

The Right to Refuse Treatment under *Rogers v. Commissioner*: Preliminary Empirical Findings and Comparisons

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Preliminary findings on the effects of the Massachusetts ruling in *Rogers v. Commissioner*, an important right to refuse treatment case, are compared with models in other jurisdictions. In sum, few cases are reviewed; in almost all reviewed, the court overrides the patients' refusal. The case raises troubling implications about due process and quality of care.

The right of the psychiatric patient to refuse antipsychotic medication is explicitly established in a number of jurisdictions.^{1,2} Even where such a right exists the law usually permits involuntary treatment in emergency situations when the patient is imminently dangerous or, alternatively, when the patient is incompetent to make treatment decisions. Ensuing procedural requirements for decision making vary widely.

In Massachusetts the *Rogers* decision³ established the right of psychiatric patients to refuse antipsychotic medication in nonemergency situations: some of the complex issues in this problematic decision are elsewhere detailed.⁴ The *Rog-*

ers court held that incompetent patients must be reviewed in full adversarial hearings, in which a judge decides to accept or reject a proposed treatment plan, based on a substituted judgment as to what the patient would have wanted if competent⁵; even those patients clearly accepting antipsychotics must be competent to give informed consent to do so or else must undergo similar judicial review. This full judicial review was felt to be required because the Massachusetts Supreme Judicial Court elected to portray antipsychotic medications as highly risky, thus requiring extensive procedural sanctions.⁶

Clinical Concerns and Unknowns

At the time the decision was handed down in its final form, clinicians voiced concerns that such a procedurally cumbersome approach would lead to long delays before treatment could be instituted, resulting in prolonged suffering of their patients and needless prolongation

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of hospital stays.⁷ The actual number of patients who would be involved in this process was unknown, but the clinicians feared that their time and attention would be diverted from caring for their patients to legal activities associated with the hearing process. The possible impact on state mental health systems, in which a disproportionate number of incompetent or refusing patients are concentrated, was similarly unknown.

Burgeoning numbers of legal counsel to handle the quantum jump in legal proceedings might well consume scarce resources, it was feared, as might the systemic requirements for mass screening for potentially incompetent accepting patients.

Other Models

Alternative models of dealing with treatment refusal have emerged in other states. Colorado has adopted a model quite similar to that in Massachusetts.⁸ In Minnesota an in-house, extrajudicial, multidisciplinary panel [treatment review panel (TRP)] reviews all incidents of treatment refusal; this idea has been well described in reports from Anoka State Hospital;⁹ these reports may not reflect statewide practice, however. The panel is composed of a physician, a psychologist, a social worker, a nurse, a patient advocate, a clinical pharmacist and a consulting psychiatrist. In New Jersey the *Rennie* court¹⁰ adopted a similar nonjudicial approach relying primarily on evaluation by independent psychiatrists.

In these models the psychiatrist functions much like a guardian *ad litem*, or special investigator for the courts, as well

as representing a kind of second opinion. Recently California¹¹ in the *Jamison v. Farabee* consent decree has experimented with a similar clinical model.

These approaches to treatment refusal have generated some empirical data. In view of the inherent importance of this issue regarding policy considerations, future judicial rulings, and the rights of patients, more investigation is warranted on the procedural realities involved. This article presents preliminary empirical findings for the experience in Massachusetts following the *Rogers*-mandated judicial model and compares them with some of the other approaches used nationally.

Methods

In January 1984 the Massachusetts Department of Mental Health (DMH) began systematically collecting data from DMH lawyers responsible for filing *Rogers* petitions at their respective institutions, including both mental health and mental retardation facilities. These lawyers submitted monthly reports detailing the number of petitions filed, the numbers of refusing and accepting patients, and the petitions denied by the courts. (Due to problems in the data collection method, denied petitions could not be connected to specific facilities, to a patient's status as a treatment acceptor versus refuser nor to the phase of the bifurcated hearing—competency determination or substituted judgment about treatment plan—when the denial took effect; nor could we distinguish multiple petitions for a single patient over time from one-time petitions.)

Data spanning the period from Janu-

ary 1984 through May 1985 were available. The sole exceptions were data from the "Boston aggregate hospitals" (the major teaching hospitals in Boston considered as a group) for which data through February 1985 were available. We obtained and tabulated these data. In addition, data on monthly admissions and census by facility were recorded to permit calculation of rates as petitions/monthly admissions and petitions/monthly census. We also reviewed the consultative case load of the Program in Psychiatry and the Law at the Massachusetts Mental Health Center in Boston.

Results

Table 1 provides a breakdown on the petitions by facilities and by acceptance or refusal of patient and presents the outcomes in terms of "petition accepted" (and refusal overridden) or "petition denied" (and refusal stands). The petitions were denied infrequently (see Table 1). Although the data collection process did not permit precise categorization by acceptor/refuser status, if we assume that all denied petitions pertain to treatment refusers (as is likely), the denial rate is just over four percent. This figure may be higher as a percentage for all patients reaching hearing, as some unknown number of petitions are dropped in prehearing negotiations, usu-

ally resulting in acceptance of treatment. Our data-collecting procedures limited our capacity to avoid this potential source of error.

Figure 1 demonstrates that the number of petitions filed has remained, with one sharp exception, relatively constant over time. However, petitions have been filed at an increasing rate for accepting patients. This is reflected in their percentage of petitions filed over time in Figure 2.

State Hospital Findings The results indicate that *Rogers* petitions are filed in a very small percentage of admissions (not a true incidence) or as percentage of average census (a more useful index). Both of these values cluster around two percent of patients for whom petitions are filed.

Retardation Nearly all petitions filed for residents of retardation facilities were in situations in which medication was being accepted; that percentage clusters around five percent of all patients. As Table 1 demonstrates, no petitions have been denied in this population.

Discussion

Number of Patients Reviewed

Perhaps the most striking aspect of our findings is the very low percentage of patients judicially reviewed. On one hand this seems to indicate that clinicians' initial fears of widespread treat-

Table 1
Number of Petitions Filed by Acceptor and Refuser Status

	State Hospitals			Retardation Facilities		
	Total	Refusers	%	Total	Refusers	%
Petitions filed	350	293	83.7	271	9	3.3
Total petitions denied	12			0		
Petitions denied, % filed	3.4	4.1		0	0	

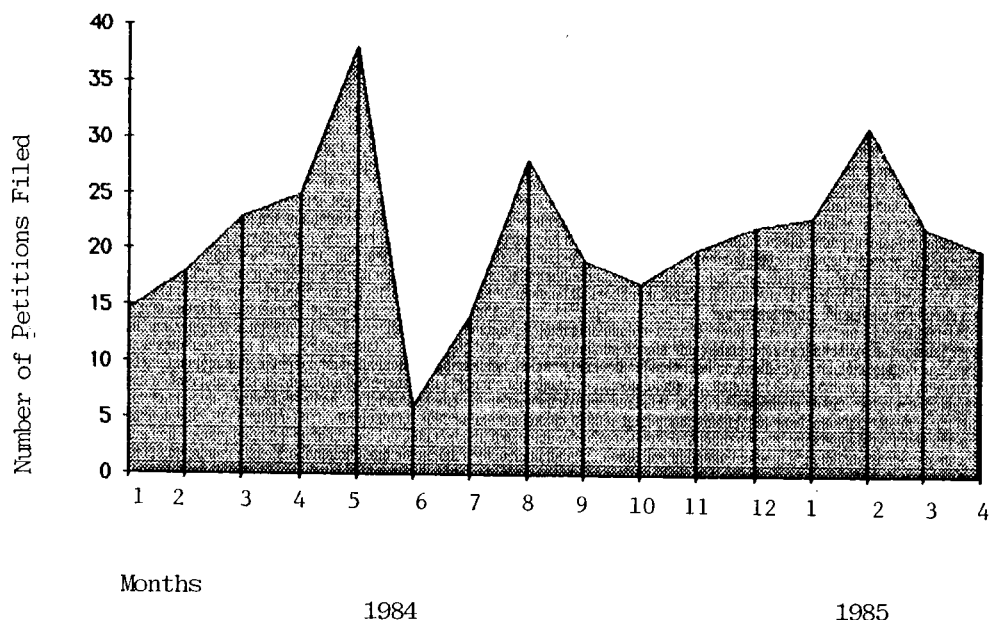


Figure 1. Number of petitions filed per month.

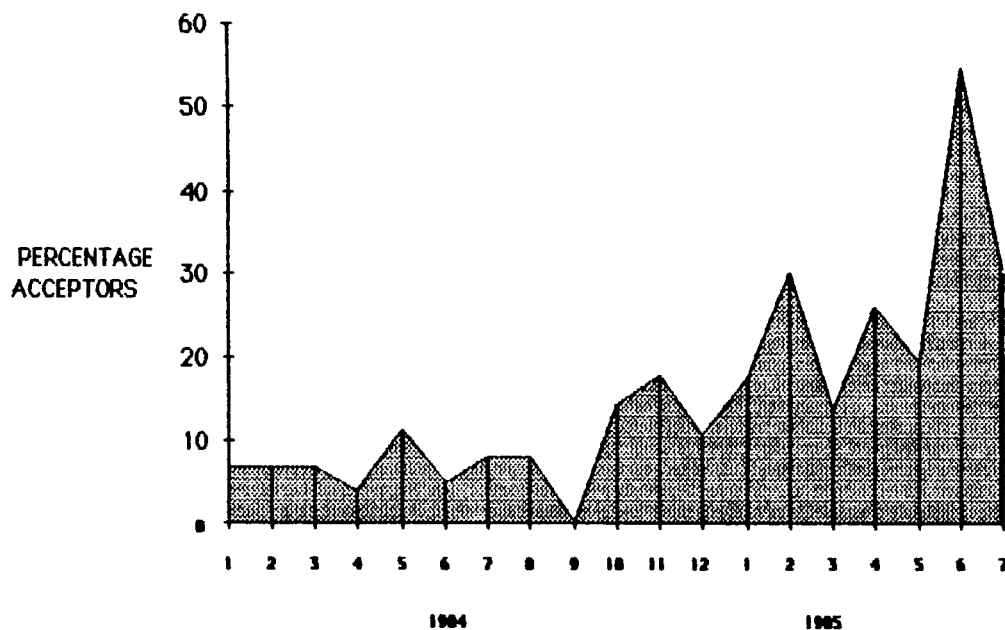


Figure 2. Percentage of petitions filed for acceptors.

ment refusal were unfounded. However, other studies of treatment refusal have reported significantly higher rates of refusal, ranging from 10.5 to 35 percent.¹²

A previous report from the Massachusetts Mental Health Center reported a 22 percent rate of lasting refusal.¹³ Studies recording rates of review report sim-

ilar numbers (due in some instances to the method of finding refusal episodes). Systems utilizing independent psychiatric reviews (J. T. Young, J. D. Bloom, L. R. Faulkner, J. L. Rogers, and T. K. Pati, unpublished manuscript)¹⁴ report rates of 10 to 13 percent. The only exception is the Napa State Hospital study (W. A. Hargreaves, M. Shumway, E. Knutsen, A. Weinstein, and N. Center, unpublished manuscript), for which nearly all patients were reviewed, regardless of refuser-accepter status, under the *Jamison v. Farabee* consent decree. Unique review processes exist in Lima¹⁵ and Anoka State Hospital.⁹ At the Lima facility an adversarial hearing, presided over by the medical director of the hospital, is the system of adjudication. This system reports a rate of review—10.5 percent—similar to that of hospitals employing an independent psychiatric consultant.

Under the review process at Anoka State Hospital, 20 percent of all admissions are referred to the Treatment Review Panel (TRP). Because some patients are reviewed more than once, we must look at TRP referrals per admission for comparison with our data. Based on reported numbers⁹ this is 37 percent, more than 10 times that of the Massachusetts experience under *Rogers*.

What accounts for the relatively low number of patients reviewed under the *Rogers* judicial model? One report from the state forensic hospital (J. Veliz and W. S. James, unpublished manuscript) cites the time required of the psychiatrist in writing the petition, preparing for court, and court time (10.2 hours aver-

age), in conjunction with lengthy delays after the petition is filed until the hearing (4.5 months average). Thus, at their facility, where they had initially estimated 800 patients as requiring a *Rogers* hearing, only 98 petitions were actually filed, and only 39 had reached court by the time of their report.

Outcome of Review Our finding that 4 percent of treatment refusals were upheld by the courts is very similar to the rates found in the larger studies of independent psychiatric review: 5 percent¹⁴ and 3 percent (J. T. Young *et al.*, unpublished manuscript).

Under the system at Lima Hospital, 14 percent of refusals were upheld. This rate is not adjusted for the 37 percent of refusers who ended refusal and did not come to a hearing. The adjusted rate is therefore over 20 percent. At Anoka State Hospital 33 percent of nonemergency refusals were upheld.

Two patterns emerge. First, the percentage of refusals upheld appears to correlate with the percentage of total census reviewed. This suggests that, as a broader cross-section of the patient population is reviewed, more ambiguous cases are included and refusals are therefore upheld at increasingly higher rates. Second, the judicial rate not upholding refusal, 4 percent, is very close to the rates of clinical review, 3 and 5 percent. It may be that *Rogers* provides more procedural protection but, for the substantive evaluation of refusal, judges remain dependent on clinical judgments. More creative review procedures, such as the TRP, which incorporate other clinical professionals, have upheld re-

fusal with greater frequency. Because of the confounding influence of the scope of review, however, at this time no one of these systems can claim to provide greater protection of the right to refuse treatment.

Cost of Review Reasoning that each Rogers hearing involves one judge, three lawyers (one for each side and a guardian *ad litem*), at least one doctor, prehearing preparation and a conservative three hours of hearing plus interruptions, the cost of such hearings for the cases in this study would be upwards of one million dollars per year. The estimated cost in California for the Napa State Hospital procedure is \$300,000; extending this model to all state facilities would cost more than one million dollars. In contrast the more informal Anoka TRP model had estimated costs per year of \$30,000.⁹

Conclusions

Our data establish that a very small percentage of psychiatric patients in Massachusetts state facilities undergo treatment refusal review under *Rogers*; of those reviewed, nearly all have their refusal overridden by the court. Actual treatment refusal, however, is probably a more frequent occurrence. There are no empirical studies to explain the apparent discrepancy in rates between expected treatment refusal (10 to 35%) and reviews (averaging 2%). It may be that clinician-patient disagreements are being negotiated more successfully. However, it seems also likely that time pressures on clinicians and procedural delays lead to clinicians' selecting for review only the most urgent cases. It is

likely that some incompetent refusing patients, who might benefit from court-mandated treatment, are being left untreated. Patients have an interest not only in the right to refuse medication, but also (as a group) in the review and proper adjudication of their treatment refusal. Treatment practice under *Rogers* serves this goal poorly. In comparison to other models, fewer patients are actually reviewed; those reviewed rarely have their refusal honored. It remains unclear whether the fundamental quality of the patient's care has been improved.¹⁶

In addition, the judicial model is an extremely expensive one. The state of Massachusetts recently designated a supplemental appropriation of \$826,000 for use in *Rogers* cases; over \$500,000 went to salaries for nine new lawyers and seven paralegals and the remainder was for fees for independent psychiatric assessments. One attorney (J. Rodgers, personal communication, 1985) has suggested that due process is intentionally designed to be expensive, slow, and cumbersome to implement as a hedge against careless and facile solutions; these qualities may enhance the perception of fairness. Treatment practice under *Rogers*, indeed, serves these goals well. But we may ask whether the patients' true interests are as well served. As clinical time and money are diverted from clinical care, the ultimate issue—quality of care—may well be subverted.

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