INvoluntary commitment and the right to refuse treatment with anti-psychotic drugs

IntroduCtion

An involuntarily committed psychotic patient experiences a massive curtailment of liberty. A patient's life becomes thoroughly regulated within an institution and there is a significant loss of physical freedom. The commitment is disruptive of social, economic, and family activities, and severely impinges upon privacy. Commitment generally means loss of control over the selection or refusal of medical or psychological treatment modalities.

There is a heavy reliance by physicians upon anti-psychotic drugs for treatment of schizophrenia and other psychotic conditions because of beneficial effects of the drugs. However, their use also involves significant hazards. Further, it is believed by some that the drugs are used primarily for purposes of behavior control and as a means of punishment, and therefore their use should be legally regulated.

Treatment with anti-psychotic drugs does not create a problem where either the patient is legally competent and consents to their use, or the patient is legally incompetent and the state, under the parens patriae power, treats the individual who is unable to make such decisions. This comment concerns the anomaly of an involuntary commitment of a legally competent individual who refuses

1. This note will deal only with commitment to state institutions and, therefore, actions by state-employed physicians will be considered state action.
3. ABA, Legal Issues in State Mental Health Care: Proposal for Change, Civil Commitment, reprinted in 2 Mental Disability L. Rev. 73, 80 (1977) [hereinafter cited as Legal Issues].
4. Id. at 81.
5. Id.
7. Plotkin, Limiting the Therapeutic Orgy: Mental Patient's Right to Refuse Treatment, 72 Nw. U.L. Rev. 461, 478 (1978). See generally 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, 1214 (1976) (examines numerous studies of the effectiveness of thorazine and concludes that such drugs should not be used forcibly because of the dangers involved in treatment and because the dangers avoided are not that great).
9. Note, Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1223 (1974) [hereinafter cited as Civil Commitment]. Parens patriae is the power that underpins laws which protect legal incompetents. It is this
treatment with anti-psychotic drugs. At the present time persons legally competent to make treatment decisions are subject to involuntary commitment in almost all states. Traditionally, involuntary commitment statutes appear to have presumed a patient's amenability to medical treatment regardless of legal competence. Recently, however, courts have found that a civilly committed mental patient has a qualified right to refuse treatment with anti-psychotic medication. Current commitment statutes are not designed to deal with this situation because determinations as to whether an individual is legally competent to make treatment decisions are not being made at initial commitment proceedings. As a result, hospital administrators who may have assumed involuntary commitment automatically rendered an individual susceptible to treatment are no longer free to operate under that assumption without incurring the risk of liability. Thus, commitment statutes and state hospital procedures may have to be redesigned in order to account for the possibility that an involuntarily committed individual may constitutionally refuse treatment.

THE MEDICAL PERSPECTIVE

Throughout history, the mentally ill have been treated with disdain and cast aside as societal rejects. The attitude of society power which has been used to authorize civil commitment of the “mentally ill” for their own good. Id. at 1207-12.

10. Legal Issues, supra note 3, at 119.


12. In 1785, a French physician described the situation of the mentally ill as follows:

Thousands of deranged are locked up in prisons without anyone's thinking of administering the slightest remedy, the half-deranged are mixed with
has gradually changed from ignoring the problem to a concern for public safety. A revolution in psychiatry began with Phillipe Pinel in the mid-eighteenth century when the mentally ill began to be viewed as amenable to treatment. Pinel began a reform movement by, quite literally, casting off the chains of the inmates and instituting social reform. He referred to his work as "moral treatment." Moral treatment espoused "respect for the individual, concern for his problems, work for his hands, and a calm environment." Pinel's humane approach to the treatment of the mentally ill and his principles of hospital management are still used. However, as late 1840 the majority of committed mentally ill patients were still confined to locked rooms, cages and outhouses. Severely disturbed psychiatric patients were managed with locked doors, barred windows and other physical restraints. The few medical means of management included the use of barbituates, bromides, narcotics and drugs for sedation, as well as soothing baths, shock therapy with insulin, atropine or convulsant drugs, and neurosurgery including prefrontal lobotomy.

The term "psychosis" is part of the historical baggage of psychiatry that has been retained by modern medicine. Although it is used loosely, the term can be defined as a persistent misevaluation of perception, not attributable to a sensory defect. The hallmark of psychosis is the inexplicable nature of the misevaluation of misperception which has the force of reality and results in distortions and delusions. In other words, an individual suffering from

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the completely insane, the furious with the quiet, some are in chains, others free in the prison, finally, unless nature comes to their rescue and cures them, the term of their misery is that of their mortal days, and unfortunately in the meantime the illness but increases instead of diminishing.

13. The Reform Movement also began in Italy under the direction of Dr. Vincenzo Chiarugi at the Hospital Bonafasio, and in England under a group of Quakers led by William Tuke at York Retreat. Id. at 117-18. F. ALEXANDER & S. SELESNICK, THE HISTORY OF PSYCHIATRY 112-16 (1st ed. 1966).
14. Id. at 113.
15. Id.
17. F. ALEXANDER & S. SELESNICK, supra note 13 at 113.
20. Id. at 2-3.
21. Id.
23. Id. at 48.
psychotic episodes is significantly out of touch with reality and is perceiving a world that does not exist. A key aspect of psychosis is that the pathological thought process is not amenable to change through rational argument. Nor is the distorted thought content related to environmental factors, limited information or sensory defect.

In the mid 1950s a series of remarkable agents, the psychotropic, i.e., anti-psychotic drugs, came into prominence and have proven to be an effective method of treatment for a wide range of psychotic disorders. Chlorpromazine, an anti-psychotic drug, was first tried clinically in an effort to produce "artificial hibernation" as a preanesthetic sedative in surgical patients, and was used first in the United States in 1954 for the treatment of manic states. The anti-psychotic properties of the psychotropic drugs proved to be remarkably potent in affecting a wide variety of pathologies. The anti-psychotic drugs not only relieve anxiety, they also directly influence the psychotic process.

Anti-psychotic drugs have played a major role in altering the

24. See id. at 48-49.
25. Id. at 49.
26. Id. at 50. The term psychosis is often applied to potentially psychotic conditions. One motive for this questionable yet frequent practice is to protect psychiatrists' self-esteem by preventing an error of misdiagnosis. A diagnosis of potential or actual psychosis has safe results for the diagnostician, but a diagnosis such as character disorder or neurosis is open to criticism if the patient should become psychotic. Id. at 49 n.2.
27. The term "anti-psychotic" is used in both a broad and narrow sense. In its narrow sense, it refers to the specific classification of phenothiazine derivatives (thioxanthine, butyrophenones, dibenzoazepines, and the indoles). H. Kaplan, A. Freedman & B. Sadock, 3 Comprehensive Textbook of Psychiatry III 2261 (3d ed. 1980) (this textbook has been referred to as the "Bible" of psychiatry) [hereinafter cited as H. Kaplan]. These drugs are marketed under trade names such as Thorazine, Prolixin, Merraril, Haldol, and Trilafron. Manual of Psychiatric Therapeutics 317-18 app. (R. Shader ed. 1975). Then substances are described as major tranquilizers, neuroleptic or anti-psychotic. Greenblatt & Shader, Psychotropic Drugs in the General Hospital, reprinted in Manual of Psychiatric Therapeutics 1, 11 (R. Shader ed. 1975).

The term anti-psychotic is preferred because it is more general and helpful while the search for drugs lacking neurological toxicity is pursued. R. Baldessarini, supra note 19, at 12.
28. R. Baldessarini, supra note 19, at 2. When anti-psychotic drugs first came into widespread use, they were hailed as the treatment that made all other forms of therapy obsolete. The impact of modern anti-psychotics on the practice of psychiatry has been compared to the impact of antibiotics on medicine. Id.
29. H. Kaplan, supra note 27, at 2257.
30. R. Baldessarini, supra note 19, at 13.
32. D. Klein, supra note 22, at xxx.
role of psychiatric treatment. Although anti-psychotic drugs do not produce a permanent cure of severe mental illness, they do benefit patients in ways that no previous treatment ever has. For many, the result has been more employment opportunities, decreased hospital stays, and more humane inpatient treatment. The fate of many patients, who would otherwise have been permanent residents of mental hospitals, was profoundly affected by medical treatment with anti-psychotic drugs. Hospital populations were dramatically reduced as patients moved into the community, nursing homes or halfway houses. The fact that the population of mental hospitals has been steadily reduced is particularly noteworthy since the admission rates have steadily increased.

The most significant benefit of anti-psychotic drugs is the "normalization" of psychotic thought processes. Treatment goals should maximize cognitive reorganization and reduce the underlying schizophrenic process. Usually there is a rapid change (four to six weeks) that takes place once treatment is initiated with anti-psychotic drugs. In short, anti-psychotic drugs offer a chance for a "normal" life to some who might not otherwise have that opportunity.

Anti-psychotic drugs have changed the nature of mental hospitals from primarily custodial institutions to places suited for temporary care. The positive effect of the anti-psychotic drugs has also facilitated the use of non-organic forms of therapy such as psychotherapy, milieu therapy and occupational therapy. Not surprisingly, there has been a flood of research concerning the effectiveness of these drugs. The reports have yielded contradictory claims. Nevertheless, the use of these drugs has been widely ac-

34. H. Kaplan, supra note 27, at 2257.
35. Id.
36. Id.
37. Id.
38. Id.
39. Id.
40. Id. at 2262.
41. D. Klein, supra note 22, at 152.
42. H. Kaplan, supra note 27, at 2257.
43. Milieu therapy implies the use of a total living experience around which activities and relationships are organized to produce therapeutic results. Id. at 2365.
44. Id.
45. D. Klein, supra note 22, at xxx. Examples of this research are two large scale, sophisticated, long term studies, conducted by the Veterans Administration and the National Institute of Mental Health, in both public and private hospitals around the country to evaluate the effectiveness of anti-psychotic drugs. O. Ray, supra note 16, at 253.
cepted by most medical practitioners. The majority of controlled drug studies have supported clinical impressions about the drugs' positive results.

Unfortunately, there are a variety of side effects that can accompany the use of anti-psychotic medication. The more severe side effects concern the extrapyramidal nervous system. Together, the pyramidal and the extrapyramidal nervous systems accomplish the coordination and purposeful function of the muscles of the body. When either system is impaired complications occur which affect muscular movements. Tardive dyskinesia, a neurological syndrome, is the extrapyramidal syndrome of greatest concern when an individual is being treated with anti-psychotic drugs. Symptoms include slow, rhythmic movements of the facial area with protrusion of the tongue, smacking of the lips, blowing of the cheeks and other bizarre involuntary muscular motions. In its most progressive state the condition may be disabling, making speech incomprehensible and breathing difficult. Tardive dyskinesia is particularly problematic because no reliable effective treatment has been found. Furthermore, any patient taking anti-psychotic drugs runs the risk of incurring dyskinesia. Although researchers have known about the syndrome since the 1950s, its serious implications are not completely understood. Reports indicate the prevalence of tardive dyskinesia among hos-

46. D. Klein, supra note 22, at xxx. The illnesses these drugs affect are different from other illnesses treated with drugs. Psychotic disorders are diagnosed purely on the basis of behavioral changes and changes in thinking and feeling. There are no laboratory tests useful in identifying a psychotic condition. Psychotic disorders without a known physiological basis are called functional disorders, as opposed to organic disorders, where the origin is usually discoverable. The only known fact is that psychotic disorders involve some kind of disruption of the nervous system. There are many theories suggesting a biochemical or genetic basis for functional disorders. O. Ray, supra note 16, at 245.

47. H. Kaplan, supra note 27, at 2257.


49. The syndrome tardive dyskinesia is so called because it manifests itself months or years after the initiation of drug therapy. This unusual syndrome was first observed in seven patients receiving phenothiazines in the late 1950s. Crane, CLINICAL PSYCHOPHARMACOLOGY IN ITS 20TH YEAR, 181 SCIENCE 124, 126-27 (1973).

50. See id. at 126-28.

51. Id. at 126-27.

52. Id. at 127. Rogers, 478 F. Supp. at 1360.

53. CLINICAL PHARMACOLOGY 865 (K. Melmon & H. Morrelli, 2d ed. 1978). Currently the preferred course of treatment is to diagnose as early as possible, reduce or eliminate anti-Parkinson drugs, and reduce the dose of anti-psychotic drugs in an attempt to strike a balance between improvement in the psychosis and amelioration of abnormal movement. Id.

54. Id. at 864.

55. Rogers, 478 F. Supp. at 1360.
pitalized patients may be as great as forty percent or higher.\textsuperscript{56}

In addition to tardive dyskinesia, other extrapyramidal or neuromuscular side effects may be induced by anti-psychotic medication.\textsuperscript{57} The extrapyramidal syndrome most commonly manifested is akathesia, an inner restlessness where the patient is driven to move around.\textsuperscript{58} Another extrapyramidal effect which could be caused by anti-psychotic drugs is a pseudo-Parkinson's syndrome, in which the patient experiences the symptoms of Parkinson's disease, \textit{i.e.}, a mask-like facial appearance and rigidity of the hands.\textsuperscript{59} Finally there is dystonia, a potentially painful side effect. Manifestations of dystonia include spasmodic muscle reactions of the neck, face or back.\textsuperscript{60}

In addition to the neurological side effects of anti-psychotic medication, patients may experience a number of nonmuscular side effects, including blurred vision, dry mouth and throat, weight gain, dizziness, fainting, low blood pressure, nausea, vomiting, and impotence.\textsuperscript{61} It is not disputed that the drugs show short term effectiveness, but the precise nature of the long term effects of each drug remains uncertain.\textsuperscript{62} Nevertheless, the drugs have been accepted by most physicians who work within the vast uncertainties of psychiatric medicine.\textsuperscript{63} Many believe that the benefits of anti-psychotic medication far outweigh their risks.\textsuperscript{64} The majority of hospitalized psychotic patients receive drug therapy in the treatment of their mental disorders.\textsuperscript{65} Often the treating physician is

\textsuperscript{56} D. KLEIN, \textit{supra} note 22, at 182. In \textit{Rogers}, the court found the prevalence of tardive dyskinesia to be as high as 56\% among hospitalized schizophrenics. 478 F. Supp. at 1360.

\textsuperscript{57} \textit{CLINICAL PHARMACOLOGY, supra} note 53, at 864.

\textsuperscript{58} \textit{DORLAND'S ILLUSTRATED MEDICAL DICTIONARY} 50 (24th ed. 1965); Plotkin, \textit{supra} note 7, at 475.

\textsuperscript{59} \textit{CLINICAL PHARMACOLOGY, supra} note 53, at 893; Plotkin, \textit{supra} note 7, at 475.

\textsuperscript{60} \textit{DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, supra} note 59, at 460. Dystonia results from a disordered tonicity of muscle.

\textsuperscript{61} D. KLEIN, \textit{supra} note 22, at 188; \textit{see also} Crane, \textit{supra} note 49, at 126.

\textsuperscript{62} D. KLEIN, \textit{supra} note 22, at xxx.

\textsuperscript{63} \textit{Id}.


\textsuperscript{65} O. RAY, \textit{supra} note 16 at 252. The tremendous impact of anti-psychotic drug treatment on the management of hospitalized patients is made clear by the 1955 statement of the director of the Delaware State Hospital: "We have now achieved . . . . the reorganization of the management of disturbed patients. . . . I believe it is fair to state that pharmacology promises to accomplish what other measures have failed to bring about—the social emancipation of the mental hospital." \textit{Id}. at 253. \textit{But see}Jeste & Wyatt, \textit{Changing Epidemiology of Tardive Dyskinesia: An Overview}, \textit{138 AM. J. PSYCH.} 297, 306 (1981) (suggesting that drug therapy should be employed only after other alternatives have been examined).
guided by the proviso, *nil nocere*, that inaction may be more harmful than action.\(^6\) Thus, depending on one's orientation, the anti-psychotic drugs may be characterized as either powerful mind-control agents with extremely dangerous side effects or as beneficial agents that are relatively safe.\(^7\)

**THE LEGAL PERSPECTIVE**

*Concomitant Rights to Treatment and To Refuse Treatment*

The right to treatment was first upheld in the landmark case of *Rouse v. Cameron*,\(^6\) where it was noted that failure to treat an involuntarily confined mental patient could constitute violations of the eighth amendment's prohibition against cruel and unusual punishment, and the fourteenth amendment's guarantees of equal protection and due process.\(^6\) The right to treatment received judicial recognition for the second time in *Nason v. Superintendent of Bridgewater State Hosp.*,\(^7\) where the right to treatment was upheld on the theory that the state hospital in which the petitioner was hospitalized was inferior to other state hospitals.\(^7\) As a result, the patient successfully argued he had been deprived of both equal protection of the law and due process because of his confinement without treatment.\(^7\) The next major development came with the case of *Wyatt v. Stickney*,\(^7\) in which the court held that civilly committed persons had a constitutional right to receive minimal treatment.\(^7\) Following the *Wyatt* decision, courts continued to support a trend towards recognizing a constitutional right to treatment in exchange for a loss of liberty.\(^7\)

In 1975, the United States Supreme Court first dealt with this issue in *O'Connor v. Donaldson*.\(^76\) The Court held that the pa-

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\(^6\) D. Klein, *supra* note 22, at 44.

\(^7\) Crane, *supra* note 49, at 124. One of the consequences of reliance on psychopharmacology has been a tendency to minimize the potential danger of longterm use. *Id.*

\(^6\) 373 F.2d 451, 455 (D.C. Cir. 1966).

\(^6\) *Id.* at 453. *See also* O'Connor v. Donaldson, 422 U.S. 563, 580-81 (1975) (involuntary commitment without treatment violative of the due process clause).


\(^7\) *Id.* at 606, 233 N.E.2d at 911.

\(^7\) *Id.* at 606, 233 N.E.2d at 913.


\(^7\) 344 F. Supp. at 376-77. The right to minimal treatment was affirmed. 503 F.2d at 1313-14.


\(^7\) 422 U.S. 563 (1975).
tient's constitutional right to freedom had been violated because he was held without treatment for over fourteen years.\textsuperscript{77} However, it was not until 1982, in \textit{Youngberg v. Romeo},\textsuperscript{78} that the Supreme Court addressed the issue squarely and held that there is a constitutional right to receive treatment.\textsuperscript{79} The Court stated: "When a person is institutionalized and wholly dependent on the State . . . a duty to provide certain services and care does exist . . ."	extsuperscript{80}

As courts began to recognize a right to treatment, the question arose as to whether that right imposed a duty to \textit{submit} to treatment. To date, the majority of federal courts which have examined this question have determined that there is a qualified federal constitutional right\textsuperscript{81} to refuse medication.\textsuperscript{82} Under certain circumstances, state courts have recently followed the same trend.\textsuperscript{83}

In the recent United States Supreme Court decision of \textit{Mills v. Rogers},\textsuperscript{84} the respondents, present and former mental patients, contended that involuntarily committed mental patients have a constitutional right to refuse treatment with anti-psychotic drugs.\textsuperscript{85} The Court, however, did not reach the constitutional is-

\textsuperscript{77} Id. at 564.
\textsuperscript{78} Youngberg v. Romeo, — U.S. —, 102 S. Ct. 2452 (1982).
\textsuperscript{79} Id. at 2462.
\textsuperscript{80} Id. at 2459.
\textsuperscript{81} The distinction between a qualified and an absolute right to refuse treatment has been made. Rennie v. Klein, 462 F. Supp. 1131, 1145-48 (D. N.J. 1979). In \textit{Rennie}, the court concluded that involuntarily confined mental patients have a qualified right to refuse anti-psychotic medication as opposed to the "absolute" right to refuse medication which protects voluntary patients under New Jersey law. Id. at 1141 (quoting N.J. STAT. ANN. § 30:4-24.2(d) (1) (West 1981)). The characterization of the right to refuse treatment as either qualified or absolute depends on the nature of the interest being protected. See \textit{Rogers v. Okin}, 634 F.2d 650 (1st Cir. 1980). In \textit{Rogers}, it was argued by those seeking to prevent forced drug therapy that the rights of privacy, freedom from bodily intrusions, and personal security were implicated when the state sought to forcibly administer anti-psychotic medication. Id. at 653.
\textsuperscript{82} See note 11 and accompanying text supra.
\textsuperscript{84} 102 S. Ct. 2442 (1982).
\textsuperscript{85} Id. at 2445. The respondents were former mental patients at the Boston State Hospital. \textit{Id.} They had instituted a class action suit against hospital officials alleging that they had been forcibly medicated with anti-psychotic drugs in violation of their constitutional right to privacy. \textit{Rogers}, 478 F. Supp. at 1353, 1365-66. They further alleged that the hospital's seclusion and medication policies violated standards of medical care and constituted assault and battery, as well as false imprisonment under common law principles. \textit{Id.} at 1352, 1383. The trial court held that mental patients not adjudicated incompetent at an independent hearing had a constitutionally protected right to make treatment decisions for themselves. \textit{Id.} at 1387-88. The court also held the charges of assault and battery were inapplicable in a state hospital. \textit{Id.} at 1383-84. The court stated that absent incompetence, a patient's protected interest could only be overridden in an emergency, where the fail-
sue. The case was remanded\textsuperscript{86} to the Court of Appeals for the First Circuit in light of an intervening decision by the Supreme Judicial Court of Massachusetts,\textsuperscript{87} in which the court had been asked to decide whether a guardian possessed the authority to consent to administration of unwanted anti-psychotic drugs.\textsuperscript{88} The Massachusetts court had affirmed the qualified right of a non-institutionalized incompetent person to refuse medical treatment despite the guardian's desire that the ward be treated.\textsuperscript{89} As a result of the re-

ure to medicate "would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution." \textit{Id.} at 1365.

On appeal, the district court's strict standard for what constituted an "emergency" was redefined by the First Circuit, where broad discretion was returned to the physician to decide when the state's police power could be used to prevent violence and override a patient's interest in refusing medication. 634 F.2d at 656-57. The First Circuit did, however, remand the case to the lower court to be "creative" in designing procedures which would protect a patient's interests. \textit{Id.} at 656.

The decisions of the lower court and the court of appeals reflect the difficulty courts have in reconciling the incompatibility of the medical reality of psychosis and the legal requirements for due process. Whether an individual has a right to demand "privacy"—and thus refuse treatment while remaining in the hospital—should not be left for judges or courts to decide. The conflict between the patient's rights, the discretion of the psychiatrist, and the interests of the state could be lessened by commitment laws which limit commitment to persons legally incompetent to make treatment decisions.

\textsuperscript{86} 102 S. Ct. at 2452.
\textsuperscript{88} \textit{Id.} at —, 421 N.E.2d at 42.
\textsuperscript{89} \textit{Id.} at —, 421 N.E.2d at 50, 62. The court held that a judicial determination in accordance with the substituted judgment doctrine was the appropriate means of effectuating Richard Roe's right to refuse medication. The court further articulated guidelines as to who may make decisions for incompetent persons and what standards must guide the decision maker. \textit{Id.} at 56-59.

However, a difficult situation could arise if a patient committed for care refuses treatment that could ameliorate his or her condition, while at the same time the family threatens the hospital with a right to treatment suit.

In order to respect a patient's right to his or her bodily integrity, application for guardianship is one potential solution. A guardian ad litem is a court-appointed representative of an incompetent individual. The guardian may be vested with complete discretion over the incompetent person's estate, may have the authority to make personal decisions for the incompetent individual, or both. \textit{In re Lindsley}, 44 N.J. Eq. 564, 15 A. 1, 2 (1888). Appointment of a guardian is especially appropriate when: (1) the patient is in need of treatment to prevent harm; (2) medication exists that would be likely to lead to an improved condition in the patient; (3) the patient refuses the medication and the patient's judgment has been impaired by the illness; and (4) alternative treatment has been ruled out. Guthiel, Shapiro & St. Clair, \textit{Legal Guardianship in Drug Refusal: An Illusory Situation}, 137 Am. J. Psych. 347, 348 (1980) [hereinafter cited as \textit{Legal Guardianship}]. Practically, however, this solution is severely limited. Ford, \textit{The Psychiatrist's Double Bind: The Right to Refuse Medication}, 137 Am. J. Psych. 332, 335-37 (1970). Petitions for guardianships may be unworkable because they are time consuming, expensive, and the patient fails to receive medication during the pendency of the guardianship proceedings. \textit{Id.}

Substituted judgment is another mechanism designed to protect the right of an institutionalized patient. The doctrine of substituted judgment requires a judge, who is theoretically impartial, to "don the mantle" of the incompetent. Superinten-
mand in Mills, the question of whether an institutionalized, legally competent individual has a constitutional right to refuse treatment remains unanswered.

*Tort Theory as a Basis For Refusing Treatment*

The right of an individual to decide whether to submit to medical treatment has long been recognized at common law under the doctrine of informed consent. This doctrine reflects the fundamental principle that individuals should be protected from unjustified intentional contacts with others. Such unwanted contacts are actionable; thus the administration of chemotherapy, though it may be therapeutic, is a battery when given without consent. However, it is widely recognized that consent by the person being "touched" negates any tort liability.

Valid consent must be informed consent and exists only when: (1) the doctor has disclosed what a reasonable patient would need to know in order to make a reasoned decision; (2) based on that disclosure, the patient has made a voluntary decision; and (3) the patient was competent to make such a decision. Justice Cardozo noted that "[e]very human being of adult years and sound mind...
has a right to determine what shall be done with his own body. . . . 94 Paradoxically, refusal of treatment by the psychotic patient is often induced by the illness itself. 95 Typically, psychiatrists work with patients who have impaired perceptions of themselves and the world. Patients may refuse treatment because they fail to recognize the illness 96 or because of a delusion, i.e., they may feel deserving of a bad fate. 97 Because of the problems of the severely ill, but legally competent psychiatric patient who is unable to balance the risks and benefits of the medication, the doctrine of informed consent inadequately protects the patient’s interest in liberty and privacy.

Violation of the informed consent requirement provides a basis for tort liability. 98 Under a claim of negligence or malpractice, the patient must show a departure from normal practice; but under a claim that the patient failed to give informed consent, no such showing is necessary. 99 If a hospital fails to obtain consent from an involuntarily committed patient, or that patient’s guardian, the hospital staff may not administer anti-psychotic drugs without incurring tort liability. 100 Conversely, a hospital should not be forced to house a patient whom it may not legally treat.

States have begun by statute to draw lines between non-intrusive and intrusive forms of therapy that would require court approval when a patient, or the patient’s guardian, fails to give the necessary consent. California 101 and Massachusetts 102 by statute, provide patients with the right to refuse electroshock treatment and psychosurgery, which suggests by negative implication that patients in those states do not have a right to refuse medication. 103 Wisconsin has, however, tried to regulate the use of medication. 104

96. D. Klein, supra note 22, at 28.
97. See id. at 61.
98. H. Kaplan, A. Freedman & B. Sadock, supra note 27, at 3070.
99. Id.
100. Id. Some circumstances exist in which informed consent may be legally inadequate. In Kaimowitz v. Michigan Dept. of Mental Health, 42 U.S.L.W. 2063-64 (Cir. Ct. Wayne City, Mich. July 7, 1973), consent for proposed psychosurgery for an involuntary mental patient was held inadequate because of the coercive setting, the speculative nature of the operation, and the irreversible effects of the surgery.
103. H. Kaplan, supra note 27, at 3072.
104. WIS. STAT. ANN. § 51.61(1) (West Supp. 1982).
Other states have taken similar approaches. Courts have likewise attempted to measure the intrusiveness of various treatments. In Price v. Sheppard, the Minnesota Supreme Court listed drug therapy as more intrusive than milieu therapy and psychoanalysis, but less intrusive than aversion therapy, electric shock, or psychosurgery.

 Constitutional Arguments for the Right to Refuse Treatment

The constitutional right to refuse medication has followed judicial recognition of the right to refuse prefrontal lobotomy and shock therapy. Rationales rest on the following constitutional bases: the fourteenth amendment rights of privacy, equal protection, and due process; the first amendment right of freedom from interference with thought processes; and the eighth amendment prohibition against cruel and unusual punishment.

The right to privacy has provided litigants with a constitutional approach to the right to refuse treatment. The fundamental right to privacy has been said to exist in the penumbras of the Bill of Rights and has offered broad protection for individual autonomy, particularly in matters centering around family life. However, the right of involuntarily committed patients to refuse treatment does not clearly fall within previously indentified areas

105. See, e.g., Mich. Comp. Laws Ann. § 330.1718 (1980) (on petition, a patient may refuse drugs until a hearing, unless he or she is dangerous).
106. 301 Minn. at 909, 239 N.W.2d at 911.
108. See also Scott v. Plante, 532 F.2d 939, 946 (3d Cir. 1976).
110. See Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973) (impermissible tinkering with mental processes raises constitutional questions). See also Winters v. Miller, 446 F.2d 65 (2d Cir. 1971), cert. denied, 404 U.S. 985 (1972) (recognizing the first amendment right of Christian Scientists, who had not been adjudged incompetent, to refuse treatment on non-emergency grounds). Religious objections to treatment, however, provide such a narrow basis for treatment refusal that it is not really available for the general institutionalized population.
111. Knecht v. Gillman, 488 F.2d 1136, 1139 (8th Cir. 1973) (forced administration of apomorphine to induce violent vomiting as treatment of inmates' behavioral problems held to be cruel and unusual punishment under the eighth amendment). Through the eighth amendment proscription of cruel and unusual punishment, the judiciary has struck down some of the most blatant abuses of drug mismanagement. Nevertheless, because of the difficulty in characterizing psychiatric treatment as cruel punishment, these holdings are of limited value to an involuntarily committed patient. Plotkin, supra note 7, at 494.
of family decision-making protected by the right to privacy. It seems unlikely that the courts will be willing to extend the doctrine in light of the First Circuit's failure to discuss the issue in Rogers and the Supreme Court's remand of the same case.

Although an individual may not be able to find protection to refuse medication under the doctrine of privacy, a person's liberty interest in bodily integrity is protected by due process. Due process requirements may limit the use of treatment techniques that infringe upon an individual's liberty interest and do not bear a substantial relationship to a legitimate state objective.

When the Supreme Court heard Rogers, it failed to reach the issue of whether, and to what extent, persons committed to mental institutions suffer a diminution in their various liberty interests. Previously, the Supreme Court had recognized that convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison. There is no apparent reason to believe that a patient in a mental health institution possesses less of a liberty interest than a convicted criminal. However, to equate the two is to blur the distinction between legal competency and incompetency as well as the legal distinction between punishment and involuntary commitment. If a constitutional liberty interest exists, it must be balanced against the state's interest before it can be overridden. It is important for the nature of the interest to be identified because the stronger the individual interest potentially affected, the greater the burden imposed on the state to justify any intrusion on that interest. For example, infringement of a first amendment interest will auto-


115. Jacobson v. Massachusetts, 197 U.S. 11, 31 (1905) (state requirement for smallpox vaccination upon a finding that the statute bore a real and substantial relation to the protection of the public health. However, physical intrusions for the purpose of obtaining evidence of a crime may be unconstitutional if they are offensive to human dignity, e.g., where suspect's stomach was forcibly pumped. Rochin v. California, 342 U.S. 165, 174 (1952).


117. Vitek v. Jones, 445 U.S. 480, 488-89 (1980) (recognizing a broad liberty interest guaranteed by the due process clause to prevent the transfer of a prisoner from the prison to a mental hospital). But see Addington v. Texas, 441 U.S. 418, 428 (1976) (civilly committed patients, although committing no crime, are deprived of their liberty because of a condition beyond their control).


119. Shapiro, Legislating the Control of Behavior Control: Autonomy in the Coercive Use of Organic Therapies, 47 S. Cal. L. Rev. 237, 249-57 (1974). See Procunier v. Martinez, 416 U.S. 396, 405 (1974) (courts often defer to the expertise of institutional administrators in performing balancing interests, but judicial restraint not mandated); Rogers, 634 F.2d at 657 (physicians should do the balancing); DuBoise, supra note 7, at 1214.
sults can be drawn from the equal protection clause and the substantive due process clause. The equal protection clause is most directly applicable since it involves a deprivation of a protected liberty interest. The substantive due process clause, however, is also applicable since it is a constitutional right that is not specifically enumerated in the Bill of Rights.

Although the Due Process Clause was incorporated over a century ago, it was not until the 1960s that the Supreme Court began to recognize that the clause protected rights that were not specifically enumerated in the Bill of Rights. The doctrine of substantive due process was employed to strike down state laws that violated the liberty interests of individuals. The liberty interests protected under the Due Process Clause include the right to decide the time, place, and manner of speech, the right to marry, and the right to have a child. The Supreme Court has also recognized that the Due Process Clause protects the right to a fair trial, the right to counsel, and the right to a speedy trial.

The Due Process Clause is a broad and all-encompassing provision that is designed to protect against governmental deprivation of liberty. The clause has been used to invalidate a wide range of state actions, including those that violate the rights of individuals, infringe on the freedom of speech, and interfere with the exercise of religion.

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health and welfare, and the police power protects actions the state must take in order to achieve that end.\textsuperscript{129} This interest has, on occasion, allowed a state to compel treatment in cases where it would otherwise have been unable to do so.\textsuperscript{130}

Third, the state has an interest in the administrative management of its mental institutions, which includes regimentation of its residents and the organization of relationships between staff and patients.\textsuperscript{131} However, treatment to further these objectives alone may be objectionable on due process grounds.\textsuperscript{132} Finally, the state has an interest in treating individuals in an effort to justify the commitment process.\textsuperscript{133} This interest is the obvious value of relief that treatment would provide for the patient.\textsuperscript{134}

**ACCOMMODATION OF THE TWO CONFLICTING PERSPECTIVES**

In weighing the rights of an involuntarily committed mental patient against those of the state, the key issue is to determine when treatment is appropriate and when it should be compelled. It is this determination that has proven to be especially troublesome.\textsuperscript{135} At one extreme there is the legal standard which places the burden on the state physician to justify the invasive procedure in the absence of consent.\textsuperscript{136} At the other extreme is the medical standard, which requires deference to medical judgment, with the

cient interest to justify compelled medication to treat a competent patient who poses no security risk.

In *Rogers*, the court reasserted the view that certain deprivations of liberty may be necessary to preserve order and to protect patients from harm caused by themselves or others. *Rogers*, 634 F.2d at 659. However, restatement of the state's police power does not go far to help evaluate the balancing process.

\textsuperscript{129} Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905).

\textsuperscript{130} Robinson v. California, 370 U.S. 660, 665 (1962) (dictum). The Court noted that a state might establish a compulsory program for those addicted to narcotics. Analogizing narcotics addiction to mental illness, the Court determined that general health and welfare required compulsory treatment involving quarantine confinement or sequestration. *Id.* Anti-psychotic medication is arguably more intrusive and more dangerous with uncertain long term benefits.

\textsuperscript{131} *Rogers*, 478 F. Supp. at 358-59. The U.S. Supreme Court has required the balancing of a number of factors:

\textsuperscript{132} *Mathews* v. Eldridge, 424 U.S. 319, 335 (1976).

\textsuperscript{133} *See* notes 107-17 and accompanying text supra.

\textsuperscript{134} *See* Rogers, 634 F.2d at 656-57.

\textsuperscript{135} DuBose, supra note 7, at 1151.

\textsuperscript{136} H. Kaplan, supra note 27, at 3069-70.
burden on the patient to show that the treatment is not justified.137 Hopefully, between these two extremes there is a position which can accommodate the interests of the individual, the medical profession and the state.

The Legal—Individual Liberty Standard

There is a growing body of legal precedent and literature regarding the "least restrictive alternative" for treatment of persons civilly committed on grounds of mental disorders.138 The least drastic means test is derived from the constitutional requirement that the state can not impose any greater restrictions on fundamental freedoms than is necessary.139 It is necessary to determine the extent of the intrusion of the anti-psychotic drug in order to establish whether there is in fact a less drastic method of accomplishing the same purpose.140 One commentator, in an analysis of intrusiveness, specifies six criteria which may be considered individually:

(1) The extent to which the effects of therapy are irreversible;
(2) The extent to which the resulting psychic state is 'abnormal,' or 'unnatural' for the person in question;
(3) The rapidity with which effects occur;
(4) The scope of change in the mind's functions;
(5) The extent to which one can resist the side effects of the drug;
(6) The duration of the change. (Minor, permanent changes might be considered more serious than profound, temporary ones).141

While it can hardly be disputed that treatment with anti-psychotic drugs is intrusive, that alone does not make use of the drugs an improper decision. Any legitimate medical decision should have at its core the principle of *primum non nocere*, i.e., first, do no harm.142 This principle cautions counsel before any medical decision is made by a physician. It requires decisions be

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137. *Id.*
138. *See, e.g.*, Covington v. Harris, 419 F.2d 617, 622-23 (D.C. Cir. 1969) (even when government purpose is legitimate and substantial, that purpose must be pursued by the least drastic means); Davis v. Watkins, 384 F. Supp. 1196, 1206 (N.D. Ohio 1974) (individual treatment plans must achieve the purposes of commitment by the least restrictive conditions).
140. *See* Shapiro, *supra* note 119, at 282.
141. *Id.*
closely scrutinized. It requires that treatment be justified by balancing the benefits and detriments, and choosing the most effective and least intrusive form.\textsuperscript{143} Therefore, medical judgments must theoretically include evaluations of the factors identified above. The result of such considerations should be that drug therapy is utilized only where it is clearly warranted.\textsuperscript{144} To deviate from these principles opens the door to abuse and misuse.\textsuperscript{145}

Civil commitment, the legal mechanism by which involuntary mental hospitalization and treatment are imposed, is a controversial subject. Civil commitment is founded on two legal theories: the state’s police\textsuperscript{146} and \textit{parens patriae} powers.\textsuperscript{147} There is not necessarily any connection between mental illness and mental incompetence.\textsuperscript{148} Over half of the states which authorize involuntary commitment by statute do not require that the individual be legally incompetent to make personal treatment decisions.\textsuperscript{149} However, courts have noted that the state’s \textit{parens patriae} power should only extend to mentally “incompetent” persons.\textsuperscript{150}

The issue of competency is relevant as to whether an individual receives treatment under both the \textit{parens patriae} and police power theories of commitment and treatment.\textsuperscript{151} The \textit{parens patriae} basis for treatment makes no sense if an adult can competently make a personal decision regarding a preferred course of treatment; it is only relevant when an individual is incapacitated and unable to adequately balance the risk and benefits of treatment.\textsuperscript{152} Likewise, under the police power, it is only when a dangerous individual is incapable of making a personal decision about treatment that the state is justified in forcing treatment.\textsuperscript{153}

Historically, persons involuntarily committed to mental insti-
tutions were presumed to be incompetent for all purposes.\textsuperscript{154} Some modern legislative statutes separate commitability from competency.\textsuperscript{155} In \textit{Winters v. Miller}, the court held that involuntary commitment did not even raise a presumption of incompetence.\textsuperscript{156} Mental health practitioners have long recognized this distinction.\textsuperscript{157} The presumption of competence continues even while the person is committed to a public or private institution.\textsuperscript{158}

Because individuals who are suffering from psychotic episodes are out of touch with reality, the psychiatrist is in a double bind when the patient refuses medication.\textsuperscript{159} The physician knows treatment with anti-psychotic drugs may greatly benefit the patient, and the physician's duty is to treat a hospitalized patient; but forcing the medication may violate the patient's sense of autonomy and result in liability.\textsuperscript{160} To allow commitment of severely ill individuals to a state hospital, and grant these same individuals the right to refuse treatment may lead to nothing more than, at best, custodial care. Likewise, however, it is unnecessary and inappropriate to force patients to be declared incompetent for all purposes simply because they need to be committed.\textsuperscript{161} Ideally, a court should make a separate finding at the commitment hearing as to a patient's competency to accept or refuse medication.\textsuperscript{162} Since the purpose of the incapacity or incompetency determination would be to separate those individuals whose refusals may be overridden by the state, the standard should focus on the ability to make rational

\begin{footnotes}
\footnote{154. \textit{Id.} at 1212 (state's power to commit the mentally ill premised on the presumed incapacity of minors and actual incapacity of lunatics to care for themselves). \textit{See also Howard v. Howard, — Ky. —, 9 S.W. 441, 413 (1888) (commitment includes a determination that the mentally ill individual "has ceased to be man.").}}
\footnote{155. \textit{Plotkin, supra} note 7, 504-25 app. (statutory survey).}
\footnote{156. 446 F.2d at 68 (noting that absent a determination of incompetency, a mentally ill patient has the right to manage his or her own affairs). An adjudication of incompetency does not require the court to render psychiatric judgments regarding treatment. \textit{O'Connor}, 422 U.S. at 583. The patient's ability to care for himself is the only issue decided at a competency hearing, and such determinations have generally been handled by the courts. \textit{Ford, supra} note 89, at 332-33. There are no uniform standards for judging incompetency. Meisel, \textit{The Exceptions to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking}, 1979 Wis. L. Rev. 413, 440 (1977). For a discussion of various standards, see \textit{id.} at 439-40.}}
\footnote{157. \textit{T. Szaz, THE AGE oF MADNESS} 237 (1973). From a medical point of view there is not necessarily any connection between mental illness and mental incompetence.}
\footnote{158. \textit{In re Roe, — Mass. at —, 421 N.E.2d at 55 n.15.}}
\footnote{159. \textit{Ford, supra} note 89, at 332-33.}
\footnote{160. \textit{Id.}}
\footnote{161. \textit{Id.} at 333-34.}
\footnote{162. \textit{Id.}}
decisions about treatment. As long as an individual who refuses treatment has weighed the benefits and risks during a rational period, the state should be precluded from forcing treatment with anti-psychotic drugs during periods of disorientation. However, the state may not be deprived of the right to confine people who pose a threat to society. Conversely, if an individual is not rational to make decisions about treatment, that individual should be declared incompetent for such purposes, and the state should determine treatment strategies.

Civil commitment statutes vary greatly in the requisite standards for involuntary commitment and in the regulation of treatments imposed. As noted earlier, certain procedures and treatments by statute require a patient’s consent, and some separate "commitability" from legal competency. Generally, however, the present commitment laws have allowed the hospitalization of legally competent patients who may have the right to refuse specific treatment. In effect, persons who suffer from psychosis are being involuntarily committed to mental institutions because they can no longer function in society, and yet they are given the right to make personal decisions to refuse treatment on the basis that they are fully capable of making such decisions.

The Medical—Need for Treatment Standard

The present commitment statutes have created problems for the medical system by making lack of consent a constitutional problem. Hospital administrators are now faced with populations they assumed could receive treatment, who may now refuse treatment on constitutional grounds, in facilities that were designed for purposes of treatment—not confinement. This is not to say that mental patients are not entitled to fundamental rights. However, the constitutionality of the problem may be misplaced. By leaving the assertion of a constitutional right in the hands of an individual when the law has deemed that individual incapable of making day to day decisions via involuntary commitment is to, at best, beg the question.

The medical model for commitment is premised on the belief that the patient is mentally ill and in need of treatment. Allowing treatment refusals by patients who have been involuntarily

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163. Civil Commitment, supra note 9, at 1216.
164. See Lane v. Candura, 8 Mass. App. Ct. 377, —, 376 N.E.2d 1232, 1236 (1978) (evidence that defendant suffered from a degree of senility and periods of confusion was not evidence that her refusal was the result of impaired faculties).
165. See notes 98-101 and accompanying text supra.
166. Stone, supra note 125, at 563.
committed defeats this presumption and may severely impact state mental institutions in that they would be prevented from treating non-consenting committed patients, while at the same time being required to house them.

Under the medical-treatment standards, statutes regulating commitment should be confined to those persons incapable of making their own treatment decisions. In making this determination, the reasoning process must be subjective and ask the narrow question of whether the individual has the capacity to reason or make a rational decision regarding treatment. If an individual can rationally decide to pursue a course of treatment, the medical perspective is that the individual is not an appropriate candidate for involuntary commitment. A general inquiry into the individual’s reasoning process is inappropriate for such a limited competency determination. Such inquiries would lead to erroneous findings of incompetence. A physician does not need to know if a patient can enter into a binding contract, but the physician does need to know whether a patient can be treated. In addition, the issue of the right to refuse treatment should in some cases be adjudicated at the commitment hearing. Although medication decisions are traditionally a separate matter, initial medication decisions might be made when an individual’s past history indicates a potential problem.

Thus, treatment of involuntarily committed individuals must be confined to legally incompetent persons. Procedural safeguards must be available to ensure that waivers of rights are “voluntary . . . knowing, intelligent acts done with sufficient awareness of the relevant circumstances and likely consequences,” and that commitment hearings are conducted according to due process. In spite of safeguards, if prescription of drug treatment would be unreasonable and unwarranted by medical standards, then administration of treatment with such drugs should automatically subject a physician to liability.

An Accommodation of Interests

A treatment review board composed of individuals representing various professions, including law and psychiatry, could provide independent expertise in the resolution of claims by legally competent patients, provided there was judicial appeal available

167. LEGAL ISSUES, supra note 3, at 92.
168. Brady v. United States, 397 U.S. 742, 748 (1970). One commentator suggests procedural guidelines that should be followed in cases of incompetent refusals, urging that if the procedures are followed only seriously psychotic, irrational patients
to prevent abuses.\textsuperscript{169} Review procedures are by no means error free, but they do provide one method for accommodating the interests of the state, the individual, and the medical community.\textsuperscript{170} The Third Circuit, in \textit{Rennie v. Klein}, granted involuntarily committed patients a qualified right to refuse treatment subject to a set of review procedures involving patient advocates and independent psychiatrists.\textsuperscript{171} The court was satisfied that patients' liberty interests had been protected by constitutional due process standards under this New Jersey procedure.\textsuperscript{172} Administrative Bulletin 78-3, issued by the Division of Mental Health and Hospitals of the New Jersey Department of Human

would be involuntarily treated. In turn, this would allow the state to further its goals of preventing needless suffering, and meet other administrative and environmental needs. Stone, \textit{supra} note 127, at 572-73.

Due process protections can be flexible, calling for procedural protections as a particular situation demands. Morrissey v. Brewer, 408 U.S. 471, 481 (1972). Due process has never required that the trier of fact be a judicial or administrative officer. Parham v. J.R., 442 U.S. 584, 607 (1979). In fact, the United States Supreme Court noted in \textit{Parham} that "[t]he judicial model for fact finding for all constitutionally protected interests, regardless of their nature can turn rational decision making into an unmanageable enterprise." Id. at 608 n.16. The Court further concluded that in spite of the fallability of psychiatric diagnosis, shifting the decision making from a judge to an administrative officer would not cure any shortcomings. Id. at 609. \textit{See also} Vitek v. Jones, 445 U.S. 480, 496 (1980) (independent decisionmaker need not come from outside the prison or hospital).

169. \textit{Civil Commitment}, \textit{supra} note 9, at 1211-12. Procedural due process is vital in order to maintain the integrity and legitimacy of treatment decisions. Whether procedural safeguards are required depends on: (1) the significance of the individual interest; (2) the risk of an erroneous deprivation through the procedures used; and (3) the governmental interest, including the cost of the state providing the safeguard. \textit{Mathews v. Eldridge}, 424 U.S. at 335. \textit{See also} Rennie v. Klein, 653 F.2d 836, 848-51 (3d Cir. 1981). It is clear that an adjudication authorizing commitment does not, per se, authorize the forcible administration of anti-psychotic medication. Even though there are numerous protections to guard against improper medication, the risks are sufficient to require that an impartial decision-maker oversee a decision to forcibly medicate.

170. \textit{Legal Guardianship}, \textit{supra} note 89, at 351. \textit{See also} United States v. Bianchi & Co., 373 U.S. 709, 715-16 (1963). Judicial review of administrative decisions is only necessary when there is a lack of substantial evidence to support the decisions. Otherwise deference is paid to the administrative decision. K. \textit{D}AVI\textit{S}, \textit{AD\textit{M}I\textit{N}ISTR\textit{AT}R\textit{IV}E LAW TEXT} § 29.01 (3d ed. 1972). \textit{See Mathews v. Eldridge}, 424 U.S. at 334, 344. There are several disadvantages to outside review boards. There may be an inability of the system to respond to the medical urgency of the situation, because of the difficulty of convening the board on short notice. Furthermore, if the doctor and review board disagree, it is unclear who is legally and ethically responsible if the patient suffers for lack of treatment. \textit{Legal Guardianship}, \textit{supra} note 89, at 351.

171. \textit{Rennie v. Klein}, 653 F.2d at 844-45, 848-49. The appellants in \textit{Rennie} argued that the district court's procedural protections were inadequate, and sought a full due process hearing. They objected to the fact that the patient advocates and independent psychiatrists were not, in fact, independent because they were employed by the state. Rhoden, \textit{The Right to Refuse Psychotropic Drugs}, 15 \textit{HARV. C.R.-C.L. L. REV.} 363, 371 n.38 (1980).

Services, sets up a procedural mechanism through which a decision to administer drugs against a patient’s will shall be made and reviewed. The procedure requires, upon initial refusal, that the patient’s physician explain the nature of the patient’s condition, the nature of the drug, the risks and benefits of treatment, and alternative treatments. If the patient continues to refuse treatment, a meeting of relevant medical and hospital personnel is held to discuss the situation, with the patient present. If the patient continues to refuse treatment the medical director reviews the patient’s record, examines the patient, and may call for an independent opinion. If the director agrees with the physician the patient may be treated. The medical director must review weekly the treatment program of all patients being involuntarily drugged. In addition, the Division of Mental Health and Hospitals adopted a practice, not incorporated as part of 78-3, of having all cases of involuntary medication reviewed by a division director or another physician in the central office. The review procedure in Rennie seems to realistically protect patient’s rights and, at the same time, take into account the physical realities and administrative necessities.

In spite of the apparent success of the New Jersey program, peer review systems are still subject to attack. To more completely protect the individual, the judicial system should provide independent supervision as a final resort for patients being forcibly medicated. The Massachusetts court, in In re Roe, noted it is the “process of detached but passionate investigation and decision that forms the total on which the judicial branch of government was created.” Administrative review of treatment decisions with an available judicial appeal is necessary because of the imprecision of psychiatric diagnosis, the nature of the drugs, and the documented misuses that accompany their use. In drug cases where the risk of error is so high, and the impact of use is enormous, the due process clause of the fourteenth amendment de-

173. Id. at 839 n.2.
174. Id. at 848-49.
175. Id.
176. Id.
177. Id.
178. Id.
179. Id.
180. Rennie v. Klein, 653 F.2d at 852. The Third Circuit was satisfied that the patients’ liberty interests had been protected by constitutional due process standards. Id.
181. See note 159 and accompanying text supra.
183. See notes 1-7, 45-55, 153, 158 and accompanying text supra.
mands that decisions to forcibly medicate be subject to review.\textsuperscript{184}

Review of drug refusals will surely require society to make an
investment of both time and money. Clearly the investment is jus-
tified, as some form of judicial scrutiny must be available to protect
individual liberties. Review procedures provide a legal model
which is amendable to the medical model of treatment.\textsuperscript{185} New
Jersey District Court Judge Stanley Brotman described the neces-
sity for protection:

Medicine has not yet found a cure for the terrible pain of
mental illness. The law cannot assist in this endeavor.
But the constitution can and does prevent those who have
suffered so much at the hands of nature from being sub-
jected to further suffering at the hands of man.\textsuperscript{186}

CONCLUSION

The alternatives discussed above are merely suggested meth-
ods in which different jurisdictions may wish to deal with the
problems of state hospitals and individual rights regarding treat-
ment. It is clear that some action must be taken before our mental
institutions are thrown back into the dark ages. Whatever ap-
proach is adopted by individual states, it is clear they must tread
carefully. To force a medical model to meet the needs of a legal
definition is to attempt to force a large square peg into a small
round hole, with potentially disastrous consequences. On the
other hand, the legal model which now allows involuntarily com-
mitted yet competent patients to refuse treatment can be made
amenable to the medical model which is premised upon the need
for, and availability of, treatment. If legal changes are not made
state hospitals may be reduced to little more than custodial cen-
ters where effective treatment of seriously ill people who refuse
drugs is no longer legally possible.

\textit{Wendy A. Hahn—'84}

\textsuperscript{184} Rennie v. Klein, 653 F.2d at 848.
\textsuperscript{185} See Reiser, Refusing Treatment for Mental Illness: Historical and Medical
U.S. 389, 407 (1971) (deference should be paid to medical decision-making that is
routine, standard and unbiased where “the spector of questionable credibility and
veracity is not present”). Richardson involved a question of discontinued payment
of social security benefits and cannot be compared with the gravity of the medical
issues involved in forcible treatment.
\textsuperscript{186} Rennie, 476 F. Supp. at 1309.