The Right to Refuse Treatment: Legal Issues*

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A number of legal commentators and advocates of the rights of mental patients have argued that people who are involuntarily civilly committed should have the right to refuse treatment.[1] They argue that such a right would be one step toward ending some of the problems currently plaguing the mental health service delivery system, particularly the often-documented indiscriminate use of tranquilizing drugs in most public mental hospitals,[2] and a further step towards the evolving recognition of the civil rights of mental patients.[3] Yet even the most ardent advocates would have to argue that there should be such a right, not that such a right exists, at least in the sense that the right to refuse treatment is a well-recognized and adequately enforced principle of law. In fact, a review of the case law reveals that in most jurisdictions the issue has been neither raised nor decided.[4]

A few courts have grappled with the issue – actually issues –[5] that such a right would involve. In *Knecht v. Gillman,* 488 F. 2d 1135 (8th Cir. 1973), the court of appeals ruled that mental patients have the right to refuse aversive treatment administered to patients not for therapeutic purposes in the strict sense, but for violations of behavioral rules. That court held that it is a violation of the Eighth Amendment's prohibition of cruel and unusual punishment to give the drug apomorphine to patients who have not given their informed consent.[6]

The much publicized *Kaimowitz v. Department of Mental Health* (Cir. Ct. Wayne Co., Mich., July 10, 1973)[7] considered a different aspect of the consent problem. In that case a Michigan state court held that an involuntary psychiatric patient is legally incapable of consenting to experimental psychosurgery since the circumstances of his confinement render him incapable of making a voluntary – meaning free from coercive elements – decision to consent. The court further ruled that even with his (invalid) consent, to proceed with this form of treatment would be a violation of his First Amendment right to generate ideas as well as his constitutionally protected right to privacy.

In *Winters v. Miller,* 446 F. 2d 65 (2d Cir. 1971), a patient objected to both basic medical care and psychiatric treatment, objections based on her long-standing religious beliefs as a Christian Scientist. The court of appeals held that to allow the state to treat her over her objection would interfere too greatly with the freedom of religion secured by the First Amendment. The state's exercise of authority was not invalid *per se* nor without a proper

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purpose, but to carry out that authority under these circumstances would violate an important right secured by the Constitution.[8]

Each of these cases addresses a rather narrow issue; *Knecht* and *Kaimowitz* are concerned with the right to refuse experimental or punitive procedures; *Winters* addresses the broad question of the right to refuse ordinary therapeutic procedures, but it was concerned with only those patients who have an objection to treatment based on a provable (and probably acceptable) religious belief. These cases, however, offer the basic model by which the issue of the right to refuse treatment will be considered in other applications of the concept.[9] The legal analysis, far too complicated to be fully detailed in the context of this paper, could be outlined as follows:

Government authority, even when properly enacted by the legislature and serving a recognized constitutional purpose, has limits. Government must still follow certain procedures, distribute benefits and burdens within the bounds of equal protection, and, when it interferes too greatly with certain constitutionally recognized fundamental interests, such as the right to privacy or the rights secured by the First Amendment, limit the exercise of its authority. Thus, while it is clearly within what are known as the "police powers" for state government to protect the public's health and to regulate the practice of medicine and the circumstances under which it is performed, attempts to prohibit altogether the performance of abortions or to prohibit the use of contraceptives have been found to be unconstitutional because they interfere too greatly with the right of privacy.[10] Or, as in *Winters,* a state government carrying out a (presumably)[11] constitutionally permissible mental health program, including involuntarily confining certain categories of people, is precluded from involuntarily treating these people if they object to the treatment on religious grounds. This preclusion is not because of the invalidity of the purpose or because of an evaluation of the appropriateness of the intended treatment, but because to provide treatment involuntarily under the circumstances would interfere too greatly with a constitutionally protected fundamental interest or value.

The critical questions, then, are twofold: (1) What are these fundamental interests? (2) When does the interference exceed acceptable limits?

As the cases cited earlier indicate, substantial arguments can be made that psychiatric treatment interferes with virtually every basic individual right from the right to free speech to the right to be free from cruel and unusual punishment to the right to generate ideas. But the focal individual right at stake is that of privacy, the right to self-determination and bodily integrity. While relatively recently recognized, the right to privacy has been jealously guarded by most courts in the last few years and is clearly what the law would consider in this context to be a fundamental interest.

Ultimately, the courts will have to weigh the interests of the state against the protected interests of the individual and decide whether involuntary psychiatric treatment interferes too greatly with the right to privacy and other constitutionally protected rights. This weighing process is not simply a balancing of the importance of interests; it is most frequently expressed as a requirement that the government show that it has a compelling interest that justifies the interference with protected individual rights. At the least, this

requires a close scrutiny of the government's purpose, both in terms of its constitutional legitimacy as a governmental objective and in terms of the likelihood that the proposed means will achieve the intended end.[12] Under such a scrutiny, psychiatric treatment could be vulnerable; the compelling nature of the need to treat will rely on the ability of the profession to show that treatment is effective or that a proposed treatment has a predictable outcome. It is also likely, as has been the trend of the cases already decided, that under close scrutiny certain purposes for psychiatric procedures will be held invalid (or at least not compelling), as in the case of unusual, experimental, or punitive procedures.

In balancing the competing interests of the government against important individual rights, many, although not all, courts have developed a concept of requiring that the state purpose be served by the least drastic alternative or prohibiting "means which sweep unnecessarily broadly."[13] The applicability of such a concept to the balancing of the governmental purpose in treating mental patients against the desire to protect individual self-determination and personal integrity is readily apparent. In fact, even this brief review of the relevant legal principles should leave a clear impression that the courts are likely to decide the issue of a right to refuse treatment not by absolute prohibition or allowance, but by balancing or compromising both the competing interests in some respects.

While the state's right to compel treatment may be recognized in the case of an incompetent patient, competent patients, or even those whose incompetence has not been determined by a court, may be entitled to participate in the treatment decisions. Or where an absolute right to refuse is not recognized, the right to consent may have to be exercised by a third party acting as a guardian for the interests of the patient. Or as is already a trend in the case law, certain kinds of procedures, *i.e.*, those that are used for non-therapeutic means, or experimental, drastic, or unusual therapies, may be subject to the patient's right to refuse. Furthermore, in fashioning a reasonable balance of the state's interest and the individual's rights, courts may focus on the conditions that must exist – or not be present – before a consent is considered informed or voluntary, as in the *Kaimowitz* decision.

These predictions of outcome are, of course, speculative. As stated earlier, the issue of the right to refuse treatment has not been settled or even frequently considered by the courts. And whatever principles are established, they will have to be applied to a variety of circumstances before the issue can in any way be considered settled law.

Most courts have shown in the last ten years an increased concern for the rights of mental patients, and an optimist would expect that among the issues that will be litigated to resolution in the next ten years will be the right to refuse treatment. Mental patients are, finally, being given the representation and access to the courts that they have been denied for so many years. And a variety of courts – not just an occasional Bazelon decision – including the Supreme Court have shown an increased willingness to accept these issues and an increasing receptivity to constitutional argument concerning the rights of people involuntarily confined in mental institutions.

Such optimism must be guarded. First of all, the willingness of the legal

system to fairly consider the rights of people we label as mental patients is only beginning. They are still in the eyes of most of us second class citizens, deserving our paternal instincts to help, but not so deserving as to enjoy the abstract values the rest of us consider civil rights. The one fact omitted from almost every legal analysis is often the most critical: the personal and professional biases of the judges who interpret the law and the lawyers who argue it are often as determinative of outcome as any of the legal principles that are purported to be the basis of their decisions.

Secondly, relatively few legal resources are actually available to involuntarily confined mental patients. Of the public interest, legal services, and public defender programs that have interests or responsibilities in this area, few want or can afford to carry out the expensive and time-consuming law reform litigation that would be required to adequately carry a case of first impression to final decision; and even if recognized, a right to refuse treatment would have to be applied and enforced. This means not just one landmark decision in one jurisdiction, but a series of cases and a continued effort to see that they are enforced.

If the right to treatment cases are any example, litigating the right to refuse treatment may be a slow, frustrating process;[14] and even if the right is ultimately upheld by the courts, the prospects for real enforcement may be doubtful at best. From recognition to practice may be a long way for a class of people who are both socially and economically disadvantaged.

These pragmatic aspects of the law, its interpretation, and its enforcement cannot be ignored. They are largely responsible for the most ironic aspect of the right to refuse treatment problem: the law in theory would require that the burden be placed upon the government to justify its purposes in interfering with the lives of individual people; the reality of the law is just the opposite. Until such time as individual patients can muster the ability to challenge that interference, the *status quo,* which generally denies patients the right to participate in treatment decisions, will undoubtedly continue, despite the partial or wholesale limits that the law, if perfectly enforced, might impose on that course of events.

While a full recognition of a right to refuse treatment – with all its various applications – is and should be a debated issue, it seems impossible for anyone to argue that patients should not be afforded such a right in at least limited forms and while, not after, the debate continues.

References

1 Good summaries of the legal arguments and the previous literature can be found in Schwartz B: In the name of treatment: Autonomy, civil commitment, and right to refuse treatment. 50 Notre Dame Lawyer 808 (1975); Shapiro M: Legislating the control of behavior control: autonomy and the coercive use of organic therapy. 47 S C L Rev 237 (1974).

2 See Schwartz, *op. cit.,* n. 1

3 The American Bar Association's Commission on the Mentally Disabled has recently funded the Mental Disability Law Reporter, reporting major legal developments and providing a clearinghouse of information on this subject. Its initial issue, July-August 1976, summarizes most of the recent decisions.

4 Some states have by statute explicitly recognized a patient's right to refuse certain procedures. California, for example, has recently adopted legislation that allows all patients an absolute right to refuse psychosurgery and a limited (it can be denied under some circumstances) right to refuse convulsive treatment, ch. 1109, Acts of 1976 amending Cal. Welfare and Institutions Code § 5325 *et seq.*

5 The concept of a right to refuse treatment has a variety of applications. See below, p. 17

6 For a related case, see *Mackey v. Procunier*, 477 F. 2d 877 (9th Cir. 1973). In that case the circuit court ruled that it is a violation of the Eighth Amendment prohibition on cruel and unusual punishment if experimental procedures are used on prisoners being treated in a psychiatric facility without their consent.

7 Cited in summary form in 42 U S L W 2063 (1973) and discussed in 50 Chi-Kent L Rev 526 (Winter 1973)

8 See also *Scott v. Plante*, 532 F. 2d 939 (E.D. Mo. 1976).

9 A full legal analysis would have to consider the interesting but rebuttable argument that the logic of the right to treatment cases, *O'Connor v. Donaldson*, 422 U.S. 563 (1975) and *Wyatt v. Aderholt*, 503 F. 2d 1305 (5th Cir. 1974), could be extended to require that the state provide adequate treatment *even if* the individual patient refuses to accept it. While such an argument is logical, it denies the reality of those cases. Adequate treatment was defined as minimally adequate physical facilities, staff/patient ratios, and individualized treatment plans. None of the right to treatment cases concerned or required treatment of any one individual patient. However, see the strong implication to that effect in *Whitree v. State of New York*, 290 N.Y.S. 2d. 486, 501, 56 Misc. 2d 693 (Ct. Cl. 1968).

10 *Roe v. Wade*, 410 U.S. 113 (1973), *Doe v. Bolton*, 410 U.S. 179 (1973). See also *Eisentadt v. Baird*, 405 U.S. 438 (1972).

11 In *Jackson v. Indiana*, 406 U.S. 715, 737 (1972), Justice Blackmun questioned the legitimacy of the traditionally accepted purposes for civil commitment: "Considering the number of people affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." In effect, Justice Blackmun was raising the as yet unanswered question of whether a need for treatment is a sufficient justification or whether an individual must also be dangerous

12 See *Roe v. Wade, Doe v. Bolton, op. cit.*, n. 10

13 See *Griswold v. Connecticut*, 381 U.S. 479 (1965) at 485. Possible applications of this concept to the constitutional analysis of civil commitment procedures and the rights of mental patients have been discussed in Chambers D: Alternatives to civil commitment of the mentally ill: Practical guides and constitutional imperatives. 70 Mich L Rev 1108 (1972)

14 *Wyatt v. Aderholdt, op. cit.*, n. 9, took over four years from original filing in the district court to the decision in the court of appeals. It is still not clear how and when the recognized right to treatment will be enforced in any real sense.