

The Constitutional Right to Refuse Antipsychotic Medications †

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The emergence within the past two years of a constitutional right of involuntarily hospitalized mental patients to refuse antipsychotic medications has set off sharp reverberations in the hospital psychiatry community, alarming, offending, angering and puzzling many members of the profession, especially those in the public sector who are likely to be most immediately affected if such a right becomes universally recognized.¹ Hospital psychiatrists are alarmed, because they see themselves enmeshed in further unwelcome legal intrusions on their practice of medicine.² They are offended because the reforms seem to be based on criticisms which they regard as unwarranted and exaggerated.³ They are angered because they view the courts' standards and procedures as unrealistic, the product of unfamiliarity with medications and hospital practice.⁴ And, finally, they are puzzled because they do not understand why traditional medical practices have unexpectedly and suddenly become constitutionalized.⁵ Some, though not all, hospital psychiatrists are convinced that the establishment of a constitutional right to refuse medications, intended as helpful to mental patients, will be counter-productive and harmful. Indeed, the battle cry of the 1980's may be, as illustrated by the title of a recent editorial in the *American Journal of Psychiatry*, that refusing patients will "rot with their rights on,"⁶ a slogan reminiscent of the catch phrase of the 1970's that the mentally ill would, as a result of legal reforms, "die with their rights on."⁷

The furor has been caused primarily by decisions in two leading federal cases, *Rennie v. Klein*⁸ in New Jersey and *Rogers v. Okin*⁹ in Massachusetts, in both of which the courts have ruled that involuntarily

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hospitalized mental patients now have a qualified federal constitutional right to refuse medications. Both courts have established standards and due process procedures to insure appropriate enforcement. As of this writing, the decision in *Rogers v. Okin* has been affirmed in principle by the First Circuit Court of Appeals, but remanded with instructions to the lower court for modifications. The Third Circuit Court of Appeals has decided to hear *Rennie v. Klein en banc*, thus further delaying a decision in that case. Other medication refusal cases have been decided by both federal and state courts in Utah, Colorado, Oklahoma, Ohio, and in the District of Columbia.¹⁰ Other cases are underway in Wisconsin and California. The U.S. Supreme Court is likely to be confronted with some of these cases soon, although it is not certain that the Court will accept and decide them.

The Legal Grounds for the Right to Refuse

Both federal courts in the two leading cases have ruled that when the state exercises its power to hospitalize and treat the mentally ill, it must respect certain constitutional rights held by these individuals to refuse certain treatments under specified conditions, even though they are mentally ill.

The major constitutional rationale relied upon by both courts is similar, although each court has placed a different stress on other constitutional doctrines. In both cases the federal judges have ruled that the constitutional right of privacy, which guarantees autonomy with respect to decisions as to one's body and mind, insures that a non-dangerous and competent patient has the right to refuse medications.¹¹ The *Rogers* case also stressed as a rationale the First Amendment right to freedom of thought, reading and communicating.

The *Rennie* Court, while acknowledging the First Amendment as a potential ground for medication refusal, did not apply it because of the facts in that case. The First Circuit, in reviewing *Rogers*, did not pass on the applicability of the First Amendment.

The *Rennie* Court also mentioned, without applying it, the Eighth Amendment prohibition against cruel and unusual punishment. But recent United States Supreme Court decisions strongly indicate that this rationale, designed for criminal cases, is no longer applicable to civil cases such as *Rennie* and *Rogers*.¹²

It is likely that the right to autonomy ground will be upheld by the Supreme Court. The First Circuit Court of Appeals has already affirmed that rationale. None of the parties in either case has challenged the applicability of the right of privacy to medication refusal.

Having established the right, both courts also provided circumstances under which the right can be overridden. Essentially, medication refusal can be overcome in situations where the patient is either incompetent or dangerous. The patient cannot insist on the honoring of his refusal if that refusal is either based on irrational reasons which result from his

mental illness, or if he is dangerous to himself or to others in the hospital.

The Remedy

The really controversial issue in the medication refusal cases is not the existence of the right itself, which is acknowledged by many (though not all) in the psychiatric community, but rather the standards and procedures which shape and define the right. Those who are familiar with law recognize that a right can be expanded or contracted depending on the standards and procedures used. Thus, the pivotal issue in the medication refusal cases has become one of standards and procedures.

The procedures provided by the *Rennie* and *Rogers* courts have been significantly different. The *Rogers* court ruled that in the event of a medication refusal there should be a judicial hearing to determine the patient's competence. If the patient were determined to be competent, his refusal would be honored. Otherwise, a guardian would be appointed who would have the authority to decide on the patient's behalf whether he should accept or refuse medication. This procedure has already been set aside by the reviewing court as too cumbersome.

The *Rogers* procedure was an elaborate one, providing for judicial review, lawyers, and the appointment of a legal guardian for each incompetent refusing patient. To the extent that the ruling was regarded as excessively judicializing the medication refusal process, it was vigorously criticized by hospital psychiatry representatives. Some of these criticisms have been accepted in the First Circuit Court decision.

The decision in the *Rennie* case, in contrast, established a set of in-hospital procedures whereby all medication refusals not subject to informal resolution would be reviewed by an Independent Psychiatrist to be retained by the State Commissioner of Human Services. The refusing patient would be assisted by a Patient Advocate, also retained by the Commissioner. A significant feature of the *Rennie* procedure is that the reviewer is not a judge or administrator, but a psychiatrist, and that review of medication refusals is modeled on traditional medical peer review.

The *Rennie* decision has drawn modest psychiatric criticism, but not as much as did the *Rogers* ruling. Nor has the hospital psychiatry profession paid much attention to *Rennie*. Rather, evaluation and criticism has focused on the *Rogers* case, tending to identify medication refusal with the *Rogers* approach, including *Rogers'* reliance on the First Amendment, and the procedures established in *Rogers*, ignoring or neglecting the more practical approach of *Rennie*. A major function of this Article is to correct psychiatry's misperception that legal solutions to the medication refusal problem are identifiable exclusively with *Rogers*.

In this Article, an effort will be made to explain why medication refusal has become an issue; the rationale behind the court's response;

and why certain remedies have been chosen as a way to address the problem. The criticisms of hospital psychiatry will be discussed and analyzed. Finally, some general proposals and approaches will be suggested.

Why a Constitutional Right to Refuse Medication?

Why has the medication refusal issue surfaced at this time? Psychiatrists who have accepted legal regulation of psychosurgery and electroshock therapy¹³ nevertheless tend to view such regulation of antipsychotic medications as inappropriate, in large part because the risk-benefit balance in the administration of this mode of treatment has seemed so overwhelmingly to favor benefit for the patient that there has been no occasion for legal intervention. Antipsychotic medications have for a quarter of a century been the major treatment of choice for schizophrenia, universally regarded as customary and uncontroversial.

Recently, however, courts have been made aware that the original view of antipsychotic drugs as predominantly beneficial but not significantly harmful is no longer valid. Antipsychotic drugs, though beneficial, may also be harmful. To the extent that this harm is imposed by the exercise of state power, the courts are required to intervene, because of the traditional role of the court in protecting the individual against harmful state interventions regardless of intention.

In considering whether the courts should intervene and establish a limited constitutional right to refuse, the first question to be addressed is: How much benefit and how much harm results from the use of antipsychotic medications?

The Benefits of Medications

Antipsychotic medications provide a substantial benefit for many mentally ill persons, as well as for their families, friends, neighbors and fellow workers and society generally. Since their discovery in the early 1950's, antipsychotic medications have played a significant role in the release of thousands of patients from mental hospitals and have tended to insure more humane treatment for those patients who have been compelled to remain in the hospital. In fact, antipsychotic medications have been regarded by many doctors and others as almost a panacea in dealing with mental illness. Lawyers, judges, legislators and the general public have for many years shared this view.¹⁴

The benefits of medication are generally characterized as severalfold. First, they have made it possible for the mentally ill to function in the community, thus facilitating a significant deinstitutionalization of hospitalized patients, shifting the focus of care from the institution to the community. National hospital populations have dropped from over half a million in 1950 to less than 200,000 in 1979.¹⁵ Second, hospitalization stays have become shorter. In 1971, for example, a median hospital stay was 44 days. By 1975, it was only 26 days.¹⁶ Third, it

is claimed, though not without significant controversy, that medications permit the mentally ill to become more accessible to other forms of treatment, such as psychotherapy. Fourth, for those who must remain in the hospital, medication reduces violence and disruptiveness by eliminating or diminishing hallucinations and delusions. This has resulted in more humane treatment by mental hospital staff, who have resorted less to seclusion, physical restraints, and brutality. As patients are calmed by medications, hospital staff can afford to be less fearful, harsh, or punitive. Thus, benefits accrue not only to patients, but to hospital staff as well. Fifth, the effect of medications has also assuaged the fears and anxieties of families and others in the community, who as a consequence have become better prepared to accept former mental patients in their homes, neighborhoods and working places, facilitating the process of deinstitutionalization.

The benefits of medications described here are not without controversy. Their most effective use seems to be in the treatment of short-term acute cases rather than with long-term chronic cases.¹⁷ Although studies report that the rehospitalization rate of unmedicated patients can be twice as high as that of medicated patients, other studies indicate that the functioning of both in the community is about the same and that unmedicated patients sometimes make better adjustments than do those who are medicated.¹⁸ These and other studies suggest that the benefits of longer term medication, especially for those who are chronically mentally ill, are not always clear-cut. Such decreased benefit must be weighed in the balance with increased cost, especially to the chronic patient.

The Cost of Medications: Side Effects

In the general euphoria that followed the discovery of antipsychotic medications, relatively little attention was paid to their human costs in the form of side effects. At first it was widely thought that most side effects were trivial, controllable and reversible. At worst, some side effects were regarded by doctors, though not by patients, as mere annoyances or nuisances.

It is now reluctantly recognized by the psychiatric profession that many medication side effects are significant, capable of causing serious physical, emotional, and cognitive distress. It is critical to keep in mind that side effects occur even where medication is responsibly and competently administered, with great care and consideration for the patient. But the distress caused by side effects is significantly worse where medications are administered carelessly, insensitively, incompetently, or abusively. Evidence emerging from major litigations, legislative inquiries, and newspaper accounts indicates that hospital medication usage, especially in the public sector, is frequently negligent and even abusive. In this connection, however, it should be clearly understood that legal remedies involved in medication refusal cases are not

designed exclusively to protect against negligence and abuse. These legal protections apply equally to the most responsible and careful administration of medications for the reason that, because of the intrinsic character of certain antipsychotic medications, the harm done by the medications outweighs the benefit for a significant number of medicated persons.

The Nature of the Side Effects

A total catalogue of the side effects caused by antipsychotic medications, including the most and least common, would be a horrendous document. Numerous studies identify a wide variety of side effects ranging from dry mouth to death.¹⁹ For our purposes, and for this readership, only the most commonly observed side effects need be referred to, and in a manner that demonstrates reasons for concern by the courts.

Let us first consider physical side effects. These include, among many others, blurred vision, which makes reading difficult; dry mouth; physical restlessness; and an interminable pacing or shaking of the arms and feet, a condition known as akathisia, often accompanied by extreme anxiety. Patients have colorful names for some of these conditions. In Wisconsin there is the "Mendota Shuffle" and the "Prolixin Stomp," which refers to foot bouncing. It is not unusual for a patient to report that medication causes excessive sleepiness, a "torn-up stomach," and the like. In addition, medications can cause constipation; palpitations; skin rashes; low blood pressure if the patient stands up too quickly; faintness; and extreme fatigue. The patient may also experience a state of diminished spontaneity; slowing up of his processes; and a feeling of extreme weakness and muscle fatigue, referred to as akinesia.

The medications often cause unpleasant sexual problems. They may affect a woman's menstrual cycle. Some men are unable to ejaculate, a serious problem where self-esteem and competence are at stake.

Anthropologist Sue Estroff has described a group of medication takers as typically showing "the shakes, stiffness, blank expression, gait, leg jigging, eye rolling, and facial grimacing."²⁰

Secondly, let us consider emotional side effects, which include listlessness and apathy. The term "zombiism" has come into widespread use in mental hospitals to describe aspects of this condition. Some patients feel that life does not seem worth living when they are on medication. They characterize their lives as "empty," "aimless," or "unenthusiastic."

Third, let us consider cognitive side effects. Some patients cannot concentrate or think straight because of their medications. Reading or talking becomes impossible, and the patient retreats into an intellectual vacuum. For a patient who has even modest intellectual interests, cognitive side effects can be extremely distressing.²¹

Finally, there are interactive social side effects that have not yet been

adequately analyzed. Anthropologist Sue Estroff, who has lived with mental patients, reports a "complex and as yet obscure interaction [that] takes place between the subjective experience of self and body while on medications and [the patient's] social and interpersonal environment." Estroff describes "clients who experience side effects, especially of the akinetic type, [as] often simultaneously depressed; appearing blunted and sad, detached and disinterested and feeling morose, hopeless, and gloomy. Clients who experience akathisia look and feel restless and agitated. They find it difficult to stand still, pacing, shifting back and forth from foot to foot, bouncing their legs, feeling the need to move." Estroff suggests that "akinesia and akathisia as experienced by the client and others with whom they interact, contribute to withdrawal and isolation, depressions and despair. . . . The depression and anxiety, in experience for the client and in appearance for others, serve to perpetuate separateness and lack of involvement." Says Estroff, medications "make you feel uncomfortable, physically and mentally, with yourself." She notes that psychiatric personnel may be aware of the limitations of drug therapy, but questions their awareness of the "actual and potential social and interpersonal costs of medications."²²

Tardive Dyskinesia

One side effect has emerged as so serious that separate discussion of it is warranted. This is tardive dyskinesia.²³ Psychiatrists traditionally have regarded this condition as not serious. A characteristic view of tardive dyskinesia, expressed as recently as 1972, is that "the net good of phenothiazines is so overwhelming that [tardive dyskinesia] is an undesirable but acceptable level of side effects. It is not catastrophic."²⁴ In 1972 there was less evidence to warrant challenging this view. Now there is more evidence of seriousness. Nevertheless, in 1980 the same attitude still prevails.²⁵

It is generally acknowledged that for some patients, most especially chronic patients who have used medications for a long period of time, tardive dyskinesia can be a seriously disabling physical condition, characteristically manifested by grotesque movements of the face, tongue, mouth and limbs. These bizarre movements generally cause enormous embarrassment and humiliation to the patient and frequently result in significant physical malfunctioning. In the *Rennie* case, for example, evidence was presented concerning a patient who because of involuntary mouth movements was unable to wear dentures, as a result of which she was compelled to live on ground food. To add insult to injury, hospital staff taunted this patient as "the lady with her tongue out."²⁶

The most distressing aspect of tardive dyskinesia is that for many medication users it is irreversible and generally discovered only when the condition has already become seriously disabling. Tardive dyskinesia has no known cure, although cases of apparent spontaneous remission

have been known to occur, giving rise to the question whether there are at least two general types of tardive dyskinesia, one reversible, the other not.²⁷

Long-standing psychiatric perceptions that the incidence of tardive dyskinesia is negligible are now being revised. Recent studies suggest that in some mentally ill populations, in the community as well as in the hospitals, the extent of tardive dyskinesia ranges from 25% to 50% of all persons who have received antipsychotic medications over a prolonged period of time. The issue of the incidence of tardive dyskinesia is, however, highly controversial and reported figures vary sharply.²⁸

From a legal point of view, it is not necessary to document that the incidence of tardive dyskinesia is as high as 50%. Even a much lower rate, such as 20%, acknowledged by many, involves a large enough proportion of persons to warrant legal protective action.

Patient Reaction to Side Effects

Some side effects can be counteracted in a variety of ways, including corrective medication, a change to a different antipsychotic medication or by a discontinuation of medication. Other side effects, such as tardive dyskinesia, appear to be irreversible in a significant number of cases, although there remains hope that techniques may become available which will minimize its impact.²⁹

In some cases a medication change can eliminate a side effect problem. Sometimes it is discovered that an inappropriate medication was originally prescribed, or too much of it. An inappropriate and harmful medication may be prescribed because of faulty diagnosis. It is not uncommon to discover that the patient doesn't need medication at all. Hospitals have been known to discontinue medications for certain groups of patients, finding that these patients do as well — or better — without medications.

Some side effects are merely disagreeable. Other side effects are intensely unpleasant, intolerable, and uncontrollable. Some patients particularly dislike certain drugs, such as Prolixin.³⁰ Corrective drugs used to counteract side effects have their own side effects, including blurred vision and dry mouth.

It is not yet known why some patients respond to side effects with greater distress or suffering than do others. Some patients seem able to cope successfully with side effects. Many others experience considerable distress from side effects. For some, psychosis itself may not be intolerable. Indeed, the problems of psychosis may be more acceptable to certain patients than a permanent medicated state which may result in a potentially irreversible disfigurement or in a perpetually unpleasant loss of zest for life.

Psychiatric research which indicates that only relatively small percentages of patients may experience certain side effects seems irrelevant to the mental patient who does experience great discomfort.

While it is true that many side effects are reversible if the medication

is terminated, for many chronic patients on maintenance antipsychotic therapy, side effects are permanent, since they invariably accompany the ever-present medication.

Psychiatric Reactions to Side Effects

Given the adversity of side effects routinely encountered in antipsychotic drug use, why do most psychiatrists tend to deprecate their significance?³¹ Hospital psychiatrists generally view side effects as of modest consequence in relation to their benefits. A typical response to the issue of side effects is: "What's a little dry mouth?"

How has psychiatry as a profession responded to the problem of side effects? Until recently, there seems to have been insufficient sensitivity or concern. For years many leading researchers and hospital psychiatrists denied that tardive dyskinesia was a problem, some estimating that less than 2 to 3% of medication users were affected by it. Some psychiatrists insisted that behaviors labelled as indicative of tardive dyskinesia were really a product of the mental illness itself, and not of drugs.³² A medical authority on psychopharmacology has reported that despite "a considerable body of evidence" concerning the seriousness and extent of tardive dyskinesia, "many physicians are still unaware of this problem or seem to be completely unconcerned about it. . . ."³³

Testimony presented in the *Rennie* case indicated that psychiatrists on hospital wards did not appear to observe any significant extent of tardive dyskinesia, although the bizarre motor movements of their patients were at times highly observable by others. For example, Ancora Hospital reported for accreditation purposes that not a single patient there was suffering from tardive dyskinesia.³⁴ A short time later, however, under legal pressure, Ancora's medical director estimated that approximately 25 to 40% of Ancora patients were probably afflicted with tardive dyskinesia.

In 1974, in response to allegations that large numbers of Ancora patients were suffering from tardive dyskinesia, an "independent study" was conducted by a team from the New Jersey Medical College. Remarkably, members of the team did not personally examine any patients for the study. Rather, the team determined the nonexistence of tardive dyskinesia from an examination of Ancora's hospital charts. Since the charts contained no references to any symptoms of tardive dyskinesia, the team concluded that there was no tardive dyskinesia among Ancora patients.

In 1978, following the onset of the *Rennie* litigation, yet another chart review was done. The conclusion was reached that still no cases of tardive dyskinesia were uncovered³⁵ and other side effects were characterized as "minimal." Still later, an independent expert, in a survey of a sample of 100 Ancora patients, found 20% of them suffering from tardive dyskinesia and another 15% manifesting signs of drug-induced parkinsonism.

The judge in the *Rennie* case observed that Ancora's medical director had personally reviewed the use of antipsychotic drugs for Rennie and, even though Rennie's case was then in litigation, had failed to record obvious abnormal jaw movements which indicated that Rennie might be suffering from tardive dyskinesia.³⁶ The judge concluded that the medical director's failure probably reflected institutional self-interest. If the medical director had acknowledged that Rennie suffered from potentially irreversible side effects, such recognition might "impugn the wisdom of previous use of psychotropics and would necessitate less reliance on drugs in treating the patient in the future."³⁷

The *Rennie* court, after hearing extensive evidence, described Ancora doctors as "blatantly ignoring" side effects.³⁸ Some Ancora psychiatrists had dismissed side effects by claiming that their patients, including Rennie himself, were "faking" although in one case an independent expert later testified that the patient's movements were "so gross" that she could not possibly have faked nor did she have a motive for doing so.

Denial of side effects at Ancora Hospital was so massive that staff members who persisted in calling attention to them were subjected to reprisals. The *Rennie* judge noted that a nurse who had recorded Rennie's abnormal jaw movements was later criticized and intimidated for doing so not only by doctors, but also by nursing supervisors.³⁹

In many hospitals, psychiatrists apparently do not perceive or acknowledge the gross physical manifestations of tardive dyskinesia. Nor are these physicians sensitive to other side effects reported by patients, such as extensive sleepiness, anxiety, agitation, and excessive motor activity. As one leading researcher has pointed out, "[S]chizophrenics have been asked every question except, 'How does the medication agree with you?'"⁴⁰

In some cases the psychiatrist may assume that the side effect is a function of the mental illness itself, failing to recognize that it is the medication that is causing agitation, insomnia, or bizarre facial movements. This consistent inability to recognize side effects may be in part the result of poor training, in part the consequence of insensitivity. But even when side effects are acknowledged, they are typically regarded as an unfortunate but necessary concomitant of treatment.

Abuse

The case for legal limitations on the administration of medications does not rest, as some psychiatrists seem to think, on allegations of abuse.⁴¹ But since the administration of medications, especially in public mental hospitals, lends itself to abuse, it should be mentioned that the *Rennie* record revealed appalling evidence of it. Indeed, the abuse was so rampant that even the American Psychiatric Association *amicus curiae* brief acknowledged it and attempted to explain that it was caused by understaffing in the New Jersey hospitals which resulted in a denial of proper care.⁴²

At Ancora State Hospital psychiatrists, over protest, prescribed drugs that were not necessary, but which were harmful to the health of the patient.⁴³ Doctors prescribed medications in what was later described as a “grossly irresponsible” manner.⁴⁴ Psychiatrists carelessly overlooked and lost medical records with critical information in them.⁴⁵ Doctors and nurses “criticized and intimidated” a nurse who recorded a patient’s abnormal facial movements.⁴⁶ Psychiatrists “blatantly ignored” one patient’s side effects.⁴⁷ Psychiatrists retaliated against patients who refused drugs or protested against them. In one case, when a patient protested against injectable Prolixin, the doctors withdrew a drug that had partially alleviated Prolixin’s side effects.⁴⁸ When John Rennie complained about Prolixin, the doctors doubled his dose. In still another case, a patient was threatened because she called a lawyer. She allegedly went into heart failure because her requests for heart maintenance medication were ignored.

In general, the care and treatment provided by Ancora State Hospital and other hospitals in New Jersey was often incompetent, callous and abusive. But New Jersey hospitals are not unique in this respect. In a recent Ohio litigation, a federal judge found that the use of antipsychotic drugs at Lima State Hospital was “countertherapeutic” and “for the convenience of the staff and for punishment.”⁴⁹ A high official of the California Department of Health who had been director of a California state hospital characterized the drug practice on the wards there as “abominable,” and called attention to the fact that most of the doctors knew no psychopharmacology, learning what they knew about medications from drug company detail men. There was extensive polypharmacy. The official concluded, “It was a mess.”⁵⁰ Similar problems have been revealed in New York.⁵¹ These reports emerge in litigation, as a result of legislative investigations, newspaper reporting, and in other nonsystematic ways. There is reason to believe that systematic inquiries in other states would reveal a large body of similar data indicating extensive abuse.

Respect for Patient Autonomy

In the challenge to unrestricted use of antipsychotic medications, two concepts have emerged that have long been neglected. The first is the concept of individual autonomy, the right of self-determination about one’s body or mind. The second is the concept of competence. These two concepts, though separate, interlock in such a manner that discussion tends to treat them as one issue. Analysis is clearer when the two are treated as independent, though closely related, ideas.

The value of personal autonomy is deeply rooted in law. Within recent years it has become particularly expressed in constitutional law in the form of what has come to be known as a right to privacy. In constitutionalizing autonomy rights, the United States Supreme Court has, in a series of critical cases, ruled that state and federal statutes, and

state actions mandated or validated by them, are constitutionally invalid if unacceptable limits are placed on the exercise of decision-making by an individual with respect to his mind or body. In the abortion cases the Supreme Court ruled that the state did not have the power to prevent a woman in the first trimester of her pregnancy from aborting her foetus, on the basis that a pregnant woman should have, at that time, absolute autonomy, or freedom of decision, to make choices about the future of her body and the foetus within it.⁵² It is not a decision for the state to command or for the doctor to make; it is the woman's decision.

It is now well established that many beneficial forms of medical treatment also involve significant risks. It is equally well recognized that a decision whether or not to accept a risk is, barring exceptional circumstances, the choice of the patient and is not a purely "medical" decision for the doctor to make. While the doctor's input into the decision is usually critical, the law does not permit the doctor to make the decision without the consent of the patient, whose right to balance the risk and benefit for himself is legally protected.

In the *Rennie* and *Rogers* cases these concepts have now been incorporated into constitutional law because the intrusion involved on the individual's body or mind results from an exercise of state power. Absent a valid exercise of its police power, the state is not permitted to interfere with the "autonomy over his own body" of a competent individual.⁵³ As the Massachusetts Supreme Judicial Court has put it, "The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."⁵⁴

On this proposition, all courts agree, and it is certain that the Supreme Court will also agree if it decides this issue. This is the short answer to the question posed by psychiatrists Appelbaum and Gutheil, "How did we arrive at the point where good faith medical actions are unconstitutional?"⁵⁵ The issue is not whether the individual doctor's faith is good or bad. To the extent that the psychiatrist acts as an agent for the state, he is bound by limitations placed on state action.

Should a psychiatrist nevertheless be permitted to make treatment decisions for a mentally ill patient? Psychiatrists tend to believe that overriding the autonomy of their patients and compelling treatment without consent is not only ethically proper but also a practical necessity.

A doctor tends to regard a treatment decision as his professional responsibility. He believes that his decision is purely in the interest of the patient, as he sees that interest. The doctor is trained, socialized and conditioned to perceive that the patient, even if competent, may not understand a treatment decision, especially in a complex matter, and that time spent explaining the decision is often wasted, better spent on

other more constructive purposes. Moreover, patients can become frightened or be psychologically damaged by an explanation of risks. For these reasons, even when dealing with fully competent patients, many doctors ignore the requirements of informed consent or accept such requirements with reluctance. All the more reason that doctors should justify this approach in dealing with the mentally ill.

The Competence Issue

Psychiatric decision-making for the hospitalized mentally ill has traditionally rested for its justification on two assumptions about patient incompetence. The first is that a mentally ill patient is not competent to make treatment decisions. The second is that compelled medication is a logical extension of court-mandated hospitalization. It is argued that to compel hospitalization but not compel medication is illogical.

The first of these two propositions, once widely accepted, is now widely recognized as fallacious. An individual is no longer regarded as generally incompetent because he is mentally ill. It has long been recognized that many mentally ill persons retain capacities that permit them to function in a competent manner. Mental illness often strikes at certain limited areas of functioning, leaving other areas unimpaired.

There is ample evidence that many patients, despite their mental illness, are capable of making rational and knowledgeable decisions about medications. The fact that a mental patient may disagree with the psychiatrist's judgment about the benefit of medication outweighing the cost does not make the patient's decision incompetent. The decision whether or not to accept drugs is for many patients a difficult one in which the patient is often between Scylla and Charybdis. It is difficult for some patients to know which is worse, the illness itself or the side effects of medication. Patients' decisions about medications vary from time to time. In effect, many patients turn away from one form of distress to a different form, and then back again, in a pendular fashion.

In the *Rogers* case, the judge concluded that,

The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages. Indeed, a fundamental concept for treating the mentally ill is the establishment of a therapeutic alliance between psychiatrist and patient. Implicit in such an alliance is an understanding and acceptance by patient of a prescribed treatment program.⁵⁶

A mentally ill person should be regarded as retaining his autonomy to make medication decisions unless it has been demonstrated that, as a factual matter, he is incapable of making such decisions, whatever his capacity or incapacity may otherwise be. The question is then: In what manner and at what time should a determination of competency be made? This issue will be discussed in connection with consideration of procedures.

How to Implement the Right

Once a court has decided that there is a constitutional right to refuse medications, two additional questions must be decided. The first: What qualifications are there to the exercise of the right, and how are they to be defined? The second: What procedures, if any, are required to insure appropriate implementation of the right? These substantive and procedural issues are often intertwined. First, the procedural issues.

The Failure of Self-Regulation

There is a threshold question: Are judicially ordered procedures necessary? Could not a court articulate a constitutional right and leave the procedural implementation of it to the state? Here, both courts designed a remedy to provide for the enforcement of the right, on the basis that the remedy was absolutely necessary, and that without such a procedural system, the newly ordered substantive rights would be ignored and become meaningless.

In *Rennie*, the court in considering whether it should permit the state to engage in self regulation, evaluated two forms of self-regulation previously attempted by the state: first, that of individual doctors in the hospitals; and second, that of the state.

Evidence presented to the court established that individual doctors were unaware of or insensitive to side effect problems and had made no effort to monitor their own medication practices. Moreover, an effort on the part of the state division of mental health and hospitals to regulate medication practice through the issuance of a Bulletin which contained guidelines for medications was either ignored or openly rejected by hospital medical directors. One medical director of a large mental hospital went so far as to order his staff to ignore the Bulletin.

The *Rennie* court, having carefully analyzed this feeble attempt at self-regulation, concluded that self-regulation would not work, and that court-imposed procedures would have to be designed. As Dr. William Keating had said about the need for regulation in California, "We wrote [regulations] because the hospitals were not regulating themselves. Well, you can imagine how the psychiatrists responded. There were a lot of bruised egos, a lot of people saying that doctors should regulate themselves. I said, "That's right, you should, but haven't been. That's why we are."⁷

The Rennie Remedy

The *Rennie* court decided that the constitutional right to refuse medications should be made subject to two qualifications and could be overridden in two basic circumstances. The patient is not permitted to refuse if he is incompetent. Nor may he be permitted to refuse if he is dangerous to himself or to others within the hospital. The *Rennie* court set forth two types of dangerousness, although neither one was defined with precision. The first is emergency dangerousness; the second, longer-term dangerousness. Both bases for overriding the right of treatment refusal, incompetence and dangerousness, are grounded in two basic powers of the state; the police power, used to protect all members of society against danger, including the dangerous person himself; and the *parens patriae* power, used to protect individuals who are incapable of caring for themselves because of impaired judgment.

Rennie Hearings

The *Rennie* decision provides that in the event of a patient refusal of medications the following procedure operates. The refusing patient is notified that within 5 days he may have a hearing at which he can present his case before an Independent Psychiatrist. He has the right to the assistance of a state-supplied Patient Advocate. Both Independent Psychiatrist and Patient Advocate are selected and paid by the Commissioner of Human Services, not by the hospital director. But before the hearing takes place, an informal resolution of the issue is attempted. These negotiations often work. Alternative medications are selected, a lower dosage prescribed, or a discontinuation tried, etc.

Where informal efforts fail, a hearing is held by the Independent Psychiatrist, who hears both the patient's case and the hospital's case. The Independent Psychiatrist has access to hospital records and is entitled to examine the patient himself if he wants to. All hospital employees may be asked to appear and testify, but their appearance is not required.

The Independent Psychiatrist is required to make a written finding in which he either supports or denies the patient's right to refuse. In doing so, he is to consider four factors: (1) whether the patient is physically dangerous to himself or others in the hospital; (2) whether the patient is "competent," *e.g.*, has the capacity to decide about his treatment; (3) whether a less "restrictive" treatment is available; and (4) the significance of risks of permanent side effects from the proposed treatment. The Independent Psychiatrist is required to weigh and balance these factors in an effort to determine what is best for the patient.

But the treating physician need not resort exclusively to this procedure in all cases. There are two additional procedures available to him under which medications can be imposed without the patient's

consent. The first is where he finds the patient to be "functionally incompetent." The second is where there is an emergency.

Functional Incompetence

Absent an emergency, and provided there is a final order of commitment (a condition currently found to create problems), a treating psychiatrist can at any time impose medication on an unwilling patient whom he certifies to be "functionally incompetent," meaning a patient who is unable to provide knowledgeable consent to treatment even though he is "legally" competent in that he has not formally been declared judicially incompetent.

The decision to certify a patient as functionally incompetent must be referred to the Patient Advocate, who has the discretion to seek review of the decision by the Independent Psychiatrist. Enforced medication may be imposed without consent until such review takes place, if requested, but for not more than 15 days.

When and How is Incompetence to be Determined?

Since medication can be imposed on a nonconsenting patient if he is incompetent, a critical question is: How and when should a patient be viewed as incompetent?

A popular position among psychiatrists is that a committed patient is *ipso facto* incompetent. The argument is made that the judicial decision to commit the patient inherently includes a tacit determination that the patient is incompetent. Before the First Circuit Court in *Rogers* the state urged that "once admitted to a mental institution, a patient is deemed incompetent to decide whether or what to accept by way of treatment, in either an emergency or nonemergency situation."⁸

The argument was rejected both in *Rogers* and *Rennie* and has more recently been rejected by the First Circuit. The adoption of such a position would subvert the principle that mentally ill persons retain autonomy unless declared incompetent as to a specific function. A significant number of states have enacted legislation which stipulates that an order of hospitalization is not to be interpreted as a judicial determination of incompetency.⁹ A separate and independent determination has to be made as to the competence of the committed patient to perform a specific function.

This makes sense even in the absence of specific legislation. A patient should not be compelled to accept treatment decided upon by a physician simply because the patient is in a hospital. Were that the case, a patient could, for example, be involuntarily lobotomized, regardless of risk, and without a determination having been made about his capacity to consent. A decision to hospitalize does not give the physician an automatic right to impose risky treatment modalities under the theory that the power to impose treatment subsumes under a commitment order. The question, then, is whether antipsychotic

medications are a sufficiently "risky" treatment. The discussion on side effects indicates that it is.

In committing a patient the judge ordinarily does not address himself to the issue of treatment, nor does the lawyer present evidence on that question. The judge does not inquire about or rule upon the respondent's capacity to make treatment decisions. Rather, the question is whether the patient should be hospitalized because his mental illness causes him to be dangerous to himself or others, or to be gravely disabled. The judge in considering these issues does not deal with the subtle and complex issue of the balance between cost and benefit in medication treatment.

Does this reasoning apply to jurisdictions in which the commitment statute requires a finding that the capacity of the mentally ill person to determine his need for treatment or hospitalization is impaired? If a *parens patriae* commitment is based on such a finding does the judge implicitly make a ruling with respect to the patient's competence?⁶⁰

Again, this is not the case. In such cases the judge typically considers only whether the mentally ill respondent's resistance to hospitalization is rational or irrational. The judge does not consider the issue of medications, nor does he make findings about the patient's capacity to make decisions about the cost-benefit ratio.

Finally, the same is true for those jurisdictions that permit hospitalization only after a finding that the respondent is not only mentally ill and dangerous or disabled, but also "in need of treatment." It is illogical to say that because a patient is hospitalized for treatment he must accept whatever treatment is selected for him. As the Third Circuit Court of Appeals has recently said, "A right to treatment does not create a corresponding duty to submit to any treatment whatsoever; such a simple equation would sanction unacceptable invasions of personal autonomy."⁶¹

Under such circumstances it would probably be regarded by courts as a violation of the patient's right to substantive due process of law to presume his incompetence with respect to accepting or rejecting medication without a hearing on that precise issue, at which the facts were considered.

It has been recommended that legislation be enacted which would direct the committing judge to pass at the time of a commitment hearing on the patient's capacity to accept or refuse medications.⁶²

One objection to this proposal would be that such a finding might be quickly outdated. The incapacity found by the judge at the time of commitment would in many cases change to capacity, especially under the influence of the very medications administered by judicial order. If so, would the judicial finding of incompetence continue to be valid? Not under the United States Supreme Court's decision in *O'Connor v. Donaldson*,⁶³ which ruled that under the substantive due process clause a judicial order of commitment is invalid when the basis for the order has ceased to exist, *e.g.*, if the patient is no longer mentally ill, dangerous, or

whatever. In such a case the patient must be released. If the factual basis for a finding of incompetency has changed, the order based on that finding loses constitutional validity. This could happen very quickly in the case of a medicated patient. At most, a judicial finding of incompetence would be valid for a relatively short time. If an order were made terminal within a short period of time, at which point review would be required, such an order might be valid.

A second objection to the proposal is that decisions about competence with respect to medications might be made perfunctorily. A judge would ordinarily be reluctant to commit a mentally ill person to a hospital under conditions that are objectionable to the hospital staff. Thus, the decision to commit would tend to also determine the judge's evaluation of the patient's competence. Once the judge decided that commitment was necessary, the other would tend to inevitably follow.

Notwithstanding these concerns, there is some merit to the approach if the commitment judge were required to make an appraisal of the four factors suggested in *Rennie* and limit the duration of his order to a short period of time. A period of four to six weeks has been suggested. The length of the initial trial period should be determined by experience as to how long it ordinarily takes for medications to work on a significant number of patients. The benefit for the patient in such an approach would be an opportunity for restoration from psychosis. The cost would be relatively modest if there is little risk of long-lasting tardive dyskinesia, and other side effects are reversible. Once the patient is restored and regains competence, he can then make medication decisions for himself. A further advantage of this approach is that the initial decision about treatment competence would be made by a judicial or administrative official after hearing all the evidence, including psychiatric testimony.

The "functional incompetence" approach of *Rennie* has the advantage of flexibility, in that it permits avoidance of a hearing by the Independent Psychiatrist. Its disadvantage is that this short cut is subject to abuse. There is informal evidence that in New Jersey hospitals, review of "functional incompetence" decisions has not been actively requested by Patient Advocates, as a result of which the provision may have become a loophole, permitting unconsented-to medication and bypassing some needed Independent Psychiatrist hearings.

Dangerousness and Emergencies

The police power basis for overriding medication refusals has been couched by the *Rennie* court in terms of "dangerousness" and "emergency." In *Rennie* the court permits involuntary medication if the Independent Psychiatrist makes a finding that the patient presents a "physical threat [of life or limb] to patients and staff." Involuntary medication is also permitted if there is an "emergency," defined as a

“sudden, significant change . . . which creates danger to the patient himself or to others in the hospital.”

Under *Rennie*, the emergency period can last for three days, which is then extendible to six. Thus, where necessary, doctors can medicate a refusing patient involuntarily for almost a week, providing time for other procedures to operate.

In *Rogers* the court also permitted unconsented-to emergency medication, defining emergency as a situation in which a failure to medicate “would result in a substantial likelihood of physical harm to that patient, other patients, or to staff. . . .” The court rejected a standard offered by the state which would have permitted the administration of medication as an emergency measure to prevent further suffering by a patient or to prevent the rapid worsening of his clinical state. This latter definition of emergency was more compatible with a psychiatric approach, but posed dangers of vagueness in application. The First Circuit Court, without being very precise about it, in effect urged the lower court to reconsider its rejection of the “suffering and worsening” standard.

Further, the court interpreted the District Court’s more limited definition of emergency as requiring a “unitary standard of quantitative likelihood that violence would occur if no medication is administered” and characterized such a standard as insufficiently complex or flexible, or at least inadequately descriptive or detailed for the purpose of providing sufficient guidance to hospital staff.

It seems that psychiatrists, in attempting to implement *Rogers*, inadequately understood what was legally required of them, and tended to react by conservatively withholding medication because they felt they could not predict with accuracy that the patient, would, if unmedicated, engage in violent behavior. In some cases the withholding may have caused patient decompensation which resulted in violence.

The Circuit Court inferred that the psychiatric approach, which was to withhold medications unless dangerous behavior could be predicted by at least a preponderance of evidence, was encouraged by the court’s definition, which failed to describe the nature of the dangerousness decision, and failed to more effectively define “dangerousness” so as to make it operationally meaningful.

The district court, in seeming to focus too single-mindedly on the predictive element, did not articulate, as the United States Supreme Court has done in an earlier case,⁶⁴ the notion that a finding of dangerousness requires a balancing between liberty interests and a number of other factors. At minimum, said the Circuit Court, a definition of dangerousness requires “an individualized estimation of 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.” In setting forth its definition of dangerousness, the Court included factors used by the court in *Rennie*.

In fact, a definition of dangerousness should realistically include consideration of at least the following five elements: (1) the magnitude of the threatened harm; (2) the nature of the threatened harm, whether physical or psychological, to persons or to property; (3) the probability of the harm occurring; (4) the imminence of the harm; and (5) the interactive factor — what provocation in the patient's environment may stimulate the potential for harm.⁶⁴ Dangerousness can be an extremely complex, elusive, and much misunderstood concept. To the extent that it is a critical concept in the medication refusal situation it requires more elucidation than has yet been offered by the courts and in this necessarily brief analysis.

Least Restrictive Alternative

Among the four factors articulated by the court in *Rennie* for determining whether medication should be imposed on a nonconsenting patient, and in what manner, is the concept of the least restrictive, or intrusive, alternative, which requires that when objections to medication are made, consideration should be given to alternatives to the current treatment regime. These might include an alternative medication, an alternative dosage, an alternative therapy, or perhaps a discontinuation of medication temporarily or permanently. Often, a patient does not object to medication as such. Rather, he objects to a particular medication, such as Prolixin, because he reacts badly to it. In the New Jersey case of *Mark B.*,⁶⁵ for example, the patient was treated as a medication refuser because he rejected the particular medication, Prolixin, selected by his treating physician, even though he made it clear that alternative medication might be acceptable to him. Ultimately the patient did accept an alternative medication, Mellaril, which had never been offered. It is not uncommon for patients to refuse Prolixin and agree to other medications, yet be forced to take Prolixin.⁶⁶ Some patients may even prefer a short period of seclusion to compulsory medication.

The least restrictive alternative doctrine, if properly applied, encourages the striking of a balance between efficacy and intrusiveness. The emphasis is not exclusively on avoiding an intrusion. Rather, the concept stresses the avoidance of unnecessary or gratuitous intrusions which may occur because of rigidity, inattentiveness or lack of sensitivity. The efficacy issue is important. An efficacious treatment, such as medication, need not be avoided because it is intrusive. Often, medications are the least restrictive alternative. It is not always easy to adjust the balance required by the least restrictive alternative requirement. The value of the concept is that it calls attention to the need to strike the balance.⁶⁷

The Independent Psychiatrist: Pros and Cons

In selecting a reviewer of medication decisions the *Rennie* court had several models from which to choose. Judicial review was apparently regarded as impractical and rejected. The Massachusetts Psychiatric Society in an *amicus curiae* brief submitted in the *Rogers* case had recommended three member panels consisting of two psychiatrists and a lawyer. This was rejected, presumably because too cumbersome and expensive. In choosing a single reviewer, the court could have opted for a lawyer or informed layman, but instead chose an Independent Psychiatrist.

In selecting a psychiatrist the *Rennie* court used a peer review system as a general model. A critical factor in the court's procedure, however, is that the Independent Psychiatrist reviewer is to be independent of the hospital medical directors and of the Division of Mental Health and Hospitals.

The value in using a psychiatrist as reviewer is self-evident. A well chosen psychiatrist should be knowledgeable about medications and capable of evaluating the advantages and disadvantages of a particular medication program.

The Independent Psychiatrist shares the socialization process, the values, the experience, and the professional outlook of the treating doctor. He may be able to negotiate a change in treatment program most effectively. His knowledge of alternatives should be superior. His capacity to settle a dispute should be enhanced because of his professional identity. His "reversals," when necessary, are likely to be more palatable than those of non-medical reviewers.

But there are significant risks. It is not clear that psychiatrists of appropriate ability and independence can be attracted to or will be selected for such a position. The role of Independent Psychiatrist is likely not to be regarded, from the point of view of payment, status or function, as desirable. State compensation tends not to attract first-rate professionals. In fact, when the Commissioner of Human Services first advertised for Independent Psychiatrists, only \$30.00 an hour was offered. There were no takers. Later, the hourly compensation was raised to a more realistic rate of \$75.00 per hour.

Nor is the reviewing function particularly attractive to psychiatrists, involving as it does the prospect of rejecting the treatment decisions made by colleagues, who do not welcome the intervention of outsiders, even that of fellow-doctors. Some of the reviews are likely to involve either implicit or explicit criticism of the competence and performance of psychiatric colleagues.

A more serious risk is that an Independent Psychiatrist is likely to share the approach, perspective, and biases of the treating doctor, whereas non-medical judges or administrators would be likely to more effectively balance libertarian and autonomy values along with treatment

considerations. Such professional perspectives are deep-rooted. Among psychiatrists there tends to be confidence in the efficacy of medication and impatience with concern expressed about side effects. The natural inclination of an Independent Psychiatrist may be to share the general approach of the treating physician. If the Independent Psychiatrist is to implement not only the letter but the spirit of the *Rennie* standards he should undergo a rigorous re-training and resocialization process. But it is far from clear that this will either occur or help.

Finally, under the *Rennie* scheme the Independent Psychiatrist is to be selected by the Commissioner of Human Services who is also responsible for the operation of the hospitals in which the doctors serve whose treatment decisions are to be evaluated. The Commissioner may be reluctant to see the hospital psychiatrists countermanded or embarrassed and may be under pressure to appoint Independent Psychiatrists who would tend not to rock the boat. The Independent Psychiatrists might be more truly independent if they were hired by some other truly independent department of government.

The Patient Advocate: Pros and Cons

Another crucial aspect of the *Rennie* ruling is the decision to entrust the representation of patients to Patient Advocates rather than to lawyers. This represents a significant departure from previous practice, since in the past representation on treatment issues has been handled primarily by lawyers. It was, for example, a lawyer who initiated the *Rennie* case in the first instance.

This decision seems to represent an effort to de-legalize the decision-making process, perhaps making a "bitter pill" more palatable to psychiatrists and other hospital staff. Using lay advocates rather than lawyers might minimize resistance to *Rennie* procedures and insure more good faith cooperation.

But the cost may be high. The Patient Advocate is a linchpin in the whole system, with significant advisory as well as advocacy roles. The Patient Advocate should not only provide services to patients who request them, but should also be prepared to initiate a series of activities which would tend to insure an effective monitoring of medications practices.

An important issue not touched upon in *Rennie* is the complex question of identifying refusals. Many patients do not refuse with sufficient assertiveness. Doctors and other staff have shown a reluctance to acknowledge refusals and have even responded to refusals vindictively. Many potential refusals may not be identified as such. This is a problem that could be addressed by a vigilant and aggressive Patient Advocate, but which would be neglected by a passive Advocate.

There should be routine monitoring of charts to insure that nonconsensual medication is being provided with proper attention paid to *Rennie* standards. Informal evidence is accumulating to the effect that

psychiatrists under *Rennie* are recording in charts only that the patient is "functionally incompetent" or that there is an "emergency," without explanation. It should be the task of the Patient Advocate to insure that this does not occur, but such a function was not spelled out in the *Rennie* order and there is reason to believe that such scrutiny has not been taking place.

Informal evidence is emerging that the choice of Patient Advocates has not met high standards and that there is passivity on the part of some Patient Advocates and a failure to perform in a manner intended by the *Rennie* court. This would surely have been avoided had the judge selected lawyers, who are trained and socialized to perform the roles described, and who tend to do so with greater assurance. The price paid to win the cooperation of the psychiatrists or to gain greater acceptance by appellate courts may prove to have been too high, considering the key role of the Patient Advocate in making the system work.

Psychiatric Objections to the Right to Refuse Medication

The legal literature on the right to refuse medications is already extensive, with more to come.⁶⁸ Psychiatrists have been slower in responding, although their literature is growing as well.⁶⁹ An analysis made at this time of psychiatric reaction to the evolving right to refuse medications necessarily depends on an embryonic body of writing. Yet enough has emerged to indicate certain lines of objection. The following analysis is presented with the hope that it will sharpen the issues and more clearly indicate where we need more data, research, and thought. It is recognized that the analysis is in part speculative because of a lack of empirical data.

Principled psychiatric objections to the right to refuse medications seem to be severalfold. The first is that the cost of procedural implementation will be inappropriately high. The second is that valuable personnel and resources will be diverted away from treatment toward due process procedures. The third is that the care and treatment of the mentally ill will be adversely affected. The fourth is that legalistic protections are illusory in that they do not actually protect.

1. The Cost Argument

It is argued that the cost to the state of protective procedures would be great, undoubtedly requiring additional appropriations by the legislature.⁷⁰ This is certainly so. There is little doubt that the establishment of a right to refuse will result in some greater cost, but it is not self-evident that the cost will be either disproportionate to its value or large. One New Jersey mental health official has acknowledged informally that, to date, the cost of implementing *Rennie* has been nominal.

The cost objection has often been made before. Psychiatrists on earlier occasions have argued that other legal reforms are too costly; a

right to treatment is too costly; due process is too costly; periodic reviews are too costly.

The *Rogers* court responded to the cost issue by saying, "There may well be additional administrative expense and burden attached to recognizing a . . . right to refuse treatment . . . it might be less expensive for the state to deny, rather than recognize, such a right. But, factors of convenience and cost have long been regarded as inadequate justifications, standing alone, for a state's failure to recognize and respect constitutionally protected rights."⁷¹

In determining whether a right should be constitutionally protected, and particularly by what means, the United States Supreme Court has indicated that cost is a legitimate consideration. In considering protective procedures, a court should weigh the nature of the deprivation against the cost to the state of rectifying a problem. In the recently decided *Parham*⁷² case the Supreme Court refused to order new procedural protections for minors on the basis that the scant evidence of harm involved in the hospitalization of minors did not justify the cost of the particular procedures urged by the plaintiffs. Other, less costly, procedures were ordered.⁷³

In designing a remedy, it is not inappropriate for a court to carefully balance cost against the nature and extent of the harm. If the harm can be rectified without the use of a costly procedure, then the court should not order that procedure. But if the harm cannot be rectified without setting up hearings and other elements of procedural due process, and the cost for these is not too high, the court should order it.

Experience acquired in dealing with related problems in mental hospitalization has taught us that the cost of procedures, even if initially substantial, is likely to diminish dramatically once a program has shaken down, as psychiatrists and other mental health personnel adjust to legal requirements. Within a reasonably short time there will be fewer hearings, more informal adjustments, less diversion, and less need for the participation of patient advocates. The cost will probably become nominal and easily absorbed into the routine operation of the system. Moreover, there will be unexpected savings. Ancora Hospital has already reported that, as a result of *Rennie*, \$100,000 has been saved on medications in one year. Comparable savings in other hospitals should tend to offset the cost of due process hearings.

2. *The Diversion Argument*

A related criticism is that mental health personnel, particularly psychiatrists, who are in short supply, will be diverted from treating patients to participating in due process procedures.⁷⁴ This is particularly a concern in the public sector where most hospitals are inadequately staffed.

Some psychiatrists are even more concerned about diversion if their medical judgments are ultimately vindicated because the due process

procedures will then appear to have used up precious time and energy to simply affirm what the doctor had already decided upon in any event.

The Supreme Court, in the *Parham* case, expressed its reservations about diversion, indicating that the anticipated benefits to be gained by hearings in the admission of minors would in that case be outweighed by the loss of services of “mental health professionals [who] will be diverted even more from the treatment of patients in order to travel to and participate in — and wait for — what could be hundreds — or even thousands — of hearings each year.”⁷⁵

The court in *Rennie* anticipated the concern about diversion and designed a procedure that minimizes it. Since all hearings are to be held in the hospital where the treating psychiatrist works, no significant travel or waiting time is involved. The hearings are likely not to be lengthy. Moreover, most refusal issues will be resolved on an informal basis, without the need for a hearing. Only the hard core disagreements will end up in a hearing. Thus, it can reasonably be anticipated that the diversion of personnel resources will be modest. But, further, the concept of “diversion” should be examined. Implicit in the term “diversion” is the idea that a psychiatrist is being shunted from a valuable activity, treating patients, to one which is far less useful, appearing in a hearing before another psychiatrist for the purpose of justifying his choice of medication. Dr. Alan Stone, then president of the American Psychiatric Association, complained that legal advocates for the mentally ill “have treated rights as if they constituted the needs of the mentally ill.”⁷⁶

Is peer review of medication decisions of little help to patients? Or does peer review not tend to insure that there is proper supervision of psychiatric practice in a setting in which it has been amply demonstrated that such review is urgently needed.

The process of reviewing treatment decisions is an intrinsic part of treatment itself, insuring its integrity. It is not an extrinsic intervention. Time spent on it should be recognized not as a diversion but as a necessary and appropriate allocation of resources.

3. *The Adverse Effect on Care and Treatment Argument*

It is argued that the right to refuse medications will “seriously impede the proper and humane care of the mentally ill.”⁷⁷ A number of reasons are given for this. First, patients who need treatment may not receive it at all. “[I]f the situation is insufficiently emergent and if a guardian cannot be found, or if the patient is adjudged legally competent, the patient may go untreated indefinitely.”⁷⁸ Appelbaum and Gutheil have colorfully described this situation as patients “rotting with their rights on.”⁷⁹

Second, even if refusing patients ultimately are compulsorily medicated or finally accept treatment willingly, there may be harmful delays which could cause an “increased likelihood of an acute psychiatric illness

becoming chronic." In addition, the unnecessarily prolonged state of mental illness and decontrol resulting from non-medication could result in a severe "narcissistic injury" to the patient which might result in suicide or damage to the patient's self-esteem.

Third, the right to refuse will be a "disruptive factor on inpatient wards."⁸⁰ This is probably a reference to a nondangerous and competent refusing patient agitating other patients on the ward and generally being disruptive toward both patients and staff in such a way as to damage the therapeutic ambience, and therefore harm the care and treatment of others. A few poorly controlled patients are able not only to disturb whole wards, but also to divert to themselves staff time and attention needed by other patients.

Fourth, hospital doctors would be sufficiently reluctant to respond to a review of their medication decisions that they would medicate less and rely more on physical restraint, isolation, and seclusion.⁸¹

Fifth, permitting drug refusal "represents a significant strain on the treatment alliance . . . the negativism that may be expressed in drug refusal often extends to the treatment effort in general."⁸²

Sixth, if a right to refuse is addressed to psychiatric abuse of medications, the most sensible response to the problem is not to grant a right to refuse, but to improve the quality of care and treatment.⁸³

Seventh, psychiatrists will be unwilling to work in mental hospitals if their decisions about treatment often lead to adversarial judicial or quasi-judicial procedures. Thus, important staff may be lost.⁸⁴

In the absence of empirical data, these seven criticisms are necessarily speculative. So are the responses. Administration of the right to refuse treatment in Massachusetts, New Jersey, and in other jurisdictions, will, in time, reveal whether these speculations are valid. By the time the medication refusal cases confront the U.S. Supreme Court we may have a body of experience and knowledge which will be helpful in addressing the problem. In the meantime, without the benefit of a systematic study of this experience, we must make an evaluation on the basis of that which is available.

1. As to the argument that some patients would receive no treatment at all, the likelihood that patients will "rot" because of invocation of their rights is fanciful. The most that could happen under the *Rennie* approach is that a patient who cannot be persuaded to continue his medication would decompensate to a point where he would almost certainly be considered functionally incompetent and thus subject to compulsory medication.⁸⁵ This is on the assumption that the patient would insist on refusing, despite good faith efforts on the part of staff to persuade the patient to accept medications. Appelbaum and Gutheil recognize that virtually all refusers subsequently accept medications, without having been harmed by their previous refusal.⁸⁶

It is well known that attentive and concerned staff can "win over" most recalcitrant refusers without any significant damage being done.

But this requires that there be such a staff, both qualitatively and quantitatively. The doctors should use flexibility in determining whether medication is needed, which medication to use, how many medications, what doses, how frequently, by what means (pill or injections), and with what medication added to correct or reduce side effects. The staff should also be prepared to deal with and overcome irrational reasons for refusing medications, *e.g.*, anger at the doctor, etc. Informal evidence from a variety of hospitals indicates that with proper staff care no one will "rot."

2. The second argument concerning long-term dangers resulting from delay in medicating, assumes significant delay. This assumption is based almost exclusively on a limited experience at Boston State Hospital in the earlier stages of the *Rogers* case. As pointed out earlier, problems arising in the early stages of a new and inadequately understood approach tend to be ironed out later. A new approach should not be rejected because of what takes place during a shakedown period, especially where the ruling is temporary and staff may hope that a demonstration can be made that the rule is unworkable. Under *Rennie*, unlike the situation in *Rogers*, which called for the appointment of a legal guardian, there is no reason for delay. Hearings on refusal can take place promptly and the emergency and functional incompetence provisions allow further flexibility.

3. The third criticism is that of ward disruption. The *Rogers* court pointed out that out of 1,000 cases at Boston State Hospital there was not a single case of disruption that was not appropriately handled, so that transfers were not necessary.⁸⁷ The First Circuit Court, in reviewing this finding, suggested that the *Rogers* court "may have overlooked or misconstrued evidence of specific acts of violence occurring as a result of defendants' difficulty in applying the court's standard." On the other hand, said the First Circuit Court, "throughout this litigation defendants and their supporting *amici* have erroneously attributed the acts of violence to the strictness of the court's standard."⁸⁸ A paper by one of the *Rogers* case defendants, Dr. Michael Gill, documents turbulence and even some violence that occurred during the litigation, much of which, he points out, was provoked by the litigation itself.⁸⁹

It is understandable but regrettable that during a controversial litigation which causes confusion and anxiety, and which divides staff, that the patients may also become provoked and act out more disruptively, in relation to their perception of new rights being granted to them. But these are temporary problems that tend to subside when the litigation is resolved, and the merits of granting such rights should not be evaluated on the basis of short-term over-reactions.

In his thoughtful paper, Dr. Gill, with admirable candor, indicates that overly zealous staff may have, on occasion, consciously or unconsciously, tolerated or even encouraged patient deterioration by withholding medications and by applying the court standards in a

particularly conservative way in order to assist the defense during litigation by "proving" that permitting refusals results in disturbance and violence.

Now that the *Rogers* trial is long over, and the district court has been mandated to clarify and modify its order, it is likely that turbulence can be controlled. Certainly no turbulence has been reported in connection with the implementation of *Rennie*.⁹⁰

This is not to deprecate the difficulty of the problem faced by some staff. One of the functions of medication is to assist in the management of patients who might otherwise be disruptive or assaultive. Work should not be made too difficult for staff, whose legitimate interest in safety should be acknowledged.

On the other hand, the problem has been that staff too often abuses the management function of medications and slips into the use of medications for its own convenience.

This is particularly easy to do in a public hospital that is understaffed, where there is a perception that there is an insufficiency of staff to take the time to provide a more therapeutic response to a troubled patient, and where the patients are in a low socio-economic class. Using medications is an easy way to deal with more subtle problems accompanied by a built-in rationalization that the easy way out is "treatment." Thus the mental health professional can, in effect, avoid a more burdensome responsibility without the guilt.

Legal controls should be designed to effectuate an acceptable balance between staff needs and patient rights.

There is yet another cost referred to by Dr. Gill, who points out that a number of otherwise admissible patients were refused entry into the hospital during the *Rogers* litigation because they were "difficult management problems" who had in the past refused medications. One of these later stole a truck and was shot to death by pursuing police.

What should the hospital do with a drug refuser who becomes a management problem? Does the hospital have an ethical responsibility to admit or retain such a patient? One leading psychiatrist has suggested that refusing patients should not be held "in a custodial status" but should be released "even though professional judgment dictates otherwise."⁹¹ If other ways are available to deal with drug refusers, and especially if their refusals are temporary, the decision not to admit or retain seems to be one that should be more closely examined.

4. Fourth is the argument that psychiatrists will respond to reviews of their medication decisions by medicating less and using physical restrictions more. Appelbaum and Gutheil suggest that doctors may resent review to such an extent that they will subvert it and turn to a mode of dealing with patient problems that, in their own professional judgment, has less efficacy, but which may represent less of a personal threat or affront to themselves or require less of their time and energy. Supervision of restraint or seclusion is ordinarily left to other staff,

whereas the defense of a medication decision has to be made by the doctor himself. It is suggested that doctors may make decisions not for the benefit of the patient but for their own convenience and to preserve their *amour propre*.

Under *Rennie*, all that is required is that treating physicians cooperate with an Independent Psychiatrist whose function it is to inquire and negotiate about medications before resorting to an informal hearing. In the first stage of patient refusal, the treating psychiatrist is required only to discuss his treatment regimen with an Independent Psychiatrist who is likely to be sympathetic with any legitimate treatment program and who will recommend alternatives only in cases where the patient presents a plausible case.

The *Rennie* procedure is not significantly more time-consuming or cumbersome than the procedures which had been provided by the state of New Jersey in its own Bulletin. The primary difference between the two is the independence of the Independent Psychiatrist, who is in no way beholden to the treating physician. The issue, therefore, is whether the care of a patient warrants the treating physician spending time and effort to discuss the case with an independent colleague. Will hospital doctors actually be reluctant to engage in this level of review? In New Jersey, evidence so far indicates the contrary.

Most refusal cases are successfully negotiated before going to a hearing. A few go to hearing where disagreement remains between the treating physician and the Independent Psychiatrist.

It is hypothesized that some treating physicians will be reluctant to participate in a "hearing" because of unwillingness to be challenged, fear of examination and cross-examination, unwillingness to prepare or spend the time, and the like. Treating psychiatrists may in a passive-aggressive manner concede and accede, perhaps against their better judgment, to the patient's asserted wishes in order to avoid participation in such procedures. But experience with thousands of civil commitment proceedings indicates that in the relatively few cases in which negotiation fails, psychiatrists have been willing to participate in legal proceedings that are more formal and time consuming than those now proposed in *Rennie*.

It is further argued that hospital doctors who are unable to medicate will resort more freely to physical restraints or seclusion. If so, such resort would ordinarily not be legitimate, because the same circumstances that would tend to justify physical restraint and seclusion would also justify nonconsensual medication.

5. Fifth is the argument that giving a patient the right to refuse will impair the treatment alliance. In discussing this issue, it is not only necessary to inquire into what is meant by the term "treatment alliance," but also to acknowledge with candor that in many public mental hospitals there is no such thing as a real treatment alliance, however defined.

It may be useful to consider three models of doctor-patient relationship. The first is the "activity-passivity" model. The second is the "guidance-cooperation" model. The third is the "mutual participation" or "informed consent" model.⁹²

In the activity-passivity model the patient tends to be inactive. The doctor is in complete control of treatment. The model is authoritarian and paternalistic. Doctor not only "knows best," but is also expected to exercise unquestioned authority and power. This model is characterized by distance between the psychiatrist and patient. The nature of medications reinforces the distance. In a sense, the physician as therapist plays less and less of a role. Treatment is turned over to the medications. For many doctors there is no relationship at all. It is well documented that many public mental hospital psychiatrists do not see their patients for weeks and months on end. In *Rennie II* the court reported that, "There is also overuse of medication orders which specifically leave discretion to the staff for many days, or weeks, despite hospital rules against such practice."⁹³ Medications are often selected by the nurse, sometimes even by the ward attendant. Distance enhances the psychiatrist's authority, regardless of the extent to which he simply rubber-stamps the decisions of others or makes his own. According to evidence presented in the *Rennie* case, this model has prevailed in New Jersey state hospitals.

In the guidance-cooperation model, the model apparently favored by the American Psychiatric Association, the psychiatrist makes the decisions, informs the patient of them, giving him information about medications, and attempts to obtain the patient's cooperation. A number of hospitals operate on this model, including Boston State Hospital before the *Rogers* case was begun. In the event of a disagreement, however, the psychiatrist maintains final authority to override the patient's objections or refusals.

The third, mutual participation or informed consent model provides for significant, though not absolute, patient autonomy. The patient is given information about medication. He is then free to accept or reject it unless it is decided that he is incompetent to make rational decisions about treatment.

This model, the most advanced physician-patient relationship, is based on an assumption of the competence of the patient to participate in the medication decision-making process. The psychiatrist plays the role of expert advisor.

This model incorporates an effective solution for the refusal of the paranoid, depressed, or otherwise resistant patient whose illness leads him to reject medication because he regards it as "poisoned," or of "no use," or because he is "not ill," etc., all reasons stemming from his mental illness. It is argued that such a patient's "negativism . . . expressed in drug refusal often extends to the treatment effort in general" and puts a significant strain on the treatment alliance."⁹⁴

As previously discussed, it is the responsibility of staff to attempt in good faith to overcome such resistance. Indeed, it is arguable that one significant consequence of a right to refuse is that staff will spend time persuading rather than overriding, with positive therapeutic consequences. But if staff cannot persuade, the doctor is not foreclosed either by this model or by the law from compelling treatment where the patient is incompetent to make treatment decisions for himself. But the model, and the law, both protect the decisions of the patient, whether "rational" or not, if he is competent.

A medication refusal is often an amalgam of rational and irrational reasons, mental illness and non-mental illness induced. The psychiatrist should attempt to identify and respect the non-mental illness induced reasons if they predominate. An interesting case dealing with this issue is *In re Yetter*,⁹⁵ in which a hospitalized mentally ill woman refused surgery, giving reasons that were both mental illness induced and non-mental illness induced. She had articulated some of the reasons before the onset of mental illness. Said the court, "The delusions do not appear to us to be her primary reason for rejecting surgery. Are we then to force her to submit to medical treatment because some of her present reasons for refusal are delusional and the result of mental illness? Should we now overrule her original understanding but irrational decision?" The court concluded, ". . . we are unwilling now to overrule Mrs. Yetter's original but competent decision."⁹⁶

A psychiatrist accustomed to the exercise of total authority may be threatened by the informed consent model. It is arguable that a true therapeutic alliance is enhanced if the patient perceives that he can play a significant role in controlling his own therapy. If patients are best able to evaluate certain significant subjective effects of medication on them, it seems desirable that their input not only be solicited and evaluated, but also acted upon, unless there are compelling reasons for not doing so. It can plausibly be contended that this form of relationship is a true "alliance," which maximizes the patient's dignity and self-respect, thus enhancing treatment, without depriving the psychiatrist of the ultimate authority to compel medications in those situations in which his authority should prevail.

This is not just a legalistic view. Some psychiatric opinion tends to support this third approach to the therapeutic alliance. See, e.g., Loren Roth's conclusion that, "The traditional mental commitment approach, wherein two physicians declare that the patient is ill and that he will be treated at the doctor's discretion (doctor knows best), must . . . give way."⁹⁷

Current research suggests that the mutual participation-informed consent model is workable. Appelbaum and Gutheil conclude that permitting "limited refusal" is "generally innocuous" and often results in gains accruing from the accompanying negotiations. Their study reveals that even among the most difficult class of refusers there was

“subsequent positive response to medication” and “the development of an effective therapeutic alliance.”⁹⁸

Testimony presented to the court in the *Rogers* case reinforces these findings. Dr. Michael Gill testified that in the more than two years between May 1, 1975 and June 23, 1977, only 12 patients out of 1,000 at Boston State Hospital refused their medication for a prolonged period of time, and “most of those changed their minds within a few days.”⁹⁹

6. Sixth is the argument that upgrading the quality of care in the public mental hospitals is the answer to an “inadequacy of psychiatric care in the state hospitals” stemming from “poor clinical judgment and questionable medical and hospital practice.”¹⁰⁰ In commenting on the *Rennie* decision, a prominent New Jersey psychiatrist, Dr. George Wilson, has written,

If we grant that the state hospitals are understaffed in all respects, and specifically lack an adequate number of well-trained psychiatrists, we do not need to conclude that the only answer is to prevent the hospitals from treating the most seriously ill patients. Another Federal Court, in the *Wyatt v. Stickney* decision, addressed the problem by requiring the state to upgrade staffing at the hospital in question. This approach to the problem of inadequate or poor treatment would seem to be more rational.¹⁰¹

The argument that the problem could better be addressed by providing better staffing rests on two assumptions. The first is that state hospitals can be sufficiently upgraded within an acceptable period of time. The second is that the problem is one involving medical competence only, and not other factors.

It seems clear that one aspect of the medications problem would be significantly improved if the state would not only attract more and better psychiatrists to its state hospitals, but would also provide more and better support staff (nurses, attendants and others) so that problems that arise in connection with the administration of medications could be handled in a less impersonal and more attentive way. The more and better the staff, the less need for regulations.

But is this a realistic answer? Can we assume that the public sector is able to attract a significant number of doctors whose greater competence will avoid the problems revealed in *Rennie*? Will the state pay for more and better support staff? The answer seems to be “no” in both cases. Many state systems cannot attract enough competent psychiatrists, because of insufficiently high salaries, the unattractiveness of state hospitals and the patients in them, and because of an unattractive geographic location in some cases. Many public mental hospitals are compelled to rely on ill-trained and barely competent doctors, many of whom are foreign and unable to speak English adequately or to pass a psychiatric examination, or on doctors with greater competence who

exploit the public sector. The problem is exacerbated by the fact that far fewer American doctors are now going into psychiatry generally.¹⁰²

While upgrading is desirable, it is difficult to accomplish and is therefore not an available alternative answer to this specific problem. Indeed, the *Wyatt* illustration invoked by Dr. Wilson is an unfortunate one, because eight years after the original *Wyatt* upgrading order, the Alabama federal court was compelled to place Alabama mental health facilities in receivership because of "substantial and serious non-compliance" with the court's 1971 order.¹⁰³

But Dr. Wilson's criticism suggests the value of considering a new approach. It may be that *Rennie* is not an answer where the standards of care for patients have fallen too low. It is arguable that less competent psychiatrists either will not or cannot respond to the demands of *Rennie*. If this is so, what may be needed in order to provide quality care is to de-emphasize the role of the psychiatrist in the administration of medications, transferring some of that authority to nurses, pharmacists, or psychologists, who would be carefully trained to perform that function.

The second assumption involved in the "upgrading" argument is that the problem is either exclusively or largely one of medical and staff competence. But, in fact, the problem exists even where the competence of doctors is reasonably high, since it concerns the insensitivity of competent doctors and their unwillingness to grant significant autonomy to their patients, even to the extent of listening to, and responding to, their complaints. Dr. Wilson's statement seems unwittingly to reflect the physician's characteristic unwillingness to grant autonomy to the mental patient. Says Dr. Wilson of the risk-benefit trade-off in the use of antipsychotic drugs, it "is indeed a complex clinical judgment, but [Judge] Brotman writes of it as such an evident and great risk that even the psychotic patient can make that judgment."¹⁰⁴ In his statement, Dr. Wilson seems to regard the medication decision as exclusively a medical judgment. In criticizing the *Rennie* judge, Dr. Wilson says, "To say that untreated schizophrenia is a better choice than the risk of tardive dyskinesia is to show ignorance of the course and outcome of the illness."¹⁰⁵ This statement misses the point of the *Rennie* case. Judge Brotman did not make the choice for the patient. The *Rennie* decision is designed to permit the patient to make the choice for himself.

7. Seventh is the argument that psychiatrists will tend to refuse or quit jobs in mental hospitals if their treatment decisions are subjected to "judicial or semijudicial procedures." Similar gloomy predictions have been made during the last decade on the occasion of every expansion of due process procedures. Despite frequent claims, no significant evidence has been presented that this has happened or will happen. Those doctors who work in public mental hospitals despite the unattractiveness of these places to others, do so for a variety of reasons that make these

jobs attractive to them. These positions often pay well in relation to demands made upon competence and time. Court ordered review of medications decisions is not likely to significantly alter the effect of these more basic considerations that influence psychiatric decisions to work, or not work, in a public mental hospital.

4. *The Futility of Regulation Issue*

A final criticism is that *Rennie* imposes government regulations upon psychiatrists in situations where flexibility, medical discretion, and unregulated authority are more appropriate.

There are two leading arguments against the type of external regulation ordered in *Rennie*. The first is that it is not needed because internal self-regulation is adequate. The second argument acknowledges that while in certain places like New Jersey self-regulation has been "deficient," external regulation would be even worse. The remedy would give the "appearance of certainty," but in fact offer "little more than rigidity."¹⁰⁶ Within this notion is the contention that regulation is naive and counterproductive, causing unintended consequences that might work in the opposite direction. Drs. Appelbaum and Gutheil have suggested that, "To structure a system with the assumption that sadism is the norm may smother benevolent intent in legalistic controls and thereby create a self-fulfilling prophecy."¹⁰⁷ Willard Gaylin, a prominent psychiatrist, is further quoted as saying that "the language of rights . . . that good can only be received from others by pursuit and protection of law" is a "paranoid assumption."¹⁰⁸

Let us examine each of these two arguments.

The first is that regulation is not needed because psychiatrists can regulate themselves. Evidence produced in *Rennie* and discussed earlier in this Article makes it clear that, for now at least, self-regulation is a will-o'-the-wisp. On this point the *Rennie* judge concluded that "institutional pressures . . . make it impossible for anyone in the medical director's position to have sufficient independence, much less the appearance of fairness which due process requires."¹⁰⁹

The second argument against external regulation is that its imposition on psychiatrists would be worse than non-regulation. Little analysis is offered as to why. Instead we are offered the characterization of the regulatory approach as "paranoid" and the familiar *laissez faire* argument that doctors should not be interfered with, supported by a polemical quotation from that noted libertarian, Solzhenitsyn, who, we are told, "reminds us" that "man's noblest impulses" are paralyzed by legalistic relations.¹¹⁰ We are warned that under the pressure of regulations, Dr. Jekyll may yet turn into Mr. Hyde.

Such a prediction may apply to some psychiatrists. Evidence adduced in *Rennie* indicated that certain doctors and nurses at Ancora Hospital behaved vindictively toward John Rennie and other patients who sought legal relief.

A more likely scenario, however, would be one in which psychiatrists would attempt to circumvent the impact of regulation in a variety of ways open to those who control a system. As sociologist David Mechanic has pointed out, "Most rules are easily subverted in practice; when regulations are imposed, efforts are often devoted to meeting their bureaucratic requirements without major impact on behavior; and the proliferation of regulation itself adversely affects morale and practice."¹¹

In mental hospitals subjected to legally ordered controls, provisions intended to provide reasonable leeway for flexible application could easily be abused, *e.g.*, the "functional incompetence" or "emergency" provisions could be stretched far beyond what was intended by the court. Such distortions in application could be covered by an inadequate record-keeping in which conclusions as to dangerousness, emergencies and functional incompetence could be stated without factual bases being given, rendering the decision difficult to check. Unless such records were carefully monitored and challenged, the appearance of compliance would be preserved, but not the actuality of it. Whether or not this will in fact occur will depend on the vigilance of the Patient Advocate, a weak link in the *Rennie* chain.

Conclusion

A major function of this Article, prepared for an audience of psychiatrists most of whom deal extensively with law, lawyers, and judges is to analyze the medication refusal issue and the *Rennie* response to it so as to allay inappropriate anxiety and respond to over-reactions which melodramatically exaggerate the right to refuse as a "right to rot." Experience drawn from one year of operation of the *Rennie* decision in New Jersey makes it clear that, despite original resistance, apprehension and short-term problems that require straightening out, psychiatrists and other hospital staff have adjusted well to the modest requirements of *Rennie*. The administration of medication has significantly improved. There is much less medication being used, to such an extent that one hospital has reported savings of \$100,000 in one year, half of the annual medications budget. Observers report fewer side effects. Nor have these improvements been accomplished at any significant cost to treatment values. In fact, treatment itself has improved. There are no "rotting" patients, nor have substantial additional burdens been placed on treatment personnel.

In considering the purposes of granting a right to refuse, it should be recognized that this right actually has two functions, which are independent and separable, yet interwoven. The first function, one that tends to be overlooked in most of the psychiatric literature on the subject, is to provide a regulatory mechanism which tends to insure a responsible level of medical and staff practice in the administration of medications which have a great potential for hazard to the patient.

The second, more controversial, function of the right is to provide the

mental patient, within reasonable limits, with more autonomous control over treatment administered to him, thus giving the patient a more effective bargaining position, and setting the stage for a truer therapeutic alliance. This function operates even if treatment practices are otherwise acceptable.

Leaders of hospital psychiatry tend to ignore the first function of medication refusal cases, finding it difficult to acknowledge or to make constructive contributions toward the great need for closer monitoring and regulation of medication administration, especially in our public mental hospitals. Yet, evidence produced in the *Rennie* case and elsewhere suggests that this is one of the most serious problems in hospital psychiatry today. In New Jersey, for example, the doctors could not or would not regulate themselves, and feeble efforts made by the state to guarantee an acceptable level of medication practice were brushed aside. Evidence suggests that there are many public mental hospitals in this country in which medication practices are professionally unacceptable.

The *Rennie* court, when brought into action, responded to plaintiff's claims with an order providing for an extensive regulatory system couched in terms of a constitutional right to refuse.

The *Rennie* order has already accomplished what previous efforts had not, and there is reason to believe that further improvements will occur. Among other things, the *Rennie* decision has had a heuristic effect in stimulating awareness of the nature and magnitude of the medication problem. Indeed, hospital psychiatry leaders in New Jersey privately acknowledge that even if *Rennie* were to be reversed, they would voluntarily continue to implement it.

Much of the general acceptance of *Rennie* is due to the wisdom and practicality of the remedy designed by Judge Brotman, in contrast to the much more cumbersome and less workable set of standards and procedures set forth in the *Rogers* case, which provoked a hostility from the community of hospital psychiatrists which spilled over into other approaches to the problem.

Although the regulatory function of the right to refuse has been met with some resistance in the hospital psychiatry community, it seems clear that opposition to acceptable forms of monitoring and regulation, where the need has been so amply demonstrated, cannot long persevere. Attention must necessarily turn to the design of realistic methods of regulation that will most effectively accommodate patient and staff needs.

Hospital psychiatrists, in ignoring the first, and more important, function of the medication refusal cases, have focused on that aspect of the cases which emphasizes patient autonomy.

The hospital psychiatrist tends to view a patient's refusal of medications as irrationally self-destructive, a product of such influences as anger at the therapist or family, tensions in the hospital ward, and the like. The swinging back and forth of some patients between the acceptance and

rejection of medications is generally characterized as reflecting psychotic ambivalence, although there are other realistic reasons for such fluctuations. Hospital psychiatrists tend to perceive reasons for refusing medication as unworthy.

On the other hand, the burdens imposed by refusal on psychiatrists and other staff, as well as on the patients themselves, are perceived as unnecessary and excessive. The patient may impair his own treatment. The staff may have to spend valuable time and energy attempting to persuade a patient to accept medication. Failing that, the staff may have to anticipate patient decompensation, and a possibility of disruptive behavior which may further divert scarce resources. The therapeutic ambience of the ward may be adversely affected. There may even be assaultive behavior, which poses a physical danger to fellow patients and staff.

These potentialities if they actually occurred, could put considerable pressure on an already hard-pressed staff, which would be accentuated if staff had insufficient understanding of and apprehension about legal guidelines. Staff often has no way of knowing at what point a refusing patient may become "dangerous." What is an "emergency?" When is a patient "incompetent?"

These pressures may seem particularly problematic to conscientious staff members who regard the additional price they are paying for patients' rights as unwarranted by the benefit accruing to the patient. But informal evidence indicates that much of what had been feared has not actually occurred, even in Massachusetts, where the judicial order is more awkward in its administration than in *Rennie*.

There is another perspective from which to view the medication refusal issue. The main problem is that of chronic patients. The cost-benefit trade-off for acute, short term, patients may favor compelled medications for short periods of time. But for chronic, long-term, patients, for whom antipsychotic medication is a permanent aspect of their lives, the cost-benefit trade-off changes. The benefits of medication lessen, and the cost in side effects, including tardive dyskinesia, rises in price. For chronic patients drug refusal is not necessarily irrational, sick, or frivolous. But to the extent that medication refusal is irrational, such irrationality should be dealt with as part of the care and treatment process. Medications present significant conflicts for chronic mental patients, whose occasional refusals reflect the despair of their crippled lives. It is understandable that such patients would refuse their medications from time to time, sometimes for rational and constructive reasons, often for reasons that reflect the chronicity of their illness.

Even those who most vigorously criticize the right to refuse acknowledge that most refusers accept medications within a short time following refusal. Many refusals are in reality token refusals. Others are meritorious, calling attention to the need for changes in the medication program. Refusals resulting from delusional perceptions can always be

handled by determining that the patient is incompetent and by medicating him compulsorily, as is permitted by *Rennie*.

The medications refusal dialogue between psychiatrists and lawyers should, in the future, concentrate not on opposition or resistance to the right, but on ways in which the two professions can join forces to solve the intricate and complex problems that confront both. In the difficult task that lies ahead, the patient will benefit from cooperation, not hostility, between law and psychiatry.

References

1. Dr. Alan Stone, at the time president of the American Psychiatric Association, referred to the decision in *Rogers v. Okin*, *infra*, note 9, as "The most impossible, inappropriate, ill-considered judicial decision ever made in the field of mental health law."
2. "The time of trained mental health professionals is best spent treating patients, unencumbered by further encroachment of the judiciary into clinical practice." Rachlin, 1 *Am. J. Forensic Psychiat.* 174 (1979)
3. "Rather than ascribing generally benevolent intentions to most members of the mental health system, . . . many lawyers tend to view psychiatrists as motivated solely by interests of greed, power or sadism." Appelbaum and Gutheil, "Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients, 7 *Bull. Am. Acad. Psychiat. & Law* 306, 309 (1979). Further references to this article will cite to "Rotting With Their Rights On."
4. "Much of its [*Rogers v. Okin*] logic rests on a basic misconception of the effects of psychotropic drugs." Appelbaum and Gutheil, The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot," 137 *Am. J. Psychiat.* 720 (1980). Further references to this article will cite to "Boston Hospital Case."
5. *Id.* at 722
6. Gutheil, Editorial, In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting With Your Rights On," 137 *Am. J. Psychiat.* 327 (1980)
7. Dr. Darold Treffert, a Wisconsin psychiatrist, attracted considerable attention among psychiatrists for this memorable contribution to the polemics of the law-psychiatry relationship. See, e.g., Treffert, Dying With Their Rights On, 130 *Am. J. Psychiat.* 1041 (1973).
8. There are two *Rennie v. Klein* cases. The first (*Rennie I*), which concerned John Rennie alone, is at 462 F. Supp. 1131 (D.N.J. 1978). The second (*Rennie II*), a class action covering patients at five New Jersey state mental hospitals, is at 476 F. Supp. 1294 (D.N.J. 1979).
9. 478 F. Supp. 1342 (D. Mass. 1979), affirmed in part, reversed in part, vacated and remanded, *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980). Further references to the district court opinion will simply cite to "Rogers." The opinion of the First Circuit Court of Appeals will be appropriately identified.
10. See, e.g., *Goedecke v. State Dept. of Institutions*, 603 P.2d 123 (Colo., 1979) (not reaching the constitutional question because the court found a state statutory right to refuse); *In re: the Mental Health of K.K.B.*, 609 P.2d 747 (Okla. 1980) (holding a constitutional right to refuse medications for competent adults, relying on *Rennie* and *Rogers*) and *Davis v. Hubbard*, No. C-73-205 (N.D. Ohio, Sept. 16, 1980). But see *A.E. and R.R. v. Mitchell*, _____ F. Supp. _____ (D. Utah, 1980) (rejecting a constitutional right to refuse medications on the basis that a new Utah statute requires a judicial finding that "the patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment"). See also *In re Boyd*, 403 A.2d 744 (D.C. Ct. App. 1979) (substituted judgment approach).
11. The First Circuit Court of Appeals has described it as an "intuitively obvious proposition" that "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs," *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980).
12. See, e.g., *Ingraham v. Wright*, 430 U.S. 651 (1977) and *Bell v. Wolfish*, 441 U.S. 520 (1979) as interpreted by the Third Circuit Court of Appeals in *Romeo v. Youngberg*, _____ F.2d _____, _____ (3rd Cir. 1980) (slip opinion, p. 7). But see Symonds, Mental Patients' Rights to

- Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment, 7 Hastings Con. L. Q. 701 (1980).
13. For psychosurgery see, e.g., *Kaimowitz v. Michigan Department of Mental Health*, Circuit Court, Wayne County, 1973, reprinted in A. Brooks, *Law, Psychiatry and The Mental Health System* 902-924 (1974), not officially reported. Generally, see the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Report and Recommendations*, Psychosurgery (1977). On ECT see a comprehensive analysis presented in Note, *Regulation of Electroconvulsive Therapy*, 75 Mich. L. Rev. 363 (1976).
 14. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 Am. Bar Found. Research J. 769
 15. See Ozarin *et al.*, *A Quarter Century of Psychiatric Care 1950-1974: A Statistical Review*, 27 Hosp. & Commun. Psychiat. 515, 516 (1976). But see A. Scull, *Decarceration* (1976), whose thesis it is that decarceration is mainly the product of policy, not pharmacology and D. Light, *Becoming Psychiatrists: The Professional Transformation of Self* 10 (1980). In a journalistic article on *Rennie*, Dr. Peter Sterling has called attention to the same point. See Sterling, *Psychiatry's Drug Addiction*, New Republic, December 8, 1979, p. 14.
 16. See Klerman, *National Trends in Hospitalization*, 30 Hosp. & Commun. Psychiat. 110, 111-112 (1979).
 17. See, e.g., K. Bernheim & R. Lewine, *Schizophrenia: Symptoms, Causes, Treatments* 123 (1979).
 18. Compare Bernheim and Lewine, *supra* note 17, at 124, with Bockoven & Solomon, *Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972*, 132 Am. J. Psychiat. 796 (1975) and Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Science 124, 125 (1973). Interesting material on drug benefits is collected and presented in DuBose, of the *Parens Patriae* Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment? 60 Minn. L. Rev. 1149 (1976)
 19. See the discussion of the range of side effects in Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 Wis. L. Rev. 497, 535-539.
 20. S. Estroff, *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community* (1981)
 21. All these side effects are discussed extensively, with appropriate citations to the literature, in the *Rennie* and *Rogers* cases. See also Zander, *Prolixin Decanoate: Big Brother By Injection?*, 5 J. Psychiat. & L. 55 (1977).
 22. S. Estroff, *supra* note 20 at 109-110 and 112 (1980)
 23. The literature on tardive dyskinesia is increasing exponentially. One of the latest contributions is a comprehensive analysis which has been published recently by the Task Force on Late Neurological Effects of Antipsychotic Drugs of the American Psychiatric Association. See Task Force Report 18, *Tardive Dyskinesia*, issued in late 1980 and summarized in *Tardive Dyskinesia: Summary of a Task Force Report of the American Psychiatric Association*, 137 Am. J. Psychiat. 1163 (1980). An excellent legal discussion, containing much information and useful analysis, is Slovenko, *On the Legal Aspects of Tardive Dyskinesia*, 7 J. Psychiat. & L. 295 (1979). See also Klawans, Goetz & Perlik, *Tardive Dyskinesia: Review & Update*, 137 Am. J. Psychiat. 900 (1980) and Baldessarini & Tarsy, *Tardive Dyskinesia*, in M. Lipton, A. DiMascio, & K. Killam, eds., *Psychopharmacology: A Generation of Progress* 993 (1978).
 24. Hutt, *Mind Medicine's Side Effects: Are the Risks Worth the Cure?*, Wash. Post, April 9, 1972, B3, col. 1
 25. See, e.g., the A.P.A. tardive dyskinesia study, *op. cit.*, note 23.
 26. Testimony of Dr. Steven Simring, August 2, 1979, in the *Rennie* case.
 27. See, e.g., Shader & Jackson, *Approaches to Schizophrenia*, in R. Shader, ed., *Manual of Psychiatric Therapeutics* 93 (1975) to the effect that, "At the present time there is no accepted approach to the treatment of tardive dyskinesia." The package inserts for Prolixin & Thorazine both acknowledge, "There is no known effective treatment for tardive dyskinesia." For a further discussion of untreatability see Gardos & Cole, *Maintenance Antipsychotic Therapy: Is the Cure Worse Than the Disease?*, 133 Am. J. Psychiat. 32 (1976)
 28. See, e.g., Tepper & Haas, *Prevalence of Tardive Dyskinesia*, J. Clin. Psychiat. 508 (December, 1979) and Jeste & Wyatt, *Tardive Dyskinesia: The Syndrome*, 10 Psychiat. Annals 16 (January, 1980).
 29. See articles cited in note 23.
 30. See, e.g., Zander, *Prolixin Decanoate: Big Brother by Injection?*, 5 J. Psychiat. & L. 55 (1977).
 31. A number of psychiatric leaders have consistently acknowledged the importance of side

- effects, among them, Drs. Seymour Halleck, George Crane, Jonas Robitscher, and Theodore Van Putten. See, e.g., S. Halleck, *The Treatment of Emotional Disorders* 165-239 (1978) and S. Halleck, *Law in the Practice of Psychiatry: A Handbook for Clinicians* (1980); Crane, *Tardive Dyskinesia in Patients Treated With Major Neuroleptics: A Review of the Literature*, 124 *Am. J. Psychiat.* 40 (1968) and Crane, *Clinical Psychopharmacology in Its Twentieth Year*, 181 *Science* 123 (1973); J. Robitscher, *The Powers of Psychiatry*, Ch. 19 (1980); and the articles of Dr. Van Putten cited throughout this article.
32. See, e.g., R. Garber, Letter, *Tardive Dyskinesia*, *Psychiatric News*, May 4, 1979.
 33. Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 *Science* 124 (1973). The authors of a well known text have written that "most phenothiazine side effects are mild and easily controllable. Serious side effects occur very rarely . . ." D. Klein & J. Davis, *The Diagnosis & Treatment of Psychiatric Disorders* 116 (1969).
 34. Record in the *Rennie* case, Exhibit D-63
 35. *Rennie* transcript Appendix at 289(b)-291(b)
 36. *Rennie* II, at 1302
 37. *Id.* at 1302-1303
 38. *Id.* at 1302
 39. *Id.*
 40. Van Putten, *Why Do Schizophrenic Patients Refuse To Take Their Drugs?*, 31 *Arch. Gen. Psychiat.* 67 (1974)
 41. See, e.g., the statement by Drs. Appelbaum & Gutheil that the right to refuse medications is motivated by an "assumption that sadism is the norm." *Rotting With Their Rights On*, at 308.
 42. Brief *amicus curiae* of the American Psychiatric Association in *Rennie v. Klein*, pp. 19-20
 43. *Rennie* II, at 1301. Overdosage is not unique to New Jersey's hospitals, but seems to be widespread. For example, Dr. Donald Gallant has reported that when Partlow Hospital, involved in the celebrated *Wyatt v. Stickney* case, was notified that he would inspect their charts in his capacity as psychopharmacological consultant for the Human Rights Committee, antipsychotic drugs were entirely eliminated for 400 patients within the 2-month period between notification and visit. Gallant, *Commentary on Stone, The History and Future of Litigation in Psychopharmacologic Research and Treatment*, in D. Gallant and R. Force, *Legal and Ethical Issues in Human Research and Treatment; Psychopharmacologic Consideration* (1978).
 44. *Rennie* II at 1301
 45. APA Brief at 14
 46. *Rennie* II at 1302
 47. *Id.*
 48. Public Advocate Brief at 41
 49. *Davis v. Hubbard*, No. C73-205 (N.D. Ohio, September 16, 1980) (slip opinion, p. 22)
 50. See Special Report, *The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision?*, 29 *Hosp. Commun. Psychiat.* 118, 119 (1978).
 51. News Article, "Levitt Reports a Misuse of Drugs by Three State Mental Hospitals," *New York Times*, July 11, 1978. The state comptroller reported patients were being given dosages of drugs exceeding the maximums recommended in state guidelines and were being treated with several drugs simultaneously, also against guidelines. Patients were not routinely tested to determine whether the drugs in their system had reached toxic levels. "Slipshod" record-keeping and drug administration was reported.
A federal court in describing drug use in an institution for the mentally retarded has described "psychotropic drugs [as] often used for control and not for treatment, and the rate of drug use on some of the units is extraordinarily high." See *Halderman v. Pennhurst State School and Hospital*, 446 F. Supp. 1295, 1307 (E.D. Pa. 1977) *aff'd* and modified, 612 F.2d 84, 93 (3d Cir. 1979) (in banc), cert. granted, 100 S. Ct. 2984 (1980). For a close analysis of the use and abuse of antipsychotic drugs in institutions for the mentally retarded see Plotkin & Gill, *Invisible Manacles: Drugging Mentally Retarded People*, 31 *Stanford L. Rev.* 637 (1979).
 52. *Roe v. Wade*, 410 U.S. 113 (1973)
 53. *Rennie* I, at 1144
 54. *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 426 (1977)
 55. Boston Hospital Case, at 722
 56. *Rogers*, at 1361. For thoughtful discussions of how competence should be determined, a topic not developed here, see Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 *Am. J. Psychiat.* 279 (1977) and Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-making*, 1979 *Wis. L. Rev.* 413. See also R. Burt, *Taking Care of Strangers: The Rule of Law*

- in Doctor-Patient Relations (1979).
57. Special Report, The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision?, 29 Hosp. & Commun. Psychiat. 118, 119 (1978). The story of the failed effort at self-regulation in New Jersey is told in *Rennie II* at 1303-1306. Medical sociologist Eliot Freidson has observed that the tradition of medical self-regulation has in effect served to protect doctors from outside evaluation and criticism rather than to protect patients. E. Freidson, *Professional Dominance: The Social Structure of Medical Care* (1970).
 58. *Rogers*, at 1361
 59. See N.J. Stat. Ann. § 30:4-24(2)(c) (West Cum. Supp. 1978): "[N]o patient may be presumed to be incompetent because he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received." See also Massachusetts statute M.G.L.A. Ch. 123, § 25 and D.M.H. Reg. § 221.02 which "state unequivocally that, although committed, a mental patient is nevertheless presumed competent to manage his affairs, dispose of property, carry on a licensed profession, and even vote. That presumption of competency prevails unless and until there has been an adjudication of incompetency by a court, following notice and hearing. At 1361.
 60. See *A.E. & R.R. v. Mitchell*, _____ F. Supp. _____ (D. Utah, 1980)
 61. *Romeo v. Youngberg*, _____ F.2d _____, _____ (3d Cir. 1980) (slip opinion at 25)
 62. Loren Roth has made this point in a seminal paper, Roth, A Commitment Law for Patients, Doctors & Lawyers, 136 Am. J. Psychiat. 1121 (1979).
 63. 422 U.S. 563, 45 L. Ed.2d 396, 95 S. Ct. 2486 (1975)
 64. See Brooks, Notes on Defining the "Dangerousness" of the Mentally Ill, in C. Frederick, ed., *Dangerous Behavior: A Problem in Law & Mental Health* (1978) and Brooks, *Dangerousness As a Standard for Involuntary Civil Commitment*, in L. McCann & W. Dunn, Summary of Proceedings of the Second Annual Symposium on Mental Health & the Law, University of Richmond (1978). See *Humphrey v. Cady* 405 U.S. 504, 509 (1972).
 65. *In re Hospitalization of B*, 156 N.J. Super. 231, 383 A.2d 760 (Law Div. 1977).
 66. See case of Patient A reported in Myers, An Analysis of Patients' Resistance to Taking Psychotropic Drugs 26 (1978) (manuscript in Rutgers Law School Library).
 67. For a well expressed psychiatric view see Perr, President's Message: The Most Beneficial Alternative: A Counterpart to the Least Restrictive Alternative, 4 Bull. A. A. P. L. iv (1978). In *Rotting With Their Rights On*, Appelbaum & Gutheil claim that, "Legal authorities have apparently failed in general to recognize the manner in which involuntary medications may themselves represent the 'less restrictive alternative.'" At 312. On its face this charge is absurd.
 68. On the *Rennie* case, see Note, *Rennie v. Klein: Constitutional Right of Privacy Protects a Mental Patient's Refusal of Psychotropic Medication*, 57 N.C. L. Rev. 1481 (1979) and Note, 55 N.D. L. Rev. 563 (1979); See P. Christiana, Antipsychotic Medication, The Patient's Right to Refuse: An Evaluation of the *Rennie* Decision (1980) and E. Koenig, The Efficacy of the *Rennie* Guidelines at Carrier Clinic, New Jersey's Largest Private Psychiatric Hospital (1980) (both senior theses in the Princeton University Library). On *Rogers*, see Annas, Refusing Medication in Mental Hospitals, 10 Hastings Center Report 21 (1980) and Curran, The Management of Psychiatric Patients: Courts, Patients' Representatives, & The Refusal of Treatment, 302 N.E.J. Med. 1297 (1980).
- Other articles worth consulting are: Note, *Madness & Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 Wis. L. Rev. 497 (an excellent and thorough discussion); Symonds, *Mental Patients' Rights to Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment*, 7 Hastings Con. L. Q. 701 (1980); Plotkin, *Limiting the Therapeutic Orgy*, 72 Nw. L. Rev. 461 (1978); Plotkin & Gill, *Invisible Manacles: Drugging Mentally Retarded People*, 31 Stanford L. Rev. 637 (1979); Gaughan & LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 L. & Psychol. Rev. 43 (1978); DuBose, of the *Parens Patriae* Commitment Power & Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?, 60 Minn. L. Rev. 1149 (1976); Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 St. L. U. L. J. 100 (1975); Note, *The Right to Refuse Therapy Under "Emergency Restraint Statutes"*, 11 N.E. L. Rev. 509 (1976); and Michels & Himmelstein, *The Right to Refuse Psychoactive Drugs*, Hastings Ctr. Report 3, June, 1973, 8-11.
- A useful collection of materials on the side effects of drugs and on patient reaction to them is contained in Document AOR No. 31, Assembly Office of Research, California State Assembly, *The Use & Misuse of Psychotropic Drugs in California's Mental Health Programs* (June, 1977).
69. Although there is a substantial psychiatric literature on the general right to refuse treatment, the writings on the right to the refuse medications are still not very extensive. The Appelbaum & Gutheil articles are cited in footnotes 3-6. See also Tancredi, *The Right*

to Refuse Psychiatric Treatment: Some Legal and Ethical Considerations 5, *J. Health Politics, Policy and L.* 514 (1980); Malmquist, *Psychiatric Patients and the Refusal of Psychotropics*, in S. Halleck, ed., *New Directions for Mental Health Services: Coping With the Legal Onslaught* 37 (1979); Gutheil, Shapiro & St. Clair, *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 *Am. J. Psychiat.* 347 (1980); Reiser, *Refusing Treatment for Mental Illness: Historical & Ethical Dimensions*, 137 *Am. J. Psychiat.* 329 (1980); Amarasingham, *Social & Cultural Perspectives on Medication Refusal*, 137 *Am. J. Psychiat.* 353 (1980); and Ford, *The Psychiatrist's Double Bind: The Right to Refuse Medication*, 137 *Am. J. Psychiat.* 332 (1980); Roth, *Involuntary Civil Commitment: The Right to Treatment & The Right to Refuse Treatment*, 7 *Psychiat. Annals* (5) 50 (May, 1977); and Hoffman, *The Right to Refuse Psychiatric Treatment: A Clinical Perspective*, 4 *Bull. AAPL* 269 (1976). A valuable paper, to be published in the next issue of the Bulletin, is Mills, *The Rights of Involuntary Patients to Refuse Pharmacotherapy: What is Reasonable?* See also Jonsen & Eichelman, *Ethical Issues in Psychopharmacologic Treatment*, and Stone, *The History & Future of Litigation in Psychopharmacologic Research & Treatment*, in D. Gallant & R. Force, *Legal & Ethical Issues in Human Research & Treatment: Psychopharmacologic Consideration* (1978).

For comments on *Rogers* and *Rennie*, see Torrey, *Refusing to Take Your Medicine*, *Psychology Today*, September, 1980, p. 12 (*Rogers*) and Sterling, *Psychiatry's Drug Addiction*, *New Republic*, December 8, 1979, p. 14 (*Rennie*). Johnson & Weinstein, *Right to Refuse Treatment: The Knowledge Gap*, 7 *J. Psychiat. & L.* 457 (1979) note that a substantial number of psychiatric residents are unfamiliar with the law pertaining to patient's right to refuse treatment.

70. "Unquestionably, pharmacotherapy is far more . . . costly when hedged about with . . . forensic procedures . . ." Appelbaum and Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 *Am. J. Psychiat.* 340, 345 (1980). Further references to this article will cite to "Drug Refusal."
71. *Rogers*, at 1371
72. *Parham v. J.L. & J.R.*, 442 U.S. 584 (1979)
73. *Id.* at 606. In *Mathews v. Eldridge*, 99 S. Ct. 893 (1976) the Court referred to "fiscal and administrative burdens" as bearing on how much process is due. At 903. For a thoughtful discussion of cost in constitutional mental health cases see Frug, *The Judicial Power of the Purse*, 126 U. Pa. L. Rev. 715, esp. 718-730 and 771-777 (1978).
74. "Court hearings threaten to consume a substantial number of clinical hours for the psychiatrists involved . . ." Boston Hospital Case, at 722. The *amicus curiae* brief of the American Psychiatric Association argues that "the costs of the relief ordered [by *Rennie*] will seriously restrict the state's efforts to meet the larger problems of inadequacy of its treatment delivery system for *all* patients in state psychiatric hospitals." Brief *amicus curiae* of the American Psychiatric Association before the Third Circuit Court of Appeals in *Rennie v. Klein*, p. 30.
75. 442 U.S. 584, 606
76. *Id.* Dr. Stone's remark is quoted in News Story, *Stone Says Psychiatry Needs Own Advocate*, *Psychiatric News*, October 19, 1979, pp. 3, 8. The Stone statement is referred to as an "excellent point" in Editorial, note 4.
77. Boston Hospital Case at 723
78. *Id.* at 722
79. *Id.*
80. *Id.* at 723
81. Boston Hospital Case at 723
82. Drug Refusal at 340
83. Letter from George F. Wilson, M.D., Medical Director, Carrier Foundation, to John P. Motley, M.D., October 30, 1979, hereinafter "Wilson Letter."
84. 2 *Psychiat. Capsule & Comment* #10, October, 1980, p. 3
85. In *Rotting With Their Rights On*, Appelbaum & Gutheil acknowledge that of 23 refusing patient studied, 18 "voluntarily accepted the medications again within 24 hours." The five who did not were delusional. In Appelbaum & Gutheil's view, "they would have been found incompetent to judge questions of medication acceptance and refusal." At 311. Under *Rennie* they would be involuntarily medicated.
86. Drug Refusal, *passim*
87. *Rogers*
88. *Rogers v. Okin*, 634 F.2d 650, 655 (1st Cir. 1980)
89. Gill, *The Boston Hospital Case: Its Impact on State Hospital Patients*, unpublished, presented at the Annual Meeting of the American Psychiatric Association, San Francisco, Cal., May 6, 1980
90. P. Christiana, *Antipsychotic Medication & The Right to Refuse: An Evaluation of the Rennie*

- Decision 91 (1980) (Senior Thesis in the Princeton University Library)
91. See Malmquist, "Psychiatric Patients & the Refusal of Psychotropics" in S. Halleck, ed., *New Directors for Mental Health Services: Coping With the Legal Onslaught* 41 & 46 (1979).
 92. This discussion is adapted from an analysis originally presented in Szasz and Hollander, *The Basic Models of the Doctor-Patient Relationship*, 97 *Arch. Int. Med.* 585 (1956).
 93. *Rennie II* at 1300
 94. *Drug Refusal* at 340
 95. 62 D. & C. 2d 619 (C.P. Northhampton County, Pa. 1973)
 96. *Id.*
 97. Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 *Am. J. Psychiat.* 1121, 1126 (1979)
 98. *Drug Refusal* at 345
 99. *Rogers* at 1369
 100. *Wilson Letter*
 101. *Id.*
 102. See, e.g., News Story, "Psychiatry Shortage: 'Substitution' Only Partial Answer, says NIMH," in 6 *ADAMHA News*, No. 17, August 22, 1980, p. 1, reporting that there are currently about 4,500 to 5,000 unfilled positions for psychiatrists in the U.S. The story also reports that there has recently been a 28 percent drop in the number of medical school applicants expressing interest in psychiatry. The situation is aggravated by recent limitations on the use of foreign medical graduates (FMGs). State mental hospitals, which have depended upon FMGs for up to 70 percent of their medical staff, are most heavily affected. For a recent illustration of psychiatric incompetence in public mental hospitals see News Story, *Mental Illness Found on State Hospital Staffs*, *Philadelphia Inquirer*, October 7, 1980, Section B, page 1, which reports official state findings to the effect that two-thirds of the psychiatrists at one of Pennsylvania's 18 state mental health institutions suffer from "serious mental illness." It is further reported that psychiatrists at the other 17 hospitals are in "poor health and lack the ability to communicate with patients." The report adds that the quantity and quality of doctors at most of the state hospitals is "inadequate for quality care." For a general discussion see Knesper, *Psychiatric Manpower for State Mental Hospitals*, 35 *Arch. Gen. Psychiat.* 19 (1978).
 103. See 3 *Ment. Disab. L. Rep.* 403 (1979), for a fuller discussion of *Wyatt* upgrading problems. See Note, *The Wyatt case: Implementation of a Judicial Decree Ordering Institutional Change*, 84 *Yale L. J.* 1338 (1975).
 104. *Wilson Letter*
 105. *Id.*
 106. *APA Brief*, note 52, at 27
 107. *Rotting With Their Rights On* at 309
 108. *Id.* This remarkable characterization is quoted from Gaylin, *In the Beginning: Helpless and Dependent*, in W. Gaylin *et al.*, *Doing Good: The Limits of Benevolence* 32 (1978). Gaylin's point seems to be that "good" cannot always be coerced, and that we must "go beyond the kind of moral behavior that can be defined in terms of plaintiff and litigant." At 32, Gaylin is tilting at a strawman. It would be a remarkably naive reformer who thought that law alone could accomplish what is steadfastly resisted, especially by those with power to resist. It is interesting, however, to note the uses to which Dr. Gaylin's statement is now put.
 109. *Rennie II* at 1310
 110. *Rotting With Their Rights On*, at 309
 111. D. Mechanic, *Future Issues in Health Care: Social Policy and the Rationing of Medical Services* 105 (1979). Mechanic warns us that, "Although the identification of problems usually elicits the response that 'there ought to be a rule,' such rule making designed to constrain behavior or to punish violators is negative in its approach and does little to increase sensitivity or educational dialogue." *Id.* at 106. On the other hand, Mechanic notes that a "grievance procedure offers opportunities for sensitizing health professionals to patients' perceptions and concerns." *Id.* at 119. It is to be hoped that the rule making resulting from the *Rennie* model will be positive, not negative, and that it will operate to increase both sensitivity and educational dialogue. Otherwise we are constrained to helplessly accept incompetent or insensitive medication practices in our public mental hospitals.