

Realism and Drug Refusal: A Reply to Appelbaum and Gutheil

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Appelbaum and Gutheil recently published in the **Bulletin** an appropriate call for research relevant to issues raised by the dispute over the legal right of committed mental patients to decline treatment.¹ In support of their call, they described their own limited study of refusers and discussed the right to refuse medication dispute in light of what they regarded as the "clinical realities" of the situation. Certainly, empirical information would be of immense value in addressing the morass presented by the refusal issue, but I believe that Appelbaum and Gutheil have, in their effort to emphasize the clinical perspective, done injustice to other concerns and that further research should not proceed in the absence of greater sensitivity to these concerns.

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Appelbaum and Gutheil urge that objections to unlimited medical authority to medicate involuntary patients are based to a large extent upon factual errors or, at best, oversimplifications. Further, they conclude that their own research suggests that the interests purportedly protected by the right to refuse medication are seldom at issue in refusal situations, at least from the patients' perspective. I propose to demonstrate that the most serious objections to unlimited medical authority are not as easily disposed of as Appelbaum and Gutheil suggest and that their evaluation of the interests raised by refusal situations understates the importance of refusals. I then proceed to suggest other issues in the medication refusal debate, which should figure prominently in any future research undertaken in the hope of addressing this important issue in a more informed fashion.

I. [Mis]conceptions Regarding Psychotropic Medication

To a large extent, the refusal debate must involve a balance between the intrusion upon resisting patients' interests and the benefits to be derived from unlimited medical authority in this area. Recognizing this, Appelbaum and Gutheil address a number of what they perceive to be misconceptions that lead to an underevaluation of the value of unlimited medical authority.

Undoubtedly, they are to some extent correct and their efforts at identifying misconceptions are a useful contribution to the debate. For example, they quite properly suggest that those who deny the existence of any scientific evidence supporting the effectiveness of psychotropic medications and those who regard such medication as inherently "brainwashing" patients' minds into "alien states" or as rendering patients docile and easily-managed robots are ignoring a great deal of reliable factual information, but identification of these gross misperceptions regarding medication does not end the inquiry. In pursuing the matter, however, Appelbaum and Gutheil artificially emphasize some matters and unrealistically ignore others.

A. Psychiatrists' Motives

Appelbaum and Gutheil perceive as "perhaps the most serious misconception" an ascription of motives of "greed, power and sadism" to psychiatrists seeking to medicate resisting patients. While some have no doubt engaged in such ascription, serious debate on the refusal issue rises above this level. As vigorous an opponent of psychiatric coercion as Szasz has urged that debate not become bogged down in dispute regarding psychiatrists' motives.² Serious discussion of the refusal issue must proceed on the assumption (which I regard as consistent with fact) that those psychiatrists who do or want to medicate resisting patients are motivated by a sincere belief that such medication is in the best interests of the patients and consistent with their own legal and ethical responsibilities.

B. Realities of Public Mental Health Care

Appelbaum and Gutheil correctly conclude that reasonable empirical support exists for the proposition that psychotropic medications are not inherently sedative or nonspecific, but they fail to address the additional concern that cannot be ignored in any discussion concerning the use of these drugs in practice and in the delivery of public institutional mental health care in particular: To what extent in actual practice are the medications used in a manner consistent with the degree of skill shown in the scientific research? Medications capable of being used without sedative side-effects for specific diagnostic syndromes may be used with sufficient ignorance or carelessness that, as a practical matter, they become nonspecific and extensively sedative.

It seems quite likely that the real world of public institutional care involves delivery of care on different bases than the delivery of care studied in many of the "scientifically rigorous studies" relied upon by the authors. Even if psychiatrists of the skill and training of those who participated in the studies constituting the literature pose insufficient risk of "unscientific" use of psychotropic medication, understaffed public hospitals are a different situation. American Psychiatric Association President Dr. Donald Langsley recently stated: "Many, if not most, of the medical staff [of State mental hospitals] turn out to be poorly trained in comparison with psychiatrists from other settings."³

This is a general problem with Appelbaum and Gutheil's approach—they appear to give no serious consideration to the danger that clinical practice in the public mental health system may be different than the practice evaluated in the scientific literature. It seems clear, however, that actual practices falling far short of clinical ideals are an important factor in persuading courts that legal limits upon the use of medication are required. In *Davis v. Hubbard*,⁴ for example, the court described the picture drawn by the witnesses as follows:

[T]he testimony at trial established that the prevalent use of psychotropic drugs is counter-therapeutic and can be justified only for reasons other than treatment — namely, for the convenience of the staff and for punishment . . .

Psychotropic drugs are . . . freely prescribed . . . by both licensed and unlicensed physicians [who] . . . regularly prescribe drugs for any patient in the institution without regard to whether he is personally assigned to the patient or whether he has even seen the patient. It is not unusual for attendants to recommend a certain dosage or increased dosage. Such recommendations are often accepted by the physician without having examined the patient. Further, when dealing with an especially disturbed patient, attendants can obtain additional medication by submitting appropriate forms to the pharmacy when there is no physician available. Also, drugs are at times prescribed to be given PRN, or "as necessary." When this is done, an attendant may request medication without review by the authorizing physician.⁵

C. Prediction of Effects of Nonmedication

Citing research on the natural history of severe untreated mental disorders, the authors challenge the perception of psychiatrists as unable to accurately predict what will happen to a patient who is not medicated. This research involves the ability to anticipate changes and deterioration in a patient's clinical condition. For the refusal issue, however, the emphasis must be upon the further question of the failure to medicate upon those characteristics of the patient that are relevant to the right to compel treatment. At a minimum, a right to compel treatment springs into operation only after a person is found to meet the jurisdiction's standards for "commitment" or other compelled treatment. It follows that the right to treat persons who meet these standards is limited to treatment reasonably designed to restore them to a situation in which they no longer meet the relevant standard. It is not a right to treat them in any way that is clinically indicated by their "best interests." What should be at issue, then, is the ability of psychiatrists to predict whether nonmedication will cause patients to come within that group the law defines as subject to involuntary treatment.

Despite the plethora of recent litigation concerning civil commitment criteria, there remains substantial variation among jurisdictions concerning commitment standards and uncertainty as to what limits Federal (and State) constitutional doctrines have upon the criteria that State legislatures may constitutionally adopt.

1. Dangerousness Standards

The trend seems clearly to be towards utilization of a commitment standard requiring that the proposed patient pose a risk of serious harm to himself or others. Schwitzgebel⁶ found 28 jurisdictions using such a standard and reported that nine of these adopted such a standard between January, 1976 and September, 1977. Under such criteria, the most important question is the ability of psychiatrists to predict the impact of nonmedication upon the risk which the proposed patient poses of self-destructive behavior or assaultiveness directed at other persons. Only if psychiatrists are able to acceptably determine the effect upon this characteristic of proposed patients of nonmedication has a legally-relevant effective ability to predict been established. A variety of considerations other than the proposed patient's present clinical condition undoubtedly affects the proposed patient's dangerousness. It certainly does not follow from clinicians' ability to predict the course of this clinical condition that they are also able to acceptably predict the proposed patient's dangerousness.

2. Need for Hospitalization Standard

Even if it is assumed that the legal standard makes the proposed patient's general "need" for hospital treatment a relevant (or possibly controlling) consideration in compelling treatment, the authors' emphasis misses the mark. The proposed patient's clinical condition and its course of development are unquestionably relevant to this issue, of course, but also involved

are such nonclinical matters as the circumstances to which a proposed patient would return if not hospitalized and the events that may occur involving the proposed patient in the community. The ability of psychiatrists to predict such events and circumstances and to evaluate the result of their interrelationship with the patient's clinical condition may well be quite less developed than the skills addressed in the cited research. Perhaps more directly relevant to the refusal issue is the research suggesting that hospital staff persons are not better able than courts or patients themselves to determine when continued hospitalization will increase the likelihood of favorable adjustment to the community upon discharge.⁷ Evidence of the absence of special expertise on this issue suggests that concerns regarding psychiatric expertise on the issues most relevant to the refusal debate are not as ill-founded as the authors suggest.

3. Practical Realities

In addition, the authors again ignore the likelihood that practice in the real world of public institutional care will not live up to the expectations created by carefully designed research studies. Dr. Langsley's recent comments⁸ on the State hospital system, noted above, also noted the frequency with which physicians in State hospitals have backgrounds creating great cultural (and sometimes language) gaps between them and their patients. This and the frequent failure to integrate state hospital programs with community programs and followup care suggest that the ability of state hospital staff members to predict the course of an impaired person's future is probably less than what might be attainable under more adequate conditions. Again, it is reality that must be accommodated in setting legal and public policy.

D. Risk/Benefit Balance

Characterizing legal discussions as assuming that psychotropic medications are "unusually dangerous and toxic" and that the risks of such medication are "gregiously" out of proportion to the benefits, Appelbaum and Gutheil counter that the overwhelming preponderance of the available data indicates a "high" benefit/risk ratio for such medications, but their characterization of the issue obscures two distinct subquestions.

The first is whether legal debate overstates the side-effects and risks of the treatment. Some matters—such as the incidence of tardive dyskinesia in a population of patients who have received long-term medication therapy—should be capable of statement in precise objective terms whose accuracy can be easily evaluated. In practice, however, the information necessary to state definitive conclusions on these matters is often lacking. To the extent that legal discussions misstate the results of reliable research on these matters, of course, they cannot be defended, but evaluation of the side-effects and risks also involves a more subjective evaluation of the

importance of these matters. It is difficult to be objective in one's evaluation of statement of risk that rests in part upon such assessments. How significant a side-effect is must rest in part at least upon the subjective perspective of it by the patient. Whether or not patients' fear of ECT, for example, is objectively justifiable, the existence of that fear and the discomfort it causes cannot be ignored in evaluating the intrusiveness of ECT as a treatment modality. Inquiry should include the availability of information concerning the manner in which involuntarily medicated patients perceive the impact of their treatment, especially the side-effects. Despite the evidence cited by Appelbaum and Gutheil, many patients may—albeit sometimes wrongly—perceive medication as presenting a low risk/benefit ratio and thus experience significant and relevant apprehension and discomfort from its administration. Many of the legal discussions cannot be as easily dismissed as objectively inaccurate as the authors suggest.

The second subissue involves the relevance of much of the collected data to present or future public hospital practice. If careful administration and monitoring of medication can produce an objectively high benefit/risk ratio, as Appelbaum and Gutheil suggest, it may still be the case that given the inadequacies of public institutional care delivery, the practical ratio—which the patients experience in practice—will be far less favorable. There is no need to quarrel with their assertion that most psychotropic drugs are relatively poor sedatives. What is important is whether those actually administering and supervising the use of medications in the public mental health system are able and willing to use the care and skill necessary to prevent what sedative effects the medications can produce, or whether—intentionally or not—there is a practical danger of uncritical acceptance of sedating side-effects as useful in addressing management problems.

E. Less Intrusive Alternatives

Appelbaum and Gutheil suggest that legal discussions often naively assume that "second rank" — and presumably less intrusive — treatment modalities are "consistent with ethical standards of medical practice." This is a puzzling statement, because it seems to suggest more than that legal discussions overstate the availability of alternatives. The authors may be indicating that legal discussions proceed on the basis that alternatives should be used which a sensitive psychiatrist would regard as ethically inappropriate. Is this because the alternative is so less likely to be effective that the physician's ethical duty should preclude him or her from rendering it available? If this is the meaning, the statement ignores the significance of the patient's preference. If a patient prefers to sacrifice the greater efficiency of certain treatments as the price for avoiding other results of them, do ethical considerations preclude the physicians from rendering the treatment of the patient's choice? If so, the analysis has sub rosa determined that the patient is not entitled to participate in the choice of treatment, but that is the basic issue.

The authors criticize legal discussions as failing to recognize that, given the rapidity of discharge possible with drug treatment, drug treatment may be a less restrictive alternative, but this ignores the patients' perspective, and assumes that objective "restrictiveness" is the sole or major consideration. Privacy considerations are best regarded as protecting patients' interests in receiving the least "intrusive" treatment. While restrictiveness is certainly a factor in evaluating intrusiveness, it need not be the only consideration and the decision may be a largely subjective one. The authors do not address why a patient's own evaluation should not be respected or considered. While they may regard a short period of institutional drug treatment as less intrusive than a longer period of institutional care involving other treatment methods, a particular patient might not agree. The focus should be on relative intrusiveness, with emphasis upon the patients' perspective, rather than on merely duration of institutionalization.

Physicians may, of course, have professional and ethical concern regarding the provision of what they regard as less than the "best available" care, but the significance that must be given to this concern must be evaluated in light of the context in which it arises, the provision of **involuntary** care and treatment. In a private contractual patient-physician relationship, a physician may certainly decline to provide care unless the patient agrees to (and does) follow the physician's recommendations concerning treatment regimes, but where the physician is acting as agent of the State and providing care contrary to the expressed desire of the "patient," it is at least arguable that the controlling considerations are far more "legal" in nature than is true in the private relationship context and, therefore, the physician's clinical judgment as to the effectiveness of alternative courses of proceedings is entitled to less weight.

Perhaps more important, however, is that the authors again ignore what may be practical reality. Given financial and other considerations, it is not unreasonable to speculate that a significant number of patients hospitalized under medication regimes could, if community-based treatment programs were available, be enabled to lead a less restricted and perhaps more self-rewarding life. To the extent that the availability of medication makes institutionalization an "acceptable" method of dealing with these patients, it may prevent the development of an incentive for broader use of these alternatives, alternatives that may already be available to affluent patients. Perhaps the ethical issue is precisely the opposite of that posed by the authors: May a physician ethically participate in the provision of a program of institutional care with medication where there is some possibility that respecting the patients' desire to avoid medication might stimulate the development of less intrusive programs?

F. Patients' Interests Involved

Turning to the policies sometimes offered in support of a right to decline medication, Appelbaum and Gutheil engage in an empirical inquiry into the

extent to which the interests underlying these policies were actually involved in the studied patients' efforts to avoid medication; 23 patients who engaged in a total of 72 episodes of refusal in a 40-bed inpatient unit over a period of three months were studied. After examining the reasons articulated by the patients for resisting medication, the authors question whether those interests which the law seeks to protect were actually at stake in most instances of refusal.

No patient, the authors note, claimed that medication would encroach upon his or her freedom of speech or thought and none "raised" the "issue of medication as punishment." To the extent that the authors suggest that the failure of patients to articulate their objections in legal terms means that the interests which the law seeks to protect are not endangered, the analysis misses the mark seriously, but in regard to the most significant legal doctrine, the right of privacy, the authors do not pursue this approach and, instead, look at whether the reasons articulated by the patients might reasonably be regarded as raising interests protected by the right of privacy.

The authors' conclusion that 23 of the 46 reasons articulated by the patients raised privacy concerns confirms the trend in the caselaw to regard the right of privacy as the major legal foundation for a right to resist certain forms of treatment, but Appelbaum and Gutheil seem not to have a well-structured notion of privacy. At one point, "mental privacy" is defined as "a freedom from unwarranted interference with the generation of . . . thoughts." Whether or not this is an acceptable definition of "mental privacy," the privacy that is at issue in drug refusal situations is a broader concept. While it is admittedly elusive, privacy can best be defined as an interest in being free of physical intrusions into or upon the body and of anxiety-producing stimuli. The authors appear to covertly recognize this, because they categorize objections to side-effects and even "angry" responses as involving privacy interests, but a more structured conceptualization of privacy would have been useful.

The authors suggest that an individual has no legitimate interest in having a psychotic thought process remain free from intrusion, and that, therefore, the right of privacy should not be defined so as to respect refusals that are related to such symptoms. There may well be merit in this claim. The fact of commitment reflects a determination that a patient's illness sufficiently intrudes upon social interests to justify intervention. If a patient's resistance to a particular kind of intervention is clearly one symptom of that illness, it can be argued that the commitment decision necessarily involves a determination that the patient's interest in choice is not entitled to protection, but as the Appelbaum and Gutheil study demonstrates, determining whether this is the case is difficult. Of the 23 refusals resting upon what the law would regard as privacy interests, 10 were found to have a delusional core; it is not unreasonable to regard these as involving no interest legitimately protected by privacy, but the authors disclaim an ability to determine whether seven of the 23 — almost a third — were

similarly based and conclude that five were justified objections to side-effects. Despite the fact of commitment, reasonable regard for personal integrity suggests that a person's choice be regarded as the product of a thought process entitled to protection unless convincing evidence of the opposite is brought forward. Appelbaum and Gutheil seem to have established that legitimate privacy concerns were raised with significant frequency in the studied population: over half of the 23 refusals based on potential privacy concerns (apparently constituting half of the 46 reasons studied) could not, even with their investigation, be determined to be symptomatic, and thus beyond the bounds of actual privacy concern under this approach.

On the other hand, all five of the patients whose refusals continued for 24 hours or more were categorized by the authors as symptomatic. Given the authors' conclusion that the brief refusals of the other patients did not have serious clinical consequences, the study does suggest that those refusals prolonged enough to raise clinical problems — and thus to stimulate a clinical motivation to exercise available override authority—may tend more than other refusals to be beyond the boundaries of legitimate privacy concern. This, of course, suggests that in those cases with most legal significance legitimate privacy concerns may be quite infrequent. The possibility clearly deserves further investigation.

II. Further Refusal Issues

Whatever the defects in their analysis, the emphasis by Appelbaum and Gutheil upon the need for empirical information bearing upon refusal issues is obviously appropriate, but they do not pinpoint a number of major areas of concern posed by the "refusal" caselaw as desirable targets of empirical research. This section attempts that task.

If unrealistic and polarized positions are ignored for the moment, the refusal debate can be seen to involve two basic questions: (1) Under what circumstances, if any, should a patient's refusal to consent voluntarily to medication be given effect? and (2) How should the decision be made as to whether or not a given patient's refusal meets this standard? The first is a "substantive" question because it addresses the substance of the patient's right to be free from compulsory medication. The second is a "procedural" question, because it addresses the way in which the substantive criterion is to be applied in individual cases. The traditional approach has been to rely on treating mental health professionals to resolve both matters, i.e., to develop and apply a criterion for determining whether and when to override patient objections. Identification of those issues demanding empirical information requires an analysis of how the caselaw has addressed both the substantive and procedural questions posed by the refusal issue.

A. Criterion for Overriding Objections

Many recent cases have recognized a general right to refuse treatment by

medication, subject, however, to exception in certain circumstances. There is little agreement, however, concerning when the patient's objection can be overridden. *Goedecke v. Colorado Department of Institutions*⁹ and *In re K.K.B.*¹⁰ appear to hold that only if a committed patient is found incompetent can articulated objections be overridden. *Goedecke* described the standard for determining competence as requiring, for incompetence, "That the patient's illness has so impaired his judgment that he is incapable of participating in decisions affecting his health,"¹¹ but other decisions suggest the matter is more complicated.

*Rennie v. Klein*¹² held that, in nonemergency situations, even a competent patient's objection could be overridden if the patient presents a sufficient danger of physical harm to patients and staff members of the institution. The decision to override a patient's objection on this basis must be the result of consideration of four factors: (1) the physical threat posed by the patient to staff and patients; (2) the extent to which the patient retains, despite his impairment, a capacity to decide whether to undertake a particular treatment; (3) the existence of any less restrictive or intrusive forms of treatment and (4) any risk of permanent side-effects that exists.¹³ Incompetent patients may be treated pursuant to "proper consent . . . obtained in accordance with State law," but at the request of the Patient Advocate and despite such consent, the propriety of overriding an incompetent patient's consent must be reviewed using the four-part criterion.¹⁴

Under *Rogers v. Okin*,¹⁵ at this point probably the "leading" drug refusal case, a patient's objection to medication can be overridden in a nonemergency situation only upon determinations that the patient is incompetent, i.e., that he lacks the capacity to decide for himself whether he should take the drugs,¹⁶ and that he would decide to accept the medication were he competent to make such a decision.¹⁷ *Rogers*, as the other cases, recognizes the need for flexibility in emergency situations. No determination of incompetency is necessary where the patient poses a threat of violence to himself or others. In this situation, a decision as to whether or not to medicate over objection is to be made by considering "The possibility and type of violence, the likely effects of particular drugs on a particular individual and an appraisal of alternative, less restrictive courses of action."¹⁸ Where failure to medicate could result in significant deterioration of the patient's mental health, some procedural expedition may be permitted, but overriding the patient's objection still requires a determination that the patient is incompetent.¹⁹

The *Rogers* approach seems to have been quite closely followed in *David v. Hubbard*,²⁰ holding that absent a determination of incompetency, compelled medication is permissible only upon a determination that probable cause exists to believe the patient presently violent or self-destructive and in such a condition as to present danger to himself, other patients or the staff.²¹

The caselaw, then, reveals no general agreement on the criteria that can or must be applied to determine whether refusals may be overridden. On the

most fundamental level, disagreement exists as to whether, in nonemergency situations, a determination of incompetency is always necessary. *Rogers, Davis* and other cases suggest so. *Rennie*, on the other hand, holds that a patient's risk of physical harm to the patient or others may be sufficient, in some situations, to justify nonemergency, compelled medication of a competent patient. The rather vaguely defined emergency exceptions recognized in the other cases may functionally lead to the same result, however.

Where competency is the standard, the criterion for determining competency may be ambiguous in practice. The nature and seriousness of impairment required by the competency standard is less than obvious. Moreover, a further determination must be made following a conclusion of incompetency that poses perhaps greater difficulties. It is unclear whether the patient's objections can be overridden upon a determination that medication is medically indicated or whether some more complex inquiry is necessary. *Rogers* appears to hold that an effort must be made to decide the matter as the patient would if competent. This may raise significant problems, especially concerning the weight to be given views which the patient has held or does hold. In *In re Boyd*,²² the court held that in the making of such a "substitute judgment" concerning medication of a patient who had before becoming incompetent expressed a religious objection to treatment by medication, the decision-maker should assume that the patient, if competent, would still refuse medication on religious grounds. Apparently experiencing some discomfort from this position, the court stressed that this approach was necessary only where the patient's previously held views were "absolute" and there was no evidence of "vacillation." Moreover, the court's opinion was limited to situations in which the patient's life was not at stake, although there seems little conceptual difference between refusal situations where life is endangered and those in which it is not.

If religious preference must be taken into account, what about other views held by the patient? Should a patient's cultural attitudes towards medical treatment in general or mental health treatment in particular be considered? Is it possible to determine with reasonable accuracy whether such views (and perhaps religious views as well) are held independently of the patient's impairment? What effect should be given to the patient's present articulation of his or her views?

In making the necessary choices involved in formulating the criterion, empirical information would be useful. In regard to applying the competency analysis, are difficult questions posed by the inquiry into the effects of patients' impairments upon their ability to address and consider whether to submit to medication? Appelbaum and Gutheil suggest an affirmative answer. Of the 23 refusals perceived as based upon privacy interests, the authors concluded that they could determine with reasonable confidence that 11 were sufficiently related to the patients' impairments to be the results of incompetent thought processes, but in regard to seven others, no conclu-

sion could be drawn. It is unclear to what extent the investigators' difficulty was due to imprecision or ambiguity in the definition of competency (or its equivalent) rather than the inherent difficulty of applying even an entirely satisfactory standard to difficult-to-ascertain facts. The matter clearly deserves further examination, but the study suggests, at least, that even the standards embodied in the recent court decisions may be inadequate to produce a sufficient number of reliable determinations as to whether objections can properly be overridden. Further, information would be useful concerning the sorts of problems, if any, presented when a substitute decision criterion requires that the decisionmaker take into account religious and other views held by the patient that are not part of the symptoms of his pathology.

Perhaps of even greater importance is the effect of requiring a determination of incompetency for overriding objections in a nonemergency situation. Such information is essential to evaluating the propriety of the **Rennie** position that even the objection of a competent patient can be overridden on the basis of danger to others in the institution. It would also be useful in addressing whether even broader exceptions to the requirement of incompetency might be appropriate; perhaps the need to reduce the dangerousness of even a competent patient after discharge should in some circumstances justify overriding that patient's objection to medication.

Inquiry must focus upon the results of applying various criteria. Do competent resisting patients ever pose significant threats to the safety of patients and staff that could be reduced or eliminated by medication? If so, how often? Are competent patients who resist medication retained longer in institutions because of their refusal to submit to medication, and, if so, at what cost? Are patients ever discharged under circumstances in which the risk they pose of violence to others after discharge would be significantly reduced if they had been compelled to submit to medication during hospitalization? Such information would bear directly upon the issues presented by the need to formulate a criterion for determining when a patient's articulated objection can or should be overridden.

B. Procedure for Applying the Criterion

Development of a standard for determining when patients' objections can be overridden is only the first step. Application of the criterion to particular patients whose objections may be subject to being overridden poses significant procedural problems. Once it is determined that the right to be free from compelled medication is sufficiently important to invoke due process protection, the issue becomes a classic due process one and needs to be approached by means of traditional analysis.

1. Due Process Analysis

Under due process cases such as *Matthews v. Eldridge*,²³ several considerations are relevant to determining the procedural requirements in

situations such as the medication refusal one. First, the right of erroneous decisions that is created by the existing state of affairs—relegating the matter to treatment clinicians—must be considered. Second, this risk must be compared to the risk that would be presented under various other methods of structuring the decision-making process. Third, the reduction in risk of error must be evaluated in light of the importance of the interest at stake (the right to be free of compelled medication) and the interference, if any, that alternative procedures would involve upon the government's legitimate interest in providing, with reasonable efficiency and effectiveness, treatment over objection to those patients who are appropriate subjects for it.

2. Objections to Traditional Reliance Upon the Treatment Psychiatrist

The threshold difficulty in applying this due process analysis is that we know little or nothing of the risk of error under either an approach that relies exclusively upon treating clinicians or various alternatives. There are, however, several reasons to suspect that relegation of the matter to clinicians may involve an unacceptable (even if unascertained) risk of error. First, it may well be that clinicians have not, in fact, developed, articulated or acknowledged a criterion for making the decision that is consistent with the criterion required by constitutional considerations. It is likely that, in the past, these decisions have been made largely on the basis of an intuitive clinical judgment as to what is "best" for the patient. To the extent that this is so, the criterion does not address the patient's competency or what the patient would desire if competent. While the difficulties of applying or even articulating a satisfactory criterion should not be underestimated, a practice that fails to specifically address these vital matters cannot be relied upon to produce acceptable accuracy.

A second reason is that treating clinicians' concern for what, in their view, is dictated by the patients' "best interests" may disable them from objective application of a criterion that compels consideration of other, perhaps inconsistent, matters. This concern is reflected in the analogous situation of law enforcement searches, where Fourth Amendment law assumes that even capable, expert and conscientious law enforcement officers involved in a focused investigation may, by virtue of that involvement, lack the objectivity necessary for an acceptably accurate judgment as to whether there is sufficient justification for a search involving a serious intrusion into the subject's privacy.²⁴

Finally, it can be argued that application of a criterion that is consistent with constitutional requirements involves at least some matters beyond mental health professional expertise, and, consequently, mental health professionals' clinical or treatment skills cannot be relied upon to produce acceptable accuracy. Inquiry into a patient's formerly held religious beliefs, the strength of those beliefs, and whether they would have continued had

incompetency not intervened, for example, may well be without the area of expertise of even one with acknowledged skills in diagnosis and treatment of mental illness. The final process of balancing various conflicting considerations is a matter upon which others may claim equal or superior skill as compared to a mental health professional. Some of the relevant considerations are within the realm of unquestionable clinical expertise, of course, but this does not mean that the final decision-making process is as well.

3. Alternative Approaches

There are a number of procedural alternatives to the traditional reliance upon the treating mental health professional that might be considered. These can usefully be categorized according to the locus of the decision-making authority, and can be arranged on a continuum which removes that authority further and further from the treating mental health professional. Evaluation of these alternatives should involve at least two considerations. First, the further removed the decision-making authority is from the treating physician, the less "expertise" and familiarity with the case is likely to exist in the decision-maker. Second, removal from the treating physician also is likely to increase the objectivity of the decision-maker. Perhaps the task is one of determining the optimum balance between objectivity, on the one hand, and expertise and familiarity with the case (and others like it) on the other.

The major alternatives that need to be considered, arranged in order of their increasing removal from the treating psychiatrist, are as follows:

(1) Structured internal administration. The decision might be left within the domain of the treating mental health professionals, but sufficient structure required so that the decision is not one solely of a treating physician. Thus a decision by a staff, perhaps defined as involving several professionals from psychology as well as psychiatry, might be required. This would, of course, tend to meet the objections based upon potential bias on the part of the psychiatrist with the most direct involvement in providing treatment. It would spread the responsibility for decision-making among various professionals, and therefore might well serve to balance or neutralize subjective bias on the part of any one person. To the extent that the group deliberative process resulted in preliminary discussion, the process might focus more directly upon alternatives and considerations tending to escape the attention of a single psychiatrist making the decision in the hurry of the treatment process. On the other hand, such an approach would leave the application process in the hands of professionals with no demonstrated expertise on the ultimate balancing decision and on some of the subissues involved. Thus, a major aspect of the underlying concern would not be addressed. The recent Supreme Court decision in *Parham v. J.R.*²⁵ takes this approach in a somewhat different context. The admission of a minor, at parental request, to a psychiatric facility was held to require due process, but the Court held that, in view of the clinical needs raised by the situation, due process was satisfied if the staff of the admitting facility determined that admission was

appropriate.

(2) External administrative decision-making. Reliance may well be placed upon decision-makers who are clinical personnel, but due process may require that those clinicians making the critical decisions be removed from direct responsibility for the treatment of the patient. Such an approach addresses some of the concerns expressed earlier, especially those involving potential impairments of objectivity created by personal or professional involvement with the patient's "best interests." It does not, of course, address considerations based upon general clinical orientation or the absence of training or education in legally required considerations. This sort of approach was embraced by the District Court in *Rennie v. Klein*,²⁶ which required that the decision to override a patient's objection to medication be made by an "independent" psychiatrist following an informal hearing. The administrative cost and inconvenience of such an approach is almost certain to be less than that involved in some alternatives, and decision-making is left in the hands of a presumably skilled and conscientious clinician. *Vitek v. Jones*,²⁷ addressing the due process requirements for transfer of a prison inmate to a psychiatric facility, suggests Supreme Court receptivity to this approach. In *Vitek*, the court rejected the argument that a judicial hearing was necessary for such a transfer and required only a somewhat structured hearing before an "independent"—but not necessarily judicial—decision-maker.

(3) Judicial decision-making. Provision might also be made for some or all of the critical decisions in applying the standard to be made by a judge. This, of course, would place decision-making authority in the hands of one who might be more sensitive to and expert in the sort of balancing process required by application of the standard. On the other hand, it may be that the judicial process is time-consuming and that—as Appelbaum and Gutheil suggest—it is insufficiently responsive to "clinical reality." It is likely that the authors had the prospect of judicial decision-making in mind when they referred to the need to avoid "A demoralized, harassed psychiatric care system, or one whose providers spend inordinate amounts of time in legal proceedings." The weight of such concerns with judicial decision-making might depend in part upon how it is structured. Following a determination of a patient's incompetency, a court might assume for itself the making of substitute decisions on matters such as medication. This, of course, would require periodic resort to the court pursuant to what might be time-consuming and inconvenient proceedings. On the other hand, the court might delegate the authority to make substitute judgments to a court-appointed guardian or even to staff members of the treating facility, perhaps subject to some form of supervision or review. Such an approach would most likely involve far less intrusion into clinical flexibility than the first. There is some indication that courts are inclined to favor such flexible approaches.

Rogers v. Okin²⁸ addressed such concerns by rejecting the argument that, once a judicial determination of incompetency was made, all treatment decisions had to be made by, or at least after consultation with, the court or a court-appointed guardian. Such day-by-day decisions were apparently relegated to the treating physicians or staff, although the court did suggest that due process probably required some review of these decisions. Periodic review of the patient's full treatment history by nontreating physicians, it commented, would probably meet due process requirements.

4. Empirical Information

Obviously, the procedural issue raises a number of factual questions on which empirical information would be extremely useful. Perhaps most important is evidence bearing upon the accuracy of applications of the criterion under each of the alternatives as well as under the traditional method of relying on the treating physician. Unfortunately, virtually no information is available on these matters, either in the study by Appelbaum and Gutheil or elsewhere. The reasons for this are not difficult to understand. In most jurisdictions, there is — even after litigation — substantial uncertainty as to the legal standard. If the standard is not clear, of course, it is impossible to evaluate whether or not particular cases involved an "inaccurate" application of the standard. Further, developing sufficient information concerning instances of compelled administration of medication over objection to permit a reliable judgment on its accuracy would be a difficult task that researchers may be understandably reluctant to undertake.

Appelbaum and Gutheil did, however, address a matter relevant to this concern, the bases for the refusals studied. Analyzing 46 reasons given for 72 refusals, they reported that 10 were based on complaints regarding side-effects and that, in four of these 10 cases, the physician took remedial action. In another report concerning one of these patients,²⁹ the authors note that measurement of the plasma tricyclic antidepressant levels in one patient revealed them to be in "a markedly toxic range." It is unclear to what extent these meritorious claims would have surfaced in the absence of a limited right to refuse medication. In another report of the study,³⁰ the authors note that the study followed a hospital decision to establish as hospital policy a right to decline medication. It may be that in the absence of such administrative implementation of what may be a legally-required process, these complaints would either not have been raised or would have been ignored.

Nine of the 46 refusals were considered to be the product of a thought process influenced by delusions concerning medication. Despite the uncertainty as to the meaning of "competence" to refuse medication, it seems reasonably clear that if the patient's reasoning is significantly influenced by delusional beliefs concerning the medication which are a part of the symptomology of the illness, the patient is not competent within the meaning of the legal criterion. These nine refusals, then, can be considered nonmeritorious.

Under the authors' own analysis, only nine of the 46 refusals (20%) can be said to be clearly without merit. Four (9%) appear to have been medically meritorious. This leaves 33 (or 71%) which remain uncertain. It can be argued that a showing that almost 10% of objections had clear medical merit and that almost three-quarters cannot be dismissed as pathological symptoms poses a sufficient risk of error in resolving these objections to warrant greater procedural protection than is afforded by relegating the matter to the discretion of the treating physician.

Appelbaum and Gutheil also addressed another factual matter relevant to the due process analysis: the cost of providing procedures for resolving refusal issues and the effect of this cost upon the provision of treatment to patients who are appropriate subjects of it; 18 of the 23 patients who refused to take medication agreed to accept it within 24 hours of their initial refusal. While the temporary refusals in such cases undoubtedly involved some inconvenience and irritation for the staff, there was almost certainly no serious interference with treatment involved and no recourse to expensive and time-consuming legal procedures was required.

Any legally-required procedure for overriding objections to medication, then, would have been used only five times during a three-month period for a 40-bed treatment unit. Another published report concerning these patients³¹ claims that pursuing guardianship applications involved substantial problems that interfered with appropriate treatment. These problems, however, might well have been part of the inevitable difficulties in developing a new procedure and may not reflect the costs of using a procedure once developed. Further, other procedures not requiring such extensive and formal hearings may be far less burdensome.

The authors themselves, in another report of the study,³² conclude that the policy did not "seriously impair" the "over-all treatment" of those patients whose refusal was short-lived. Even in regard to those patients whose continued refusal required recourse to further legal procedures to override the objections, the authors note that the delay did not preclude eventual positive response to the medication and the development of an effective therapeutic alliance.

The procedure most desirable or constitutionally mandated for applying a criterion concerning the right of patients to resist medication, then, involves a number of empirical questions which are not addressed in the existing literature and which Appelbaum and Gutheil do not stress. Efforts must be made to evaluate the risk of error presented by various methods of structuring the decision-making process, but such efforts cannot proceed unless and until the criterion for overriding objections is satisfactorily developed and articulated.

Further information must also be developed concerning the impact of respecting some refusals upon the patients' long-term condition, and especially upon the ability of treatment programs to restore them to a condition in which they no longer meet the jurisdiction's standard for involuntary

treatment.

The cost — in terms of staff inconvenience, patient prognosis and cash outlay—of the various ways of structuring the decision-making process must also be the subject of inquiry if the procedural issue is to be resolved on the basis of anything other than pure speculation.

III. Conclusion

As Appelbaum and Gutheil correctly assume, rational development of the drug refusal issue will require that factual information be substituted for speculation and intuition. While there have undoubtedly been some naive and perhaps irresponsible discussions of the matter in the legal literature, these can be disregarded as surplusage and the discussion can be carried on in a reasonable fashion. Ascription of improper motives to psychiatrists, of course, must be eschewed. Factual information is especially needed on the practices and reasonable expectations concerning public institutional care. How skillfully can and will medication be administered in this context as to combat symptoms of serious disorder while minimizing side-effects? How accurately can the staff of such facilities be expected to predict what will happen to an impaired person, perhaps in the community, should medication not be compelled? To the extent that clinical practice in public institutions is inadequate, efforts to upgrade are, of course, appropriate, but the drug refusal issues must be considered in light of what sort of practice can reasonably be anticipated, given present reality, the possibility of reform efforts and also the difficulty of effective changes in these situations.

In light of the developing nature of the law in regard to the criterion to be used to override patients' objections, it is important to develop factual information bearing upon the effects of various alternatives. Specifically, the extent to which various formulations of the competency standard pose difficulties in practice should be investigated and efforts should be made to determine the extent to which permitting competent patients to avoid medication in fact endangers the social interest in maintaining safety within institutions and in reducing the risk posed by dangerous mentally ill persons.

The procedural issue poses additional, but equally important, questions. When a treatment staff is relegated responsibility for making the decision to override objections, how accurately are the decisions made? To what extent would other methods of structuring the decision-making process increase the accuracy of the resulting decisions? How costly would these procedures prove in practice, once the staff (and perhaps the courts) had sufficient experience with them to iron out initial difficulties? Reality in general and "clinical reality" in particular are of obvious importance in resolving the medication refusal issue, but the issue is a legal one and factual information must be developed to address those issues made relevant by the legal framework.

References

1. Appelbaum, P.S. and Gutheil, T.G.: Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients. *Bulletin of the American Academy of Psychiatry and Law* 7:306-315, 1980. Another report of the study appears in Appelbaum, P.S. and Gutheil, T.G.: Drug Refusal: A Study of Psychiatric Inpatients. *Amer. J. Psychiatry* 137:340-346, 1980.
2. Szasz, T.: Civil Liberties and the Mentally Ill. *Cleveland-Marshall Law Review* 9:399-416, at 400, 1960.
3. Langsley, D.: Viewpoint, A Commentary by APA's President. *Psychiatric News* 60 (22):2, Nov. 21, 1980.
4. 506 F.Supp. 915 (ND Ohio 1980).
5. *Id.*, at 936-27.
6. Schwitzgebel, R.K.: Survey of State Civil Commitment Statutes. In *Civil Commitment and Social Policy* (Final Report, Public Health Service Grant MH 25955-03, June 30, 1978).
7. Scheer, N. and Barton, G.M.: A Comparison of Patients Discharged Against Medical Advice with a Matched Control Group. *Amer. J. Psychiatry* 131:1217-1220, 1974. Subsequent research has produced mixed results. Compare Byers, E.S. and Cohen, S.H.: Predicting Patient Outcome: The Contribution of Prehospital, Inhospital and Post-Hospital Factors. *Hospital and Community Psychiatry* 30:327-331, 1979 (AMA discharges not statistically related to patient recidivism) with Withersty, D.J.: Patient Responsibility and the AMA Discharge: A One-Year Follow-Up Study. *Amer. J. of Psychiatry* 134:1442-1444, 1977 (AMA patients had higher recidivism rate and higher proportion of drug and alcohol abuse than non-AMA patients).
8. Langsley, note 3, *supra*.
9. 603 P.2d 123 (Colo. 1979).
10. 609 P.2d 747 (Okla. 1980).
11. 603 P.2d at 125.
12. 462 F.Supp. 1131 (DNJ 1978), 476 F.Supp. 1294 (D.N.J. 1979) (appeal pending).
13. 476 F.Supp. at 1308.
14. *Id.*, at 1314.
15. 634 F.2d 650 (1st Cir. 1980), cert. granted, _____ US _____ (1981).
16. *Id.*, at 657.
17. *Id.*, at 661.
18. *Id.*, at 655-56.
19. *Id.*, at 660.
20. 506 F.Supp. 915 (ND Ohio 1980).
21. *Id.*, at 935.
22. 403 A.2d 744 (DC 1979).
23. 424 US 319 (1976).
24. See the classic statement of Justice Jackson in *Johnson v. United States*, 333 US 10, 13-14 (1948): "[T]he protection [of the Fourth Amendment] consists in requiring that [the usual inferences which reasonable persons draw from evidence] be drawn by a neutral and detached magistrate instead of being judged by the officer engaged in the often competitive enterprise of ferreting out crime."
25. 442 US 584 (1979).
26. 476 F.Supp. 1294 (DNJ 1979) (appeal currently pending).
27. 445 US 480 (1980).
28. 634 F.2d 650 (1st Cir. 1980), cert. granted, _____ US _____ (1981).
29. Appelbaum, P.S.; Vasile, R.G. and Orsulak, P.J., et al: Clinical Utility of Tricyclic Antidepressant Plasma Levels: A Case Report. *Amer. J. Psychiatry* 136:339-341, 1979.
30. Appelbaum, P.S. and Gutheil, T.E.: Drug Refusal: A Study of Psychiatric Inpatients. *Amer. J. Psychiatry* 137:340-346, 1980.
31. Gutheil, T.G.; Shapiro, R. and St. Clair, R.L.: Legal Guardianship in Drug Refusal: An Illusory Solution. *Amer. J. Psychiatry* 137:347-352, 1980.
32. See note 30, *supra*. □