

The Right to Refuse Psychiatric Treatment: A Clinical Perspective*

P. BROWNING HOFFMAN, M.D. * *

Within recent years, psychiatrists and lawyers have increasingly debated the right of psychiatric patients to refuse treatment. Predictably, the right has advocates as well as opponents who, although often uninformed, are still adamant.

Just last year the Academy was admonished that a right to refuse psychiatric treatment was "one right too many,"¹ since it would be "antithetical" to the right to *receive* treatment. It was further alleged that patients had a "right to be free from psychosis."² Yet Friedman and Halpern find no basic inconsistency between a right to refuse and a right to receive psychiatric treatment.³ Carnahan declares these rights to be complementary.⁴ We are indebted to the American Psychiatric Association's Task Force on Right to Treatment for resolving this debate, for they explicitly recognize *both* rights, noting that the patient, if legally competent, can refuse treatment "except in emergencies."⁵ Unfortunately, they forgot to define what constitutes an emergency. Perhaps there is some comfort in believing that an emergency, whatever its own characteristics, does not continue interminably.

My own opinion, incidentally, is that the patient's right to refuse treatment is a *necessary* complement to his right to receive treatment, assuming that both rights seek a common goal of adequate treatment. The patient should be as able to refuse inadequate or unnecessary care as to request appropriate treatment. Conceivably, the patient's right to refuse further treatment — in essence, his right to terminate treatment — may signal the *success* of treatment insofar as the patient thereby indicates a willingness to assume responsibility for his actions: a goal which is not unknown among existing therapeutic orientations.

In a different vein, the psychiatric literature evidences some confusion as to the context within which the right to refuse treatment is exercised. For some, the right finds its most eloquent expression in the patient's refusal of hospitalization; for other authors, however, the right to refuse treatment has meaning only within the context of ongoing therapy. Yet the parties — and even the controversies — differ in the two situations. In refusing hospitalization, for example, the patient contests the state's finding that institutional care is required; once within the hospital, however, the patient who refuses treatment is essentially negotiating with his therapist about the parameters of treatment. Still, the psychiatric literature often confuses these critical differences; some authors protest that patients denied treatment via civil commitment are thereby allowed to "die with their rights on,"⁶ while other authors decry institutional care rendered in the absence of a patient's informed consent and even in the face of his vehement protest. Although I shall attempt to address both situations in these remarks, I do so mindful that their differences may well outweigh their similarities.

Finally, it is obvious that law, as well as psychiatry, offers no magical insight regarding the patient's right to refuse psychiatric treatment. There is virtually no case law directly

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**Dr. Hoffman is Associate Professor of Psychiatry and Law, University of Virginia Schools of Medicine and Law, Charlottesville, Virginia 22901.

on point for a variety of clinical situations. A number of constitutional arguments can be mustered in support of a right to refuse treatment. One might argue, for example, that the first amendment can be bastardized to include a "right to mentation,"⁷ or that treatment in the face of its refusal by a patient is thereby cruel and unusual in violation of the eighth amendment.⁸ Others seek the elusive judicial penumbras of privacy, citing recent U.S. Supreme Court decisions relying upon first, fourth and fifth amendment rationales.⁹ The dichards rely upon notions of procedural or substantive due process and equal protection, citing the fourteenth amendment and raising spectres of § 1983 actions against states which treat patients against their wishes but under color of state law.^{*10}

And so the right to refuse treatment debate continues – confusing, misleading and often deterring the psychiatrist from effectively treating patients. In attempting to unravel some of this unnecessary confusion, one must briefly consider certain historical developments of the physician-patient relationship. In that way the right to refuse treatment will assume its proper medicolegal context, namely that of informed consent. Given time restraints, I shall further confine my remarks to inpatient psychiatric treatment situations, primarily those of an involuntary nature.**

The Right to Refuse Treatment in Historical Perspective

I believe that the traditional relationship between the psychiatrist and his or her patient has, over time, shifted from a *fiduciary* to a *quasi-contractual* basis.¹¹ In the former, fiduciary relationship the psychiatrist was entrusted always to act in the patient's best interests – "*premium non nocere*," or "first, do no harm." But in the wake of increasingly dramatic and unpredictable somatic treatments, consumerism and an evolving public interest in accountability for psychiatric decision-making, the psychiatrist of today must increasingly share with others – including the patient – responsibility for selecting one form of treatment over another, or even over the alternative of no treatment. Given the currently inherent difficulty of making many treatment decisions, I – as but one of many thousands of psychiatrists – welcome an opportunity to share many of these prodigious burdens with others. Historically speaking, society has only within recent yeras abandoned a basic fear of mental illness to evidence any visible concern about the potential abuses of its treatment. It is within that social concern that an interest in the patient's right to withhold consent for treatment – his legal means to refuse treatment – has emerged.

The Right to Refuse Psychiatric Treatment Within the Context of Informed Consent

It makes little sense to assert that the right to refuse treatment rests upon the degree to which the patient's informed consent is a necessary prerequisite to treatment *without* noting the contours and limitations of informed consent within the context of psychiatric treatment. From a legal perspective, informed consent encompasses three rather distinct

*Of course, a so-called compelling state interest could, in theory, prevail legally even if there were a cognizable right to refuse treatment.

**I am tempted here to digress about ethical and even economic issues connected with a right to refuse treatment. Perhaps a brief illustration of the perils involved will excuse my reluctance to take such a path. Two questions for the ethicists: (1) Would not the imposition of treatment upon unwilling patients, in violation of their right to refuse treatment, constitute a fundamental violation of their ethical rights to personal autonomy and to freedom from invasions into their most intimate thoughts by others? (2) But alternatively, would not withholding treatment by acknowledging the patient's right to refuse treatment be unethical if the treatment in question were the only available means of restoring the patient's freedom in society outside of institutional walls? And for the economists, how can one justify the costs of recognizing a patient's right to refuse treatment when such recognition not only denies society the rewards of that patient's labors but simultaneously promotes an additional public expenditure to provide continuing institutionalization?

elements: (1) sufficient *knowledge* (i.e., psychiatrist-supplied information) about proposed treatment; (2) *competence* of the patient to comprehend that information; and (3) the *absence of coercion* such that consent is voluntary. Each of these elements poses special problems within the context of psychiatric treatment. The element of *knowledge*, for example, pre-supposes that the psychiatrist can sufficiently predict the potential risks and benefits not only of the treatment recommended, but also of alternate treatments or even no treatment. We are immediately struck by the impossible sweep of such a requirement, for clinicians rarely have the ability to make accurate predictions of treatment outcome absent an empirical trial of treatment. Nor would psychiatrists necessarily agree as to precise diagnosis, let alone preferred treatment plan in a given case. Even if that were possible, few clinicians would blindly flood patients with information which, although technically correct, could be devastating to brittle but essential psychological defenses.

Nor can we glibly assume that psychiatric patients will, as a rule, meet *legal* competency requirements for the informed consent which underlies a right to refuse treatment. It is a cruel paradox that the severely ill patient who requires the most dangerous forms of therapeutic intervention is nevertheless *least* competent, either legally or medically, to offer or withhold consent for such care. Yet it is precisely for such patients that the protections afforded by informed consent requirements are intended. And it is no solution to delude ourselves that such personal responsibilities can be casually delegated to others even following a legal competency hearing and a finding of incompetency.

Finally, any notion that the psychiatric patient's informed consent to treatment can be entirely free from coercion is absurd. In reality, patients often accept treatment at the urgings and even the threats of relatives, friends, or psychiatrists, or simply because they seek an end to intolerable mental distress, and psychiatric treatment offers a sufficient promise of relief. In either instance, the decision is hardly free from coercion or truly voluntary. At best one might argue that it is made with minimal outside interference in the form of coercion, consistent with whatever degree of coercion is sanctioned by society.

Legal definitions of informed consent often fail to reflect clinical realities of psychiatric treatment for other reasons as well. Most importantly, the legal definition assumes stasis in lieu of process; it seems limited to a clinical situation rather than an ongoing clinical relationship. Most psychiatric treatment is a *process*, not an *event*, and the patient's informed consent for treatment may vary as treatment progresses. Civil commitment and the treatment which later occurs during hospitalization serve to illustrate this critical distinction. At the "front end" of the treatment process, confinement *via* civil commitment occurs without the patient's consent; in a narrow sense, he is either explicitly or implicitly deemed medically (if not legally) *incompetent* to determine all the parameters of his treatment.* But, as treatment continues, the patient is given increasing responsibility for determining the contours of his care. Indeed, it is difficult to imagine successful care and ultimate discharge from treatment absent some ability or right to refuse further in-patient care even if recommended. The myriad psychiatrist-patient decisions which determine the contours of treatment over time are simply *not* amenable to judicial determination or even to exhaustive judicial review. Instead, such decisions must depend initially upon clinical skill and discretion which, over time, give way to the patient's inclinations.

There is another flaw in relying too heavily upon the legal doctrine of informed consent to regulate psychiatric treatment. Turning again to the civilly committed patient, it is obvious to most clinicians that communications from such persons may be

*Even then, however, the patient has some means of refusing treatment, e.g., by declining to participate in verbal therapies or by physically refusing to participate in ward activities.

ambivalent in that they often contain conflicting conscious and unconscious messages. The law may have difficulty in recognizing this reality. Instead, it may be assumed that the legally competent patient knows what he wants and communicates his wishes unequivocally. Such myopia does little, however, to assist the capable psychiatrist who becomes aware of a "double message" from the patient who seems simultaneously to seek and to reject treatment.

The following case history illustrates certain perils of simplistically applying legal definitions of informed consent to the clinical setting and further suggests a personal bias, namely that the clinician must be ever mindful of the importance of the patient's informed consent for treatment. But the patient's withholding of consent as a means of avoiding or refusing treatment must also undergo clinical scrutiny. (Clinical abrogations of the patient's right to refuse treatment must, in turn, be subject to review – a requirement which will merit our attention throughout this meeting.)

Case History

One evening a middle-aged male, Mr. X, dressed in dirty clothing and smelling of alcohol, entered the psychiatric inpatient unit of a large hospital and proceeded to sit across from the nursing station. When approached, he stated he was a "visitor"; but he remained on the unit after visiting hours were over and the psychiatric resident on call was finally asked to see him.

Although Mr. X seemed fully oriented, his thought content was most unusual. He admitted auditory hallucinations – "voices" – and professed abilities to broadcast thoughts as well as to read other people's minds. Shifting rapidly from English to German accents, he announced that the CIA and the FBI were keeping him under constant surveillance. Although his affect was generally flat, he seemed inappropriately angry or frightened at times. His thoughts were disorganized, his speech rambling and his associations highly idiosyncratic and loose. Moreover, he refused to give the interviewer any explanation for his presence on the unit; instead he would offer merely his name and note – reluctantly – that he had been hospitalized at a nearby state psychiatric facility "recently," but was not currently taking his prescribed medications.

At this point the resident obtained Mr. X's hospital chart and learned that he had been hospitalized previously with a diagnosis of "paranoid schizophrenia" and for treatment of chronic alcoholism. The resident then decided to admit Mr. X to the psychiatric inpatient unit for further observation. When confronted with this recommendation, however, Mr. X politely declined. He refused to leave the ward as well, preferring to return to his seat across from the nursing station.

The resident then told Mr. X that he would have to stay at the hospital for further observation, including a physical examination. Again Mr. X declined, but he seemed rather frightened. But when the resident "ordered" Mr. X into a quiet room on the ward, he quickly responded, by going to the room and removing his clothing; he then donned a hospital robe without further assistance. At this point Mr. X seemed somewhat relieved, but he still refused to offer information to the ward staff.

Meanwhile the resident telephoned the nearby state hospital and obtained, despite their initial reluctance, a history of their treatment of Mr. X. Mr. X had been hospitalized at the state facility for approximately eleven years, and had recently been placed on convalescent leave while taking high doses of phenothiazines; he had apparently later discontinued his medications without hospital approval. Arrangements were made to transfer Mr. X back to the state hospital the following day.

The resident then returned to treat his "reluctant" patient. He reasoned, for example, that it would be many hours before an administrative assistant at the hospital could obtain a court order directing Mr. X's immediate involuntary hospitalization; such efforts might create more problems than they resolved, since judges are often critical of the need

to commit patients already legally on convalescent leave and subject to recall by the state hospital. Thus, the resident elected to forego a court order and concentrated instead upon Mr. X's immediate treatment, first by demanding that Mr. X submit to venipuncture. Mr. X refused verbally, but then held out his arm as if anticipating — perhaps consenting to? — the procedure.* A similar sequence of conflicting events occurred when Mr. X was offered, then directed, to take oral medication (a phenothiazine) and to go to bed. Mr. X was transferred back to the state hospital on the following day.

Discussion

The resident who treated our Mr. X would admit the possibility, I suspect, that he had acted outside the letter of the law in several ways. Initially he had confined Mr. X *involuntarily* judging from Mr. X's statements, yet without legal authorization. Later, he searched Mr. X's clothing without authorization and even obtained confidential medical information concerning Mr. X from another hospital without the patient's specific consent or knowledge. On at least two occasions the resident violated the person of Mr. X — a battery and possibly an assault in technical, legal terms — first, when performing a physical examination upon Mr. X, and later, when drawing Mr. X's blood for laboratory screening studies. It could be alleged that the resident had admitted, examined, treated and even transferred a "non-patient" — or at least a verbally unwilling one — without legal authorization.

As a clinician, I suspect that we would not be entirely outraged with this resident's behavior. Perhaps we can envision similar decisions had we been in his place.

Certain realities of the treatment situation *per se* command our attention. Mr. X voluntarily presented himself on the psychiatric inpatient unit and initially refused to leave. Although he *verbally* refused recommendations from the resident, his *actions* were directly and consistently opposite, as if in part he wanted, or at least would accept treatment. Prior to obtaining laboratory studies and a more complete history, there was arguably an obligation — perhaps a *legal duty* — for the resident to determine whether Mr. X's condition was indeed medically emergent; to have discharged Mr. X without pursuing such a possibility would have opened the resident to ethical or even professional censure and perhaps to malpractice litigation as well. These considerations may well offset allegations that Mr. X was unlawfully restrained by the resident. Finally, the treatment carried out relied upon intrusions of little risk, but great potential benefit. The period of confinement was short. The patient would, in effect, be allowed the chance to challenge his confinement legally within twenty-four hours of its initiation. On balance, the brief loss of liberty seems a price not too high considering the potentially dire consequences of according the patient an immediate and absolute right to refuse all treatment based solely upon his verbalizations in spite of his physical actions to the contrary. Perhaps some lawyers would dispute the resident's treatment of Mr. X, even to the point of suggesting that he could successfully sue the resident for medical malpractice on a variety of grounds. My colleague, Professor Richard Bonnie,** believes that a court of law would ultimately uphold the resident's actions for reasons stated earlier. I hope he is right. But, of course, there is no case directly on point for many of the issues raised by Mr. X's situation, so we have no final answer.

Conclusion

This case illustrates some of the problems of employing the legal doctrine of informed

*All blood tests, with the exception of an elevated blood ethanol level, were within normal limits.

**Associate Professor of Law, University of Virginia School of Law (personal communication, October 18, 1976)

consent within the context of psychiatric practice to guarantee patients an absolute right to refuse treatment. The legal doctrine simply does not address, even on its own terms, the difficulties of guaranteeing sufficient knowledge, adequate comprehension and freedom from coercion for informed consent to operate effectively within many aspects of psychiatric treatment.¹² More importantly, the legal doctrine may fail to acknowledge certain clinical realities, that psychiatric treatment is an ongoing process rather than an isolated event, and that patients often communicate their wishes in highly ambivalent ways, through conflicting behaviors having unconscious as well as conscious components.

The patient's operational right to refuse psychiatric treatment by withholding consent must therefore depend, in great measure, upon sound clinical judgment and discretion — at least initially in the treatment process when patients may be more inclined to reject than to accept much-needed therapy. This is not to say that clinicians are free to make decisions in their patients' behalf willy-nilly. The fiduciary nature of their relationships to patients must always be questioned; the clinician must account for decisions made in the absence of — or in spite of — patient input, for this is consistent with the contractual aspect of their relationship.

A most difficult question thus emerges: to whom must the clinician account when he makes treatment decisions for medically and/or legally incompetent patients? The answer to this perplexing question does not lie in facile notions of delegating informed consent, no matter how socially attractive that solution, for "surrogate" or "proxy" consent is not informed consent. What compromise would be acceptable? I suspect that psychiatrists making treatment decisions for marginally competent, or obviously incompetent, patients will increasingly accept — if not welcome — external review of their actions. Indeed, the tragedy is that so few psychiatrists have given much thought to the "who" and the "how" of such review. My own bias is that courts, legislatures and even lawyers are, as one alternative, as inadequate for that review task as are proposals limiting it to purely professional opinions. Perhaps the answer lies in collaborations across disciplinary boundaries; at least one commentary has already suggested this course of action.¹³ I hope that other proposals will emerge as we continue our discussions during this meeting.

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- 9 See *Kaimowitz*, *supra*, and also *Griswold v. Connecticut*, 381 U.S. 479 488 (1965), *Roe v. Wade*, 410 U.S. 113 (1973), *Winters v. Miller*, 466 F. 2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) and *Olmstead v. United States*, 271 U.S. 438 478 (1928)
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