserves some attention. Happily, this concern is largely academic than real. The number of patients who voice religious objections to treatment is small. For patients with bona fide religious beliefs, I would suggest that the proposed declaration still be used, but that its effect be limited solely to an initial week or so. Thereafter, imposed treatment would require a court-adjudicated determination of incapacity to consent. By so narrowly limiting the effects of the declaration, the constitutional burden might well be met. It is important in this context that civil commitment and treatment under the proposal are only available for what one might term quasi-emergencies. That is, where the patient is ill, incompetent, and

dangerous or disabled.

To recapitulate: I believe the proposed declaration makes a reasonable and necessary reallocation between the sometimes competing equities of patients' rights and patients' welfare.

The other major issue is that of allowing the effect of the proposed declaration to be extended beyond the initial period of a week (or so). Is this reasonable; does the proposed differentiation between pure *parens patriae* commitments, (where such extensions would not be allowed), and all other commitments (where they would be), make sense; is the proposed time period, of an additional week, reasonable?

As implied in the proposals section, the ostensible rationale for allowing a treatment extension (via an additional declaration) is to insure that violent patients have access to treatment until a comprehensive adjudication can take place. Treatment discontinuities are apt to be more deleterious (with the patient and/or other patients and/or staff potentially being injured) with dangerous patients than with nondangerous ones. Further, the first period of one week corresponds roughly to many states' initial duration of commitment or pre-commitment. Until the next level of commitment is reached, judicial review is often rather limited. Typically, at least a week is required to schedule a hearing in a contested commitment case. Still, short commitments make good legal sense: man's liberties should not be infringed upon lightly. Psychiatrically, however, they are problematic: some of the major pharmacotherapies (*e.g.,* tricyclic antidepressants) have scarcely begun to be effective within the period of commitment. Further, with some therapies (*e.g.,* Lithium) a cessation of treatment for several days means that the therapeutic clock is reset at zero. In terms of treatment there is ample reason to extend therapy briefly into the next level of civil commitment (pending formal adjudication) if the extension is brief. Legally, of course, the question is whether such an extension is warranted or justifiable. The answer depends both upon the limitations placed on treatment and the nature of the commitment.

As previously explained, the protection involved in extending the proposed declaration is considerable, including: the time limit of one week; the actual process of the psychiatrists rereading and re-signing a new document; the new allegation that the patient's incapacity will last a significant portion of the extended commitment; and altering the wording of the "reasonable person" test in regard to therapy. Further, the protections contained in the original declaration persist: that involuntary therapy will continue only so long as the patient's incapacity continues, that the patient will be informed of the document and the proposed therapies, and that certain therapies will not be imposed. Upon which patients then may additional therapy be properly imposed? The two extreme cases, patients who are dangerous to others and those who are ill and in need of treatment but not dangerous, are the most clear. The state's police power interest in those patients who are

dangerous to others is manifest. Under the proposed systems, dangerous, ill, incompetent patients could be treated for up to two weeks.

The proposed system is open to criticism. In requiring alleged incompetence before treatment can be imposed it assumes a "libertarian" stance. To be sure, dangerousness is difficult to predict; probably impossible over the long term given the present state of the art.[92] It is, therefore, legally and ethically unclear whether treatment for dangerous, ill, but competent persons can properly be imposed.[93] Thus, any proposed system should probably err on the side of no treatment. This is what the proposal does. Still, it would be naive not to observe that some patients who are, in fact, competent may be unjustly treated under the rubric of their alleged incompetence.

The courts and legislatures need to take a clear stance on the problem of imposing treatment for dangerous, ill, competent patients. That has not happened yet, and, until it does, treatment without medication[24] and confinement for limited periods is probably the most reasonable alternative.

For nondangerous, psychiatrically ill, gravely disabled patients, one might argue that any imposed treatment is improper until incompetence is adjudicated. A more moderate approach would allow brief, circumscribed treatment. I would argue for such a viewpoint on practical grounds. First, the distinction between self-harm by act and by failure to act is often difficult. Consider the schizophrenic patient walking in traffic lanes on the expressway. For that patient the essence of distinction concerns intent. Yet if the patient is mute or has floridly loose associations, intent will be nearly impossible to ascertain. Second, some nondangerous patients will have transitory organic brain syndromes (*e.g.,* post-phencyclidine ingestions) which remit within a brief period. Medically, some of these patients are apt to require sedation for optimal though not emergent management. Third, ward administration is eased if patients in similar classes (*e.g.,* all those who are being detained on the first brief commitments) are treated similarly. If one grants that nondangerous, ill patients should potentially be able to be treated, then the question is at what point does one stop treatment, pending adjudication of incompetence. The proposed period, at the end of a week or so, is reasonable because at that point many organically ill patients will be stable, and because further assessment will have enabled staff to more fully ascertain the issues of diagnosis, treatment, and whether (though not part of the initial commitment) dangerousness is a concern.

This leaves the suicidal patient. Commitments for these patients fall under the combined rubrics of *parens patriae* and police power so that the proper legal course is not immediately evident. The reasoning here is best analogized to the case of the patient who is a danger to others. Theoretically, both kinds of patients could be "managed by the use of restraint pending adjudication of incompetence." If involuntary

treatment is judiciously imposed (it is to be hoped that psychiatrists would not treat every patient they could "legally" treat and, instead, would weigh the specific costs and benefits of imposing treatment) it would be used only when significant harm could be avoided by treatment. In such circumstances, I believe it is more humane to allow treatment. Obviously this is a personal value, but one which is widely validated in the profession.

What about combined commitments, where the person is alleged to be manifesting dangerous, as well as nondangerous, behavior? Having proposed that dangerous persons, whether dangerous to others or themselves, can be briefly treated beyond the initial commitment, it would follow that the presence of additional nondangerous conduct should not change the result. Put succinctly, police power interests should prevail. The presence of nondangerous behavior, in addition to dangerous behavior, should not vitiate the above rationales.

## Conclusions

The foregoing discussion has suggested that the traditional manner of treating psychiatrically ill, involuntary patients over their objections must give way. In its stead a new model is offered in which psychiatrically determined incompetence is important. Where incompetence is alleged, brief treatment is permitted, though certain therapeutic modalities are prescribed. Following this initial treatment, a distinction is drawn between those patients for whom the state has only a *parens patriae* interest, and those for whom the state has some police power concern. For the former, treatment may not be imposed further until a formal adjudication takes place, and then, only if incompetence is found. For the latter, treatment may be imposed for a brief additional period, until the matter of the patient's incompetence can be adjudicated. Under the proposed system the state would have to prevail in two allegations when longer term commitments and treatments were contemplated: first, that the ground(s) of the civil commitment continue; second, that the patient's incompetence makes treatment, even if refused, permissible. Emergency treatment could continue, but, as the name implies, only in rare circumstances.

The proposed system is designed to reallocate the present right-to-and-right-to-refuse-treatment equities. The traditional mental commitment approach — where physicians declare that the patient is ill, allege the presence of certain legal grounds, and treat as clinically indicated — is thus altered to focus awareness onto the patient's capacity to consent. Ideally, such a system should increase psychiatric sensitivity to the perspective that what is best for the patient's illness is not necessarily best for the patient as a whole. Ideally, too, the proposed system would

reassure the mental health bar that psychiatrists generally are not interested either in imposing treatment or in acting as jailers.

Where the competing equities are compelling, reasonable persons may differ as to where the best balance of interests is to be achieved. It is to be hoped that open disussion of these issues will stimulate more creative approaches to the vexing problems which still permeate the civil commitment arena.

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