

The Right to Refuse Treatment: A Broad View*

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Psychiatry shares with other professions certain common characteristics. Sociologically, a profession is defined as an occupation based on a unique theoretical and scientific body of knowledge, whose practitioners have a service orientation, and autonomy in the performance of their work (Hughes, 1965). In addition to these three core characteristics, psychiatry is beginning to experience a trend which has been occurring in other professions. This trend has been referred to as "the revolt of client" (Haug and Sussman, 1969) and is surfacing in psychiatry under the label of the patient's right to refuse treatment. In this presentation, we wish to sketch out some of the major issues surrounding this complex question of the right of mental patients to refuse treatment.

The Revolt of the Client's Attorney

The three core characteristics of a profession are interrelated. Autonomy is granted through public acceptance of the profession's twin claims to expertise and altruism. Thus, the possession by professionals of a highly technical body of knowledge not generally comprehensible to the public and of values emphasizing the needs of clients over personal needs has resulted in the granting of authority and autonomy to the professional to determine what is best in a particular case. This power exists, however, only to the extent that the professional's expertise and good will are legitimized and accepted by the public.

A major trend occurring with regard to the professions over the past decade has been a serious questioning by clients of the expertise and in some cases of the good will of professionals and a rejection of the professional's right to autonomy and authority. Colleges, hospitals, prisons and ghettos have experienced sit-ins, take-overs, violent and non-violent strikes, marches and the like by clients who have organized to challenge the right of professionals to tell them what is best. Rather than accepting the professionals' assessment, clients have been revolting for a greater and greater role both in defining the exact nature of the problem and in deciding the appropriate remedy or solution. This has resulted frequently in situations

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such as college students attempting to determine the type and substance of courses to be offered.

In this context, the newest proposed right of mental patients, the right to refuse treatment, can be seen as an extension to the profession of psychiatry of an already established pattern. Its late arrival in the field of psychiatry can be explained, at least partially, by the comparative lack of social interaction, organization, and group consciousness among mental patients, the clients served by psychiatry (Karmel, 1970). Indeed, given that most of the movement toward patients' rights has resulted from legal court cases rather than organized client activities, it may be more appropriate to refer to the movement within psychiatry as the "revolt of the client's lawyer" rather than the "revolt of the client".

The Right to Refuse Treatment: A Case Example

As McGarry (1975) points out, the status, rights, and treatment of the mentally disabled have only recently become a matter of judicial concern. In the short period of the past two decades, however, the amount of judicial and legislative activity relating to the mentally disabled has expanded greatly. The right to refuse treatment represents one of the newest proposed rights of mental patients. Quite simply, the question is whether mental patients do or do not have a right to refuse treatment. The problem, however, is that while the question can be presented quite simply, the ramifications of the question and the potential solutions are far from simple. The right to refuse treatment is, according to Stone, "a subject of enormous complexity, involving legal, psychological, ethical, and socioeconomic considerations" (1975:97). We will detail some of the more important issues which impinge upon this subject, but before doing so we would like to present a case example from some research we are currently involved in.

In February of this past year a new unit, the Court Related Unit, was established on the campus of a N.Y.S. state psychiatric center to treat male juvenile delinquents who have been adjudicated for violent crimes and who are evaluated as being in need of mental health services. The unit has two components. The Department of Mental Hygiene component, a ten-bed secure unit, provides short-term in-patient diagnostic, stabilization, and emergency services for violent, court-related youth who are considered by unit staff to be so mentally disturbed as to require in-patient treatment. This short-term component acts as a funnel into the Division for Youth component, a twenty-bed secure unit which is the long-term treatment unit for those male juvenile delinquents who require treatment. Both components provide a highly structured program consisting of counseling and therapy on both an individual and group basis, as well as education, recreation, and medical services.

In early May, a series of incidents occurred on the DMH unit: one of the patients barricaded himself in his room and threatened staff; another patient escaped from the unit; and another smashed a clock and waved the broken glass as a weapon. In reaction to these events and the atmosphere on the unit, the director ordered all of the juveniles to be placed on maintenance medication. The patients, for the most part, resisted the medication; one

youth had to be held down by six staff members while the medication was administered intramuscularly. Subsequently, attorneys from both the Mental Health Information Service and Legal Aid became involved. After speaking with the youth, the attorneys officially notified the director that as minor voluntary patients, these juveniles could not be given treatment over their objections according to the Mental Hygiene Law of New York (Section 27.8 (b) (2)) and that medication must be discontinued. The director refused. Eventually, a preliminary injunction restraining medication was filed, but the day the case was to be heard in court, the juvenile for whom it was filed was transferred, rendering the question moot. This case and the whole issue of the right of these juvenile patients to refuse medication has clearly been and continues to be the major issue surrounding this new unit. Rather than providing additional details concerning this case, we would like now to attempt to utilize this case to draw out four major issues which complicate the question of whether these patients or any mental patient should have the right to refuse treatment.

Confounding Issues in the Right to Refuse Treatment

1. Right to Treatment

One of the newly won rights of mental patients is the right to treatment. The much discussed *O'Connor v. Donaldson* case (95 S. Ct. 2486, 1975) clearly established the constitutional and statutory right of mental patients to adequate treatment. By some the right to refuse treatment is seen as a correlate of the right to treatment (Carnahan, 1975). By others the two rights are seen as antithetical, with the right to refuse treatment being considered "one right too many" (Rachlin, 1975).

In the case example presented above, this divergence of opinion was much in evidence. The attorneys involved felt that the juvenile patients had a legal right to refuse medication. The psychiatrist directing the program maintained that to allow them to refuse would severely interfere with the unit's ability to provide adequate treatment. His position was that some order and stability were necessary, both on an individual level and on a unit level, in order to deal effectively with the psychiatric symptoms being presented by the youth.

2. Involuntary Commitment

A second issue is that of involuntary commitment. There are those who have argued (Szasz, 1963) and continue to argue (Miller, 1976) that no one should be involuntarily deprived of his liberty because of mental disability. The issue of involuntary confinement is important to the right to refuse treatment question; even those strongly against this right agree that the voluntary patient "may well have the right to refuse treatment" (Rachlin, 1975), particularly since the voluntary patient can ultimately exercise the right to refuse all treatment by requesting release.

The fact that the youths in the Court Related Unit were transferred to the auspices of DMH as voluntary patients was of crucial importance. As indicated above, in New York, patients on voluntary status may not be given any kind of treatment over their objection. Other than discontinuing

medication, the only options available to the director of this unit were either to discharge the youths or to attempt to convert them to an involuntary status. He did neither, but rather continued to have medication administered in violation of state law and DMH regulations.

However, in New York, even involuntary patients have the right to object to treatment and to appeal any decision to treat made over their objection to the head of service, to the facility director and to the regional director, a process which can take several weeks.

3. Least Drastic Means

In fact, there are some forms of treatment which can be refused by any patient in New York, whether voluntary or involuntary. These include electro-convulsive therapy, surgery, including psychosurgery, and the use of experimental drugs or procedures. This list and similar ones offered by others (Stone 1975:105) distinguish between various treatments on the basis of what is considered standard and well accepted by the psychiatric profession and on the basis of severity of the treatment. Yet what is standard treatment and how does one judge severity? By at least some psychiatrists, ECT may be defined as both standard and not overly severe. On the other hand, it has been suggested that patients should have the right to be free from milieu therapy, since such therapy may be harmful for some patients (Miller *et al.*, 1976). If an involuntary patient can refuse all treatment modalities including milieu therapy, is that not then tantamount to eliminating involuntary hospitalization? Furthermore, would the psychiatrist under such conditions be liable for failing to provide treatment for the patient?

4. Informed Consent

Under the New York State Law, before these forms of therapy can be administered, informed consent of the patient who is competent must be obtained after a full and comprehensive disclosure of potential benefits and the potential of harm. There are those that suggest that mental patients and others involuntarily confined can never give true consent (Mabe, 1975).

Although in the case example the patients were minors, the situation which we found may well apply to many other patients. The youths in this unit were caught in the middle of two systems. They were taken aside by the psychiatrists and the effects of the medication were explained to them. Given this information, they would then consent to be medicated. Later in the day an attorney would arrive and inform the youths of their rights and the potential effects of drugs, and the youth might withdraw his "informed consent."

How do you go about adequately informing someone of the benefits and harms of therapy, particularly when there is much disagreement in the profession itself over the potential effects? To what extent can such a decision be freely reached when the overriding concern of the patient is to return home as quickly as possible or when the fear exists that refusing oral medication will result in "being stuck by a needle," as some of these court-related youth felt? How meaningful can such consent be when at least one study has found that only 14 of 40 patients who signed voluntary

admission forms remembered signing them 10 days later (Palmer and Wohl, 1972)?

The Right to Refuse Treatment: Its Impact on Psychiatry

It should be obvious at this point that the right to refuse treatment is an extremely complex question. To address it is to address a whole set of intertwined and interdependent issues. We have attempted to outline above what appear to be some of the major problems raised by the right to refuse treatment. There is much more that could be added concerning the right to treatment, involuntary commitment, least drastic means and competent informed consent. Furthermore, there are other relevant issues which have not even been touched upon, such as the role of the legal advocate in the mental health setting, the use of the third parties, the court or professional standards review organizations as decision-makers, and the potential benefits of a contractual model of doctor-patient relationships. Nonetheless, this overview of the difficulties surrounding the right to refuse treatment should suffice to suggest the complexities of the issues.

As noted earlier, the right to refuse treatment is the newest right to be proposed for mental patients. As such, the court decisions that have directly addressed this right are relatively few and do not provide clear or complete guidelines. Cases examining the legal right to refuse treatment have focused primarily on the right of an individual or class to refuse specific types of treatment. Important cases have been decided concerning the right to refuse potentially hazardous modes of treatment, such as electroconvulsive therapy, psychosurgery and aversive conditioning. *Wyatt v. Hardin* (No. 3195-N, M.D. Ala., 1975) established standards governing the use of such potentially hazardous treatments for patients in the State's mental institutions. In *New York City Health and Hospital Corporation v. Stein* (70 misc. 2d 944, 335 N.Y.S. 2d 461, 1972), the New York Supreme Court ruled, in anticipation of the enactment of the new state mental hygiene law, that ECT could not be administered to a non-consenting patient even though the patient's mother had consented to the treatment. Another important decision concerned aversive conditioning and behavior modification (*Knecht v. Gillman*, 488 F. 2d 1136, 1973). In this case the court ruled that the involuntary administration of apomorphine, which induces vomiting, was cruel and unusual punishment prohibited by the Eighth Amendment.

Several cases have dealt with the right to refuse experimental treatments. In *Kaimowitz for John Doe v. Michigan Department of Mental Health* (Civ. No. 73-1943-4, Slip. Op. 29-31, 1973), the court ruled that involuntarily detained mental patients cannot under any circumstances give informed consent to experimental psychosurgical procedures on the brain. Such procedures, the court ruled, have the potential for violating the First Amendment rights of patients to generate and freely disseminate ideas. The court ruled in another case, *Mackey v. Procunier* (477 F. 2d 877, 9th Circuit, 1973), that the administration of an experimental drug without the patient's consent violated his Eighth Amendment rights.

Several cases have examined the right to refuse medications. In *Winters v.*

Miller (446 F. 2d 65 [2nd Cir.], Cert. denied, 404 U.S. 985, 1971), the court ruled that Winters, a Christian Scientist who was given medication over her objections, had had her First Amendment rights of religious freedom violated. In *Welsb v. Likens* (373 F. Supp. 487, D. Minn., 1974), the court ruled that the use of medications in the state mental hospital was improperly evaluated, monitored and supervised, therefore eroding the value of drugs as an adjunct to therapy. This constituted cruel and unusual punishment and denial of due process. In a recent case, *Scott v. Plante* (532 F. 2d 939, 1976), the patient claimed that he was forced to take drugs and other treatments against his will and without the consent of any family member. The court ruled that there was a possible violation of the patient's First and Eighth Amendment rights, and the case has been remanded to the district court for further proceedings.

It is apparent that judicial involvement in the question of the right of mental patients to refuse treatment will continue to expand, as it will in other areas dealing with the confinement and care of the mentally disabled. It is also apparent that unless one is willing to accept one of the two extreme positions — that patients should never have the right to refuse any treatment recommended by a psychiatrist, or that all patients should have the right to refuse any treatment — there are no easy answers, and an adequate specification of conditions, procedures and legality of the right is unlikely in the near future.

What is less clear is the extent to which the class action suits, the legal battles, the changes in statutes, and the general level of controversy and confusion over the care and treatment of the mentally disabled benefit or harm the profession of psychiatry. By some, each new proposed right for the mental patient is seen as sounding the death knell of psychiatry. Yet psychiatry appears to survive. It does so by adapting to the changing conditions as other professions have in reaction to the revolt of their clients. It is extremely unlikely that there will be a return to prior definitions of professional-client relationships, and in this sense a revolution is in progress (Haug and Sussman, 1969). These changes within psychiatry and the proposed changes in the patient's right to refuse treatment have led and will continue to lead to administrative and financial burdens, to further questioning of psychiatric expertise, to a narrowing of authority, and to a decrease in autonomy, with lawyers, judges and patients having a greater role in decision-making in psychiatric matters. Yet many of the demands resulting from these changes, in the long run, may be to the benefit of psychiatry and the people it services. For example, having to draw up treatment plans, having to detail the level of knowledge available for various treatments, and in general having to play a more restricted expert role may actually result in the improvement of the profession and practice of psychiatry. While this may be so, it does not alter the fact that psychiatry is currently in the painful interim period between the decline of old definitions and roles and the clarification and general acceptance of any new ones.

While it provides little consolation in facing issues such as the right to refuse treatment, it is apparent, as we have discussed here, that the profession of psychiatry is not alone in this stage of confusion and controversy.

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