THE EIGHTH CIRCUIT AND PROFESSIONAL JUDGMENT: RETRENCHMENT OF THE CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION

DENNIS E. CICHON†

INTRODUCTION

In 1978, the United States District Court for the District of New Jersey, in Rennie v. Klein,1 announced that involuntarily committed mental patients have a constitutional right to refuse the administration of antipsychotic medication. Only one year later, in Rogers v. Okin,2 the United States District Court for the District of Massachusetts issued a similar holding. These two cases prompted similar litigation throughout the country.3 The recognition of a legal right to refuse medication posed a fundamental challenge to an already well-established treatment modality and to deeply imbedded notions of institutional treatment discretion. Psychiatrists, viewing this emerging legal concept as directly antithetical to their professional duty to care for and protect their patients, mounted a strong counterattack.4 The right to refuse antipsychotic medication soon became the most divisive and emotional issue between the legal and medical professions.5

† Associate Professor, University of South Dakota School of Law; B.S., 1976, Grand Valley State College; J.D., 1981, Ohio State University; LL.M., 1987, Temple University. Copyright is retained by the author. Portions of this article have been drawn from a more comprehensive manuscript on the issue of the right to refuse treatment, which the author is currently preparing.

1. The district court issued two opinions in Rennie. The first opinion was based on a motion for a preliminary injunction filed on behalf of John Rennie. 462 F. Supp. 1131, 1134 (D.N.J. 1978). The second opinion was generated by a class action filed on behalf of patients at five New Jersey state mental hospitals based on John Rennie's amended complaint. 476 F. Supp. 1294, 1296-97 (D.N.J. 1979), aff'd in part, modified in part, and remanded, 653 F.2d 836 (3d Cir. 1981) (en banc), vacated and remanded, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983) (en banc).


3. See infra notes 169-349 and accompanying text.


5. For commentary exemplifying the polemical nature of this issue, see Appelbaum & Gutheil, The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot," 137 Am. J. Psychiatry 720 (1980); Gutheil, In Search of True Freedom: Drug Refusal, Involuntary Medication and Rotting with Your Rights On, 137 Am. J. Psychiatry 327 (1980); Plotkin, Limiting the Therapeutic
After over a decade of litigation and scholarly debate, this controversy continues unabated while the status and scope of this constitutional right remains uncertain.

Although most courts addressing the issue have recognized a right to refuse, they have differed on its legal source. There is also disagreement over which government interests are sufficient to override a patient’s refusal. And finally, the procedural safeguards employed, which ultimately shape, define and protect the substantive right, have varied dramatically. While some courts have held that judicial intervention is necessary before a patient’s refusal can be overridden in nonemergency situations,6 others have held that in-house or independent professional review systems meet due process requirements.7 And most recently, the United States Court of Appeals for the Eighth Circuit, in Dautremont v. Broadlawns Hospital,8 initiated a third approach by holding that medication can be forcibly administered upon the decision of a treating physician exercising professional judgment.

Courts adopting the latter two approaches have relied heavily on United States Supreme Court opinions displaying deference to institutional decisionmaking in other contexts. The most influential of these cases is Youngberg v. Romeo.9 In Youngberg, the Supreme Court held that a proper balance between certain protected interests of a profoundly retarded institutionalized individual and competing state interests is struck where restrictions on the personal interests are the result of decisions based on professional medical judgment.10

This Article examines the confused evolution of the right to refuse antipsychotic medication. The complex and difficult issues presented by this emerging legal concept are illustrated by an analysis of the initial right to refuse litigation in Rennie and Rogers. A description of the Supreme Court’s review and remand of these two

---

8. 827 F.2d 291 (8th Cir. 1987).
10. Id. at 321.
cases as well as its intervening decision in Youngberg follows. The Article then focuses on the impact these Supreme Court decisions have had on subsequent federal right to refuse cases. Special emphasis is placed on the Eighth Circuit's unqualified adoption of Youngberg's professional judgment standard. In addition, the United States Court of Appeals for the Fourth Circuit's recent shift from a protective due process approach to the Eighth Circuit's position is described.11

The Article maintains that reliance on the Supreme Court's reasoning in Youngberg, as well as on other cases in which it has displayed a great amount of deference to institutional decisionmaking, is misplaced in drug refusal litigation. It is argued that forced medication determinations involve protected individual interests which are different from and more important than those addressed by the Supreme Court in Youngberg and similar cases. In addition, the adverse side effects posed by drug therapy present a far greater intrusion on a patient's constitutionally protected interests than do the institutional interventions previously at issue before the Supreme Court. As a result, the state interests necessary to justify forced medication must be compelling. In addition, the procedural protections necessary in medication determinations must be more extensive than those offered by the professional judgment standard.

The Article further describes state cases addressing the right to refuse issue. It chronicles how state courts have generally avoided employing the professional judgment standard either by distinguishing the relevant Supreme Court cases or relying on state constitutional, statutory or common law. Special treatment is given to the Washington Supreme Court's recent decision in Harper v. State,12 due to the United States Supreme Court's grant of certiorari. The Article concludes by maintaining that the Eighth Circuit as well as other courts which have adopted the professional judgment approach in drug refusal cases are in fact misinterpreting and misusing the standard; that while professional judgment is a procedural means for implementing a constitutional right, these courts are instead using the doctrine to define the protected individual interest involved. Moreover, even when properly employed, the standard offers inadequate protection to patients refusing antipsychotic medication, considering the lack of medical knowledge about these potentially dangerous drugs and the substandard conditions in public mental hospitals.

THE NATURE AND USE OF ANTIPSYCHOTIC DRUGS

Before the introduction of antipsychotic drugs into this country in the mid-1950's, there was no broadly applicable effective treatment for psychoses. Severely psychotic patients usually faced long-term or permanent hospitalization. Antipsychotic drugs were found to be effective in controlling psychotic symptoms, especially in patients suffering from schizophrenia and the major affective disorders. In 1955, the year antipsychotic medication was released for marketing, the state mental hospital population exceeded 558,000. However, by 1980 this number had declined to just over 137,000 despite a dramatic increase in admission rates. This decrease in the duration of hospital stays has been attributed to the effectiveness of antipsychotic medication in reducing the severity of psychotic episodes and in the lengthening of the interval between relapses. As a result, many psychotic patients, especially those suffering from acute schizophrenia, were able to be released for productive lives in the community.

While it is indisputable that antipsychotic drugs are of great benefit to many psychotic patients, claims of their overall efficacy are subject to dispute. After over three decades of use, there is still not a widely agreed upon theory of the biochemical manner in which an-

---

15. Id. at 100-01. Between 1955 and 1965, the annual admission rate to state mental institutions nearly doubled. R. Julien, supra note 13, at 149-50.
16. Gutheil & Appelbaum, 12 Hofstra L. Rev. at 100. The average hospital stay was reduced from 44 days to 26 days between 1971 and 1975 and is now even less. Brooks, "Law and Antipsychotic Medications," in Right to Refuse Treatment 248-49, 4 Behavior Sciences & the Law 247 (1986). However, assertions that antipsychotic drugs are responsible for the dramatic reduction in the length of hospital stays have been disputed by studies indicating that other factors, such as legal reforms and the policy of deinstitutionalization, are primarily responsible for this decrease. See P. Breggin, Psychiatric Drugs: Hazards to the Brain 61-65 (1983); Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & L. 179, 182 n.15 (1980).
18. Mason, Nerviano & DeBurger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 Diseases of the Nervous System 541 (1977) (indicating that over 93 percent of institutionalized patients receive antipsychotic medication); P. Breggin, supra note 16, at 10-12 (referring to studies suggesting that from 85 to 100 percent of state mental patients are administered antipsychotic medication).
Indeed, there is not even a universally accepted theory on the cause of schizophrenia, the disorder the drugs are most effective in controlling. The medication does not cure psychoses; it merely suppresses many of its symptoms. The drugs are effective only while in the patient's bloodstream, with relapse often occurring once drug therapy is terminated. Not all patients benefit from antipsychotic drugs, and there is evidence that some individuals actually deteriorate when placed on medication. For those patients who do benefit, the extent of their improvement is subject to debate.

Complicating the matter is the fact that schizophrenia is often difficult to diagnose. Studies suggest that the misdiagnosis rate may be as high as forty percent. This statistic suggests that antipsychotic drugs are inappropriately prescribed in a number of cases. Even when the mental disorder is accurately diagnosed, there is not yet a scientifically sound method to determine the most appropriate antipsychotic drug to prescribe. Once a drug is selected, its proper dos-

19. See L. Hollister, Clinical Use of Psychotherapeutic Drugs 20-21 (1977); Singh & Smith, Kinetics and Dynamics of Response to Haloperidol in Acute Schizophrenia: A Longitudinal Study of the Therapeutic Process, 14 COMP. PSYCHIATRY 363 (1979). Indeed, most psychotherapeutic drugs were developed for other purposes, with their benefits for treating mental illness being discovered rather fortuitously. L. Hollister, supra, at 5.


22. Gaughan & LaRue, The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution, 4 Law & Psychology Rev. 43, 48 (1978); Guthel & Appelbaum, 12 Hofstra L. Rev. at 100.


24. See P. Breggin, supra note 16, at 56-59; Paul, Tobias & Holly, Maintenance Psychotropic Drugs in the Presence of Active Treatment Programs, 27 Archives Gen. Psychiatry 106 (1972). The methodology of several studies indicating the benefits of antipsychotic drugs have been criticized on grounds of inaccuracy and bias. See P. Breggin, supra note 16, at 59-60; Gaughan & LaRue, 4 Law & Psychology Rev. at 55. See also Comment, Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 1980 Wis. L. Rev. 497, 539 (citing criticisms of the interpretations of even reliable statistical data).

25. Kemna, Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs, 6 J. Legal Med. 107, 115 (1985); Note, 82 Colum. L. Rev. at 1724. The drugs themselves may mask psychotic symptoms which in turn interfere with continuing diagnosis. Gaughan & LaRue, 4 Law & Psychology Rev. at 55.

The most disturbing aspect of drug therapy is that each antipsychotic drug is capable of producing a wide variety of serious side effects, even when carefully and responsibly administered. Patients often experience drowsiness and fatigue at the beginning of drug therapy. Other nonneurological side effects include dry mouth, stuffy nose, urinary retention and constipation. Blurred vision and orthostatic or postural hypotension—a faintness or dizziness upon standing due to a decrease in blood pressure—are not uncommon. Sexual dysfunctions and various endocrine and hormonal disorders frequently occur. The drugs may induce skin impairments and problems with body temperature regulation. More rare and serious nonneurological side effects include impaired eyesight, a variety of blood disorders, cholestatic jaundice and cardiovascular irregularities.

Because antipsychotic medication is neurotoxic, each drug is capable of producing a variety of serious neurologic disorders. Most of these impairments are extrapyramidal in nature, involving abnormal body movements caused by the effect of the drugs on a nonvoluntary nervous system which controls coordination of muscular movements. One category of extrapyramidal side effects is parkinsonism. Symptoms include a general slowing of motor responses, muscle rigidity, tremors and spasms, drooling and shuffling gait.

---

28. L. Hollister, supra note 19, at 46-47; Brooks, 8 BULL. AM. ACAD. PSYCHIATRY & L. at 183; Howell & Diamond, The Use of Psychotropic Drugs in Elderly Patients with Chronic Mental Illness, 29 NEW DIRECTIONS FOR MENTAL HEALTH SERV. 47, 51 (1986).
29. Gaughan & LaRue, 4 LAW & PSYCHOLOGY REV. at 51; Kemna, 6 J. LEGAL MED. at 111.
30. R. Julien, supra note 13, at 157; Gaughan & LaRue, 4 LAW & PSYCHOLOGY REV. at 51-52.
31. Males may experience reduced libido, impotence, an inability to ejaculate, or a painful reversal of ejaculation into the bladder. L. Hollister, supra note 19, at 52; R. Julien, supra note 13, at 158. Women may experience irregularities in the menstrual cycle or, more seriously, a complete blockage of menstruation resulting in infertility. Id.; Comment, 1980 Wis. L. REV. at 535.
32. R. Julien, supra note 13, at 159-60; DuBose, Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Jus\-tyf Involuntary Treatment?, 60 MINN. L. REV. 1149, 1204 (1976).
33. P. Breggin, supra note 16, at 71-74; R. Julien, supra note 13, at 159-60; DuBose, 60 MINN. L. REV. at 1204-05; Kemna, 6 J. LEGAL MED. at 111; Comment, 1980 Wis. L. REV. at 537-38.
35. DuBose, 60 MINN. L. REV. at 1203; Kemna, 6 J. LEGAL MED. at 112.
36. Kemna, 6 J. LEGAL MED. at 112; Comment, 1980 Wis. L. REV. at 530-31.
RIGHT TO REFUSE ANTIPYSCHOTIC MEDICATION

with infliction rates ranging from five to ninety percent of all patients on drug therapy. An especially distressful subcategory of parkinsonism is akinesia, a side effect characterized by a decrease in spontaneous mobility and speech along with a general feeling of apathy and listlessness.

An opposite type of extrapyramidal side effect is akithisia. This agonizing impairment is characterized by a painful irritability and a persistent desire to move. Symptoms can include persistent feet tapping, fidgeting, posture alterations and an inability to find a comfortable position. Evidence indicates that forty-five percent of the patients receiving antipsychotic medication experience this side effect at one time or another. Dystonic reactions, involving acute and painful spasms of muscle groups throughout the anatomy, are also induced by the effects of the drugs on the extrapyramidal system of the brain.

The most serious side effect associated with the chronic administration of antipsychotic medication is tardive dyskinesia ("TD"). This syndrome is manifested by uncontrollable repetitive movements principally affecting the face, mouth, tongue, trunk and extremities. At best, mild cases of TD can be socially disabling and embarrassing. In the more severe cases, patients may have difficulty in swallowing,
breathing and communicating.\textsuperscript{43} While many of the other side effects can be controlled through the administration of antiparkinsonian agents, the reduction in dosage or the termination of drug therapy, TD, if not detected in its early stages, is usually irreversible.\textsuperscript{44} And yet, early detection of the disorder is extremely difficult with symptoms often unmasked only by the withdrawal of medication for two to four weeks. Ironically, drug cessation may only aggravate the condition.\textsuperscript{45}

There is no method to predict which patients will suffer from TD and no effective way to prevent its occurrence. Once the disorder is displayed, its symptoms cannot be effectively managed.\textsuperscript{46} Afflication rates are estimated to be as high as fifty-six percent for patients receiving antipsychotic drugs over a prolonged period.\textsuperscript{47} The prevalence of the disorder is even higher in the elderly patient population.\textsuperscript{48} Considering the widespread administration of antipsychotic medication in institutions for both the mentally ill and developmentally disabled, nursing homes, community treatment centers and facilities for children, even a conservative incidence rate of twenty percent translates into one to two million individuals suffering from TD in any given year.\textsuperscript{49} Members of the psychiatric profession have labeled TD as a national health concern,\textsuperscript{50} with one physician stating that the syndrome is "among the worst medically-induced disasters in history."\textsuperscript{51} Unfortunately there is, as of yet, no cure in sight.\textsuperscript{52}

In the general euphoria over the remarkable effectiveness of an-

\begin{footnotesize}
\begin{enumerate}
\item D. JESTE & R. WYATT, supra note 40, at 45; DuBose, 60 MINN. L. REV. at 1204.
\item P. BREGGIN, supra note 16, at 90; Salzberger, 31 MED. TRIAL TECH. Q. at 204.
\item Smith & Simon, Tardive Dyskinesia Revisited, 31 MED. TRIAL TECH. Q. 342, 343 (1985).
\item D. JESTE & R. WYATT, supra note 40, at 289-90; Smith & Simon, 31 MED. TRIAL TECH. Q. at 348.
\item See, e.g., P. BREGGIN, supra note 16, at 91-99 (citing numerous prevalence rate studies); Barnes, Kidger & Gore, Tardive Dyskinesia: A 3-Year Followup Study, 13 PSYCHOLOGICAL MED. 71, 80 (1983) (indicating an incidence rate of 47 percent); Brooks, 8 BULL. AM. ACAD. PSYCHIATRY & L. at 186 (showing prevalence rates ranging from 25-50 percent); Sovner, DiMascio, Berkowitz & Randolph, Tardive Dyskinesia and Informed Consent, 19 PSYCHOSOMATICS 172, 173 (1978) (indicating a 56 percent incidence rate among chronically hospitalized schizophrenic patients).
\item D. JESTE & R. WYATT, supra note 40, at 38; Howell & Diamond, 29 NEW DIRECTIONS FOR MENTAL HEALTH SERV. at 52. The incidence rate may climb as high as 75 percent for patients over seventy years old. P. BREGGIN, supra note 16, at 92.
\item P. BREGGIN, supra note 16, at 108.
\item See Gardos & Cole, Overview: Public Health Issues in Tardive Dyskinesia, 137 AM. J. PSYCHIATRY 776, 778 (1980); Lipman, Overview of Research in Psychopharmacological Treatment of the Mentally Ill-Mentally Retarded, 22 PSYCHOPHARMACOLOGY BULL. 1046, 1052 (1986); Smith & Simon, 31 MED. TRIAL TECH. Q. at 342.
\item P. BREGGIN, supra note 16, at 109.
\item D. JESTE & R. WYATT, supra note 40, at 8.
\end{enumerate}
\end{footnotesize}
tipsychotic drugs in controlling the symptoms of psychoses, psychiatrists ignored their limitations and dangers for many years. It was not until the early 1970's that academic psychiatrists began to take notice of the potential harm posed by antipsychotic medication.\textsuperscript{53} Despite this growing recognition by the academic branch of psychiatry, the next decade was marked by a general pattern of unawareness and apathy on the part of state institutional clinicians. Drug therapy rapidly became, and continues to be, the predominant form of treatment in public mental health facilities.\textsuperscript{54} Side effects were either overlooked or viewed merely as a sign of drug effectiveness. The prevailing attitude of institutional psychiatrists was that side effects, when acknowledged, were a necessary and inconsequential cost of drug therapy.\textsuperscript{55}

In addition, investigations and litigation revealed widespread abuse and incompetence in the administration of antipsychotic drugs. In 1975, litigation challenging the medication practices at a New Jersey institution eventually produced evidence that patients were being harmed by inappropriate and unnecessary medication prescriptions.\textsuperscript{56} Polypharmacology, the universally condemned practice of administering a variety of antipsychotic drugs at the same time, was regularly practiced.\textsuperscript{57} Critical medical records were often inadequately kept.\textsuperscript{58} Staff who called attention to side effects were criticized and intimidated by their supervisors while patients who complained of adverse reactions were subjected to retaliation by doctors and staff.\textsuperscript{59} A federal court in Ohio found widespread misuse of antipsychotic drugs for the purposes of staff convenience and punishment.\textsuperscript{60} Evidence indicated that drugs were commonly prescribed by

\begin{footnotes}
\item[53] See generally Brooks, 8 BULL. AM. ACAD. PSYCHIATRY \& L. at 187-89; Gelman, 72 GEO. L.J. at 1752-54.
\item[54] See supra note 18 and accompanying text.
\item[55] See Brooks, 8 BULL. AM. ACAD. PSYCHIATRY \& L. at 187; Gelman, 72 GEO. L.J. at 1757-60, 1758 n.175. Despite the fact that thousands of patients were suffering from TD by 1978, an American Psychiatric Association Task Force Report stated that the condition was rare. See AM. PSYCHIATRIC ASS'N. TASK FORCE, PROFESSIONAL LIABILITY INSURANCE AND PSYCHIATRIC MALPRACTICE 11 (1978) cited in Brooks, The Right to Refuse Antipsychotic Medications: Law and Policy, 39 RUTGERS L. REV. 339, 349 n.31 (1987).
\item[57] Rennie, 476 F. Supp. at 1300.
\item[58] Id. at 1299.
\item[59] Id. at 1301-03.
\end{footnotes}
unlicensed physicians who had not taken the time to examine patients.\textsuperscript{61} Investigations of hospitals in other states during the late 1970's revealed similar practices.\textsuperscript{62} It is not surprising that institutionalized mental patients turned to the courts for legal enforcement of a right to refuse unwanted drug therapy.

**THE EMERGENCE OF A LEGAL RIGHT TO REFUSE: THE RENNIE AND ROGERS LITIGATION**

The common law has long recognized the values of bodily integrity and self-determination.\textsuperscript{63} The tort of battery encompasses medical procedures performed on patients without their consent.\textsuperscript{64} The judiciary has expanded on this protection through the development of the doctrine of informed consent. Under this doctrine, medical procedures cannot be performed unless a patient's consent is made in a competent, knowledgeable and voluntary manner.\textsuperscript{65}

Traditionally, courts have been hesitant to extend the protections afforded by the informed consent doctrine to the institutionalized mentally ill. The judiciary was reluctant to subject institutionalized staffs to liability in damages.\textsuperscript{66} In addition, there was a widespread notion that institutionalized patients, due to their mental impairments, are per se incompetent to make informed treatment decisions.\textsuperscript{67} As a result of this perceived inapplicability of common-law tort protection, lawyers representing patients in the initial drug refusal cases turned to the United States Constitution and state counterparts for a remedy. There was some limited precedent in support of a constitutional right to refuse psychic treatment. A few early

---

\textsuperscript{61} Id. at 926-27.  
\textsuperscript{62} See Brooks, 8 BULL. AM. ACAD. PSYCHIATRY & L. at 189.  
\textsuperscript{63} Common law protection of these values is displayed, in part, through the torts of assault, battery and infliction of emotional distress. F. MAITLAND, THE FORMS OF ACTION OF COMMON LAW 40, 43, 53 (1985).  
\textsuperscript{67} See Price v. Sheppard, 307 Minn. 350, —, 239 N.W.2d 905, 911 (1976) relying on "the need for the state to assume the decision-making role regarding the psychiatric treatment for one who, presumptively, based on the fact of commitment on the ground of mental illness, is unable to rationally do so for himself "). See also Denny v. Tyler, 85 Mass. (3 Allen) 225, 227 (1861); In re Oakes, 8 L. Rep. 122, 125 (Mass. 1845). See generally Note, 82 COLUM. L. REV. at 1722-23.
cases presented a successful constitutional challenge to compelled institutional treatment, but they were brought in the context of highly experimental and dangerous procedures such as psychosurgery and electroconvulsive therapy. These cases were viewed more as an exception to a general rule of unfettered psychiatric treatment discretion.

The first case to directly hold that involuntarily committed mental patients retain a constitutionally protected interest in refusing treatment with antipsychotic medication was *Rennie v. Klein,* decided by the United States District Court for the District of New Jersey in 1978. Only one year later, the United States District Court for the District of Massachusetts followed suit in *Rogers v. Okin.* The district and subsequent appellate court decisions in *Rennie* and *Rogers* provide the groundwork for tracing the confused evolution of the right to refuse and illustrate the complex and difficult issues involved in the recognition of such a right.

**THE DISTRICT COURT DECISIONS**

The federal district court in *Rennie* found a constitutional source for protecting an involuntarily committed mental patient's interest in refusing treatment with antipsychotic medication in the emerging right to privacy. This right was first accorded constitutional recognition by the United States Supreme Court in 1965 and, ironically, encompasses the same values protected by the common-law doctrine of informed consent. The *Rennie* court noted that two interests...
protected by the right to privacy doctrine are implicated by forced psychiatric treatment. The first is that patients have the right to be free from unwarranted government intrusions into the body or mind.\textsuperscript{76} The second is that committed patients retain an interest in making fundamental decisions in matters concerning their person.\textsuperscript{77} The court stated that these protected privacy interests in bodily integrity and self-autonomy are ""broad enough to encompass a patient's decision to decline medical treatment under certain circumstances.""\textsuperscript{78} The court reasoned that ""[w]hether the potential benefits [of treatment with antipsychotic drugs] are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion.""\textsuperscript{79}

The federal district court in Rogers also relied, in part, on the constitutional right to privacy in holding that involuntarily committed mental patients have a protected interest in deciding whether to submit to drug therapy.\textsuperscript{80} The court emphasized the intimate nature of a decision regarding ""medication that may or may not make the patient better, and that may or may not cause unpleasant and unwanted side effects.""\textsuperscript{81} The court stated that ""[t]he right to make such a decision is basic to any right of privacy.""\textsuperscript{82}

Both courts also found that first amendment interests may be implicated by the forced administration of antipsychotic drugs.\textsuperscript{83} The first amendment's protection of freedom of speech has been interpreted to encompass the freedom and capacity to think and produce ideas as a necessary corollary of free expression.\textsuperscript{84} Each court expressed concern over the drugs' potential to alter a patient's emotions and mentation.\textsuperscript{85} In basing a right to refuse on first amendment grounds, the Rogers court stated that:

Whatever powers the Constitution has granted our government, involuntary mind control is not one of them, absent extraordinary circumstances. The fact that mind control takes place in a mental institution in the form of medically

\textsuperscript{76} Rennie, 462 F. Supp. at 1144.
\textsuperscript{77} Id. at 1144-45.
\textsuperscript{78} Id. at 1144 (quoting In re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976)).
\textsuperscript{79} Id. at 1145.
\textsuperscript{80} Rogers, 478 F. Supp. at 1365-66.
\textsuperscript{81} Id. at 1366.
\textsuperscript{82} Id.
\textsuperscript{83} Id. at 1366-67; Rennie, 462 F. Supp. at 1143-44.
\textsuperscript{85} Rogers, 478 F. Supp. at 1366; Rennie, 462 F. Supp. at 1143-44.
sound treatment of mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being.\footnote{Rogers, 478 F. Supp. at 1367.}

The judicial characterization of antipsychotic drugs as “mind-altering” and “thought-controlling” has caused consternation and even outrage among members of the psychiatric profession.\footnote{See Appelbaum & Gutheil, The Boston State Hospital Case: “Involuntary Mind Control,” The Constitution, and the “Right to Rot,” 137 Am. J. Psychiatry 720 (1980); Gutheil, In Search of True Freedom: Drug Refusal, Involuntary Medication and Rotting With Your Rights On, 137 Am. J. Psychiatry 327 (1980); Appelbaum, “Mind Control,” “Synthetic Sanity,” “Artificial Competence,” and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication, 12 Hofstra L. Rev. 77 (1983); Shwed, Social Policy and the Rights of the Mentally Ill: Time for Reexamination, 5 J. Health Pol., Pol'y & L. 193 (1983).} Psychiatrists argue that although the primary effects of the drugs admittedly “alter” and “control” mentation and behavior, these effects are in the direction of normalcy. Thus, truly autonomous thought and expression are limited more by a decision not to medicate than by compelled administration of the drugs.\footnote{Gutheil & Appelbaum, 12 Hofstra L. Rev. at 100, 118; Gutheil, 137 Am. J. Psychiatry at 327.}

Neither the \textit{Rennie} nor \textit{Rogers} court disagreed with the proposition that drug therapy can assist in improving the disordered thought processes of psychotic patients. Instead, each court focused on the potentially adverse secondary effects of the drugs on a patient’s otherwise normal mental processes and communicative ability in concluding that first amendment values may be implicated.\footnote{Rogers, 478 F. Supp. at 1366-67; Rennie, 462 F. Supp. at 1144.} However, in declining to base a right to refuse on first amendment grounds in the particular case at hand, the \textit{Rennie} court articulated a limitation on first amendment applicability. The court noted that the plaintiff’s performance on intelligence tests was not impaired by the medication and that the side effects he was experiencing were mild and had a short duration.\footnote{Id. The court also held that because the plaintiff asserted a right and desire to be treated and cured, he waived his first amendment claim against the hospital’s efforts to alter his mental disorder. \textit{Id.} However, the assertion of a right and desire to be treated should not be automatically equated with consent to \textit{any} proposed treatment, regardless of the risk/benefit ratio as viewed from the patient’s perspective. If a proposed treatment has the potential to adversely affect a patient’s otherwise normal thought and communicative abilities, he should retain his first amendment protections from those undesired consequences despite an assertion of a right to treatment. See generally Comment, The Right to Adequate Treatment Versus the Right to Refuse Antipsychotic Drug Treatment: A Solution to the Dilemma of the Involuntaryy Committed Psychiatric Patient, 33 Emory L.J. 441 (1984).} The court held that this “temporary dulling of the senses” failed to reach the level of a first amendment violation.\footnote{Rennie, 462 F. Supp. at 1144.} Thus, the evidentiary showing of the nature and extent of the side
effects in any particular case may be critical to first amendment applicability.\textsuperscript{92}

Constitutional rights are not absolute, they must be balanced against the state's reasons for infringement.\textsuperscript{93} The \textit{Rennie} and \textit{Rogers} courts addressed two state interests which, under appropriate circumstances, may serve to justify the forced administration of antipsychotic medication. The first is the state's police power interest in preventing the mentally ill from harming themselves or others.\textsuperscript{94} The second such interest is the state's \textit{parens patriae} authority to care for those citizens who are unable to care for themselves.\textsuperscript{95}

In addressing the state's police power interest, both federal district courts agreed that while this interest authorizes initial commitment of a mentally disabled individual to prevent physical harm to himself or others within the community, the authority does not automatically extend to forced treatment within the hospital.\textsuperscript{96} The state's police power must be justified within the institutional setting rather than the community setting.

The scope of the state's police power authority has been defined in terms of either an "emergency" or "dangerousness" standard or both. Courts have used these labels interchangeably, but there is a major difference in scope between the underlying standards. Although the literal definitions vary slightly, emergency authority is limited to situations where the threat of physical violence is current or imminent. For example, the court in \textit{Rennie} defined an emergency as a "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital."\textsuperscript{97} In emergency situations, courts agree that the state's police power is sufficiently compelling to justify forced administration of drugs for a limited time period, at least when no less intrusive meas-

\textsuperscript{92} See Winick, \textit{The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond}, in \textit{American Bar Association Commission on the Mentally Disabled, The Right to Refuse Antipsychotic Medication} 7, 12 (1986) (suggesting that the average treatment dosage of antipsychotic drugs will meet or exceed any minimum level of intrusiveness required for first amendment applicability).


\textsuperscript{95} Rogers, 478 F. Supp. at 1389; Rennie, 462 F. Supp. at 1145. See generally Note, 87 \textit{Harv. L. Rev.} at 1307-09.

\textsuperscript{96} Rogers, 478 F. Supp. at 1368-69; Rennie, 462 F. Supp. at 1145.

ures are available. However, some courts have expanded the scope of the police power authority by employing a dangerousness standard. Under this standard, forced medication is authorized on the prediction that a patient will present a future threat of violence if not on medication. Courts have differed on the criteria and procedures necessary to authorize forced treatment based on dangerousness.

Both the Rennie and Rogers courts upheld police power authority to compel treatment on the basis of dangerousness. The Rennie court adopted a broad standard of dangerousness, defining it merely as “the patient’s physical threat to other patients and staff at the institution.” However, the court limited the decisionmaker’s discretion by holding that the finding of dangerousness is only one factor in the determination of whether to authorize forced treatment. Consideration must also be given to the potential for permanent side effects from the proposed medication and the availability of any less restrictive treatments.

The federal district court in Rogers adopted a more restrictive definition of dangerousness. The court rejected the state’s proposed “psychiatric” definition of dangerousness as “too broad, subjective and unwieldy.” Instead, the court required 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 members of the institution.” Although this definition is narrower than the one adopted in Rennie, the court did not temper this predictive determination with any further balancing of other considerations.

Both courts deemed the state’s parens patriae interest to be sufficiently compelling, under certain circumstances, to legitimize forced

98. See, e.g., Bee v. Greaves, 744 F.2d 1387, 1396-97 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985) (holding that emergency treatment cannot be extended indefinitely); Rennie, 476 F. Supp. at 1313-14 (stating that treatment based on emergency grounds is allowed for 72 hours); People v. Medina, 705 P.2d 961, 975 (Colo. 1985) (holding that court approval for emergency treatment must be obtained as soon as practicable); Rogers, 390 Mass. at —, 458 N.E.2d at 322 (stating that judicial authorization is required for continued emergency treatment).


100. Id.

101. Rogers, 478 F. Supp. at 1365. The state argued that forced medication would be justified in the following situations:

1) suicidal behavior, whether seriously meant or a gesture, 2) assaultiveness, 3) property destruction, 4) extreme anxiety and panic, 5) bizarre behavior, 6) acute or chronic emotional disturbance having the potential to seriously interfere with the patient's ability to function on a daily basis, 7) the necessity for immediate medical response in order to prevent or decrease the likelihood of further severe suffering or the rapid worsening of the patient's clinical state.

Id. at 1364.

102. Id. at 1365 (emphasis added).
When invoked to justify forced treatment of the mentally ill, the parens patriae power is based on the compelling need to help individuals who, due to their mental impairments, are incapable of evaluating their need for psychiatric treatment. Thus, both the Rennie and Rogers courts held that before compelled medication can be justified by the beneficent purpose underlying the state’s parens patriae authority, a separate determination of incompetency to make treatment decisions is necessary. Rejecting the traditional view that committed mental patients are per se incompetent, both courts agreed on two principles which have gained wide acceptance among both mental health and legal professionals. The first is that mental illness is highly selective in nature, striking a patient’s capabilities in one area while leaving others unaffected. Thus, mental illness “is not the equivalent of incompetency, which renders one incapable of giving informed consent to medical treatment.” As the court in Rogers stated, “[t]he 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.”

The second point of agreement is that involuntary commitment into a mental institution is not, as has been traditionally assumed, ipso facto evidence of a person’s incapacity to make treatment decisions. Indeed, most states have enacted legislation which expressly provides that a patient is not deemed incompetent to exercise personal and civil rights solely by reason of commitment. The Rogers court held that such legislation in Massachusetts, while not expressly granting mental patients a right to refuse medication, nonetheless “tilts the scales in favor of presuming . . . the competence of a committed mental patient to make treatment decisions, absent an adjudi-

103. Id. at 1369; Rennie, 462 F. Supp. at 1145.
cation to the contrary."110

In Rennie, the New Jersey administrative regulations for reviewing medication refusals obviated the necessity for a prior finding of incompetency. Instead, the regulations allowed forced medication on parens patriae grounds if the patient was deemed incapable of participating in other available treatment plans without medication. The regulations also allowed forced medication if it was likely to improve the patient's condition within a significantly shorter time than improvement without medication.111 In finding these criteria constitutionally deficient, the court held that before the state can justify forced medication on parens patriae grounds, a determination of the patient's competency must be made.112 A competent patient's refusal could only be overridden by a sufficient police power interest in preventing violence.113 If a patient is determined incompetent, the decisionmaker must also consider the availability of any less restrictive treatments and the risk of permanent side effects before forced medication can be authorized.114

The due process clause of the fourteenth amendment requires that procedural mechanisms be employed to determine whether an individual's constitutionally protected interests are outweighed by countervailing state concerns.115 However, procedural due process is a flexible concept.116 In Mathews v. Eldridge,117 the United States Supreme Court enunciated the following considerations which must be balanced in determining the procedures due in a particular situation:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.118

Procedurally, the New Jersey administrative regulations at issue

---

111. Rennie, 462 F. Supp. at 1149.
112. Id. at 1145-46.
113. See id. at 1145.
114. Id. at 1146. The court also stated that when forced medication is proposed for treatment purposes, consideration must be given to the hospital's ability to provide a reasonably full treatment program. Id.
118. Id. at 335.
in *Rennie* provided for a three-step in-house review of treatment refusals. The attending physician must first disclose treatment information to the patient. If the patient continues to refuse, the treatment team meets, with the patient present if his condition permits. If the treatment team does not resolve the issue, the facility's medical director or his designee must personally examine the patient and review the patient's records. The assistance of an independent psychiatrist is optional. The medical director then has the authority to authorize forced medication.\(^1\)

Pointing to evidence that institutional pressures compromised the in-house review process, the *Rennie* court stated that the procedures did "not constitute the independent determination required by the due process clause."\(^2\) The court required the implementation of a number of procedural protections including an informal adversarial hearing before an independent psychiatrist employed by the Commissioner of Mental Health.\(^3\) An authorization of compelled drug therapy was also limited to sixty days.\(^4\)

In *Rogers*, the federal district court obviated the need for procedural safeguards in situations when the state exercised its limited police power authority to medicate patients. The court ruled that because of the availability of less intrusive means for treating mentally ill patients, the state's *parens patriae* interest is not sufficiently compelling to justify the administration of antipsychotic drugs over a patient's refusal.\(^5\) The court required a judicial determination of a patient's incompetency. For those patients adjudicated incompetent, a guardian must be appointed to make the treatment decision under a substituted judgment standard.\(^6\)

**The Appellate Court Decisions**

On appeal, both circuit courts upheld the lower court decisions that involuntarily committed mental patients retain a constitutionally protected interest in refusing treatment with antipsychotic medication. In *Rennie v. Klein*,\(^7\) the United States Court of Appeals for the Third Circuit held that the potentially harmful side effects of antipsychotic drugs implicate the fourteenth amendment's liberty protection from unwarranted government intrusions on personal


\(^{120}\) *Rennie*, 476 F. Supp. at 1310.

\(^{121}\) *Id.* at 1312. The court also required the use of patient consent forms and the establishment of a system of patient advocates. *Id.* at 1311.

\(^{122}\) *Id.* at 1315.

\(^{123}\) *Rogers*, 478 F. Supp. at 1369.

\(^{124}\) *Id.* at 1361-64.

\(^{125}\) 653 F.2d 836 (3d Cir. 1981).
security. The United States Court of Appeals for the First Circuit, in Rogers v. Okin, stated:

We begin our analysis with what seems to us to be an intuitively obvious proposition: 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.

For a constitutional source of this interest, the court looked to the due process protection in the fourteenth amendment of the “right to privacy, bodily integrity, or personal security.” Both circuit courts affirmed the state’s police power authority to forcibly administer medication on emergency and dangerousness grounds. However, the Third Circuit in Rennie vacated the district court’s balancing considerations and procedures necessary to authorize forced medication. Instead, the Third Circuit ruled that the existing New Jersey administrative regulations, which left the dangerousness and necessity of medication determinations to the judgment of hospital psychiatrists subject to supervisory review, were sufficient.

Although the federal district court in Rogers did not require procedural safeguards in medication determinations based on police power authority, the First Circuit expanded professional discretion by vacating the district court’s definition of dangerousness. The First Circuit agreed with the state’s assertion that requiring a predictive finding of a substantial likelihood of physical harm is “overly rigid and unworkable.” The court reasoned that this standard would require psychiatrists to make impossible predictions of violence that meet a “quantitative level of probability.” Instead, the First Circuit instructed the district court to design procedures which would merely ensure the exercise of professional judgment in medication determinations based on police power grounds. The court noted that professional judgments should be based on such considerations as “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.”

126. Id. at 844.
127. 634 F.2d 650 (1st Cir. 1980).
128. Id. at 653.
129. Id.
130. Rogers, 634 F.2d at 653-57; Rennie, 653 F.2d at 845-48.
131. Rennie, 653 F.2d at 851.
132. Rogers, 634 F.2d at 654-55.
133. Id. at 656.
134. Id. at 656-57.
135. Id. at 655-56.
The Third Circuit in *Rennie*, as noted earlier, also overturned the district court’s required considerations and procedures necessary to justify forced medication on *parens patriae* grounds. The Third Circuit upheld the substantive and procedural aspects of the New Jersey regulations which, as discussed earlier, obviated the necessity of a prior determination of incompetency before medication could be forcibly administered. In reaching its conclusion, the Third Circuit placed heavy reliance on the Supreme Court’s decision in *Parham v. J.R.* 136 In *Parham*, the Court had addressed the procedural mechanisms necessary to protect a minor’s liberty interests upon a parental or guardian request for commitment. In applying the balancing formula previously enunciated in *Mathews* to the facts of *Parham*, the Court authorized the use of minimal informal procedures as sufficient under due process. These procedures consisted merely of a properly filed application followed by staff examination, observation and periodic review.137

In its application of the considerations announced in *Mathews*, the Third Circuit stated that the “procedures [in New Jersey] if carefully followed, pose only a minor risk of erroneous deprivation,” and that “this risk will not be significantly reduced by superimposing the district court’s own requirements on those already required by the state.”138 Central to the Third Circuit’s reasoning was its characterization of the decisions necessary in a forced medication determination as “medical” in nature.139 Thus, the court believed that the adversary hearing envisioned by the district court was “ill-suited” to these types of decisions.140

The Third Circuit supported its reasoning by quoting *Parham*, stating that “‘due process is not violated by use of informal, traditional medical investigative techniques’” when dealing with essentially medical determinations.141 The court further relied on *Parham* in stating that adversary proceedings are “more likely to be counterproductive, adding to the tensions that may have contributed to the patient’s initial commitment to the institution.”142 The court went on to reject the need for an independent review of medication determinations and asserted that the district court’s procedures would impose “substantial additional financial burdens on the state and even

139. *Id.*
140. *Id.*
141. *Id.* (quoting *Parham*, 442 U.S. at 607).
142. *Id.* at 851 (citing *Parham*, 442 U.S. at 610).
greater expenditures of staff time at the hospitals."\textsuperscript{143} However, the Third Circuit did affirm the applicability of the least restrictive alternative doctrine to medication determinations. The Third Circuit's least restrictive analysis was centered around the requirement that a professional judgment include the avoidance of medications which are unnecessary or "whose cost benefit ratios, weighed from the patient's standpoint, are unacceptable."\textsuperscript{144}

In addressing the state's \textit{parens patriae} power to forcibly medicate, the First Circuit, in \textit{Rogers}, followed an approach more protective of patient interests. The First Circuit required that a judicial determination of incompetency be made before the state can override a patient's refusal on treatment grounds.\textsuperscript{145} However, the court fashioned a \textit{parens patriae} emergency exception to this requirement, limited to situations when the immediate administration of drugs is necessary to prevent significant deterioration of the patient's mental health.\textsuperscript{146} However, even under these circumstances, the First Circuit directed the district court to devise alternative means for making incompetency determinations.\textsuperscript{147}

Further, the court allowed decisional authority to rest with attending physicians for patients determined incompetent, thus vacating the district court's requirement that a guardian be appointed.\textsuperscript{148} However, the court directed that physicians be guided by a substituted judgment standard, stating that "state actions based on \textit{parens patriae} interests must be taken with the aim of making treatment decisions as the individual himself would were he competent to do so."\textsuperscript{149} The First Circuit affirmed the application of the least restrictive alternative doctrine to forced medication decisions, but rejected the district court's suggestion that the principle may very well preclude compelled drug therapy for treatment purposes. The court stated that "reasonable alternatives to the administration of antipsychotics must be ruled out. Otherwise, the administration of the drugs would not be necessary to accomplish the state's objective. Indeed, it may be possible that in most situations less restrictive means will be available."\textsuperscript{150}

\begin{itemize}
\item \textsuperscript{143} \textit{Id.}
\item \textsuperscript{144} \textit{Id. at} 847.
\item \textsuperscript{145} \textit{Rogers}, 634 F.2d at 661.
\item \textsuperscript{146} \textit{Id. at} 660.
\item \textsuperscript{147} \textit{Id.}
\item \textsuperscript{148} \textit{Id.}
\item \textsuperscript{149} \textit{Id. at} 661. To ensure that treating physicians follow this substituted judgment standard, the court suggested the implementation of some procedural safeguards such as periodic reviews of the patient's treatment history by nonattending physicians. \textit{Id.}
\item \textsuperscript{150} \textit{Id. at} 656.
\end{itemize}
SUPREME COURT DECISIONS

While the circuit court opinions in Rennie v. Klein and Rogers v. Okin were awaiting review, the United States Supreme Court rendered its opinion in Youngberg v. Romeo.151 Although this case involved the claims of a profoundly retarded institutionalized individual to freedom from undue bodily restraint, to protection from harm by other residents, and to minimal treatment, Youngberg was to have a substantial impact on subsequent right to refuse medication cases.

In Youngberg, the Supreme Court held that an involuntarily committed mentally retarded individual retains fourteenth amendment liberty interests in reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and such minimally adequate training as is reasonably necessary to assure those interests.152 However, the Court noted that these protected interests could, under appropriate circumstances, be overridden by legitimate state concerns.153 In weighing the competing interests, the Court held that a proper balance is struck when restrictions on these personal rights are the result of decisions made by appropriate institutional authorities exercising professional judgment.154 Moreover, the Court ruled that such decisions are entitled to a presumption of validity. This presumption is rebutted only by a showing that "the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."155 The Court did not address the applicability of the least restrictive alternative doctrine, explicitly noting that the respondent did not feel it a necessary issue to the determination of the case.156

The Supreme Court subsequently vacated and remanded Rennie to the Third Circuit for reconsideration in light of the Youngberg decision.157 The Third Circuit reaffirmed its holding that involuntarily committed mental patients retain a constitutionally protected liberty interest in refusing drug therapy.158 Expressly relying on the Supreme Court's deference to professional judgment in Youngberg, the Third Circuit restated its belief that the New Jersey administra-
tive regulations governing medication refusals satisfied due process requirements. However, the en banc court split three ways over the applicability of the least restrictive alternative doctrine to drug refusal cases. Five judges believed that because the Supreme Court failed to utilize a least restrictive alternative analysis in Youngberg, it was inappropriate to employ the concept in Rennie. Four judges would have applied the least restrictive alternative doctrine, noting that the Supreme Court believed that the issue was irrelevant to the Youngberg fact situation which was distinguishable from drug refusal cases. One judge did not explicitly address the question.

The Supreme Court also agreed to review the First Circuit's decision in Rogers but was able to avoid the substantive and procedural issues involved. The Court noted that state law may create liberty interests beyond those protected by the Constitution which may demand more comprehensive procedural protections than those minimally required by the fourteenth amendment. The Court recognized that a recent Massachusetts state court decision, In re Guardianship of Roe, may confer broader protections than those offered by federal law. Deeming it inappropriate to decide the constitutional issues presented in Rogers until state law questions were resolved, the Court vacated and remanded the case to the First Circuit for reconsideration in light of Roe.

The Supreme Court did, however, give some consideration to the issues presented in Rogers. The Court noted that the "parties agree that the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs." The Court went on to state that "we assume for purposes of this discussion that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution . . . and that these interests are implicated by the involuntary administration of antipsychotic drugs." While these statements fall short of an explicit recognition of a constitutionally protected interest in refusing drug therapy, they are a strong indication that the Court is willing to recognize such a right if directly presented with the issue.

159. Id. at 269-70.
160. Id. at 269.
161. Id. at 275 (Weiss, J., concurring).
163. Id. at 300.
165. Mills, 457 U.S. at 303.
166. Id. at 306.
167. Id. at 299.
168. Id. at 299 n.16.
BEYOND YOUNGBERG: PROFESSIONAL JUDGMENT VERSUS DUE PROCESS

Since Rennie v. Klein and Rogers v. Okin, virtually every court addressing the same issue has recognized a right to refuse antipsychotic medication, although its legal source has varied. However, courts continue to grapple with the critical terms set forth in the early litigation which are necessary in defining this evolving right. Unsettled areas include the extent of the government’s police power authority. While some courts allow forced medication on both emergency and dangerousness grounds, the definitions of these terms and their criteria vary. In addition, some courts have refused to extend police power authority based on predictions of future violence. Following the Third Circuit’s decision in Rennie, there has been judicial disagreement on whether a finding of incompetency is a necessary prerequisite to a forced medication determination based on parens patriae grounds. Courts also disagree on the applicability of the least restrictive alternative doctrine to drug refusal cases. And since the Supreme Court’s decision in Youngberg v. Romeo, courts have varied drastically on the necessary procedural protections which ultimately define the true scope of the right to refuse.

THE EIGHTH CIRCUIT’S APPROACH: DAUTREMONT v. BROADLAWS HOSPITAL

Several federal courts which have been confronted with drug refusal litigation have been strongly influenced by the Supreme Court’s analysis and resulting deference to professional decisionmaking in Youngberg. Perhaps no other case better illustrates the Youngberg influence on the issues encompassed within a forced medication determination than does the United States Court of Appeals for the Eighth Circuit’s recent opinion in Dautremont v. Broadlawns Hospital.169

In Dautremont, the Eighth Circuit was presented with a constitutional challenge to the forced administration of antipsychotic drugs to an involuntarily hospitalized mental patient. The appellant, Dautremont, was initially committed to Broadlawns, an Iowa municipal hospital, in August of 1979, after allegedly assaulting his father.170 After being placed on an outpatient status in October, he ran away to Oklahoma where he was again involuntarily hospitalized. In February of 1980, he was conditionally released to his parents for readmis-

169. 827 F.2d 291 (8th Cir. 1987).
170. Id. at 294.
sion into the Iowa facility.\textsuperscript{171} He was discharged from Broadlawns later that month, but in 1983 he was committed to the Iowa facility a third time after threatening to assassinate the President. During his three involuntary hospitalizations in Iowa, the appellant was administered antipsychotic drugs over his refusal.\textsuperscript{172} Dautremont brought an action pursuant to 42 U.S.C. section 1983 against Broadlawns and two of its doctors alleging a denial of due process during his three periods of hospitalization when the drugs were forcibly administered.\textsuperscript{173}

The Eighth Circuit faced a number of issues before reaching the constitutional questions regarding the forced medication. The court first rejected Dautremont's claim that the federal district court erred in relying on documents alleged to be deficient under the Federal Rules of Civil Procedure.\textsuperscript{174} Dautremont next asserted that the district court had applied the incorrect statute of limitations in barring his claims based on the first two hospitalizations at Broadlawns. The Eighth Circuit ruled that the district court had erred in applying a special six-month statute of limitations applicable to municipal employees. The Eighth Circuit stated that instead, under a 1985 Supreme Court ruling, Iowa's two-year statute of limitations for personal injury suits was applicable to section 1983 actions.\textsuperscript{175} The court applied the Supreme Court's ruling retroactively to bar Dautremont's claims based on his first hospitalization but held that the claims arising from the subsequent two hospitalizations were timely.\textsuperscript{176}

The court also addressed Dautremont's assertion that the claims arising from his initial commitment were not barred due to Iowa's tolling statute. That statute extends the limitation periods in favor of mentally ill individuals for one year after their disability terminates.\textsuperscript{177} The court held the tolling statute inapplicable to Dautremont, reasoning that although he was mentally ill, he was nonetheless cognizant of his legal rights during the relevant period.\textsuperscript{178} The court supported its holding by citing Iowa legislation which explicitly stated that involuntary hospitalization is not to be equated with, nor does it raise a presumption of, incompetency for

\textsuperscript{171} \textit{Id.}
\textsuperscript{172} \textit{Id.} at 293.
\textsuperscript{173} \textit{Id.}
\textsuperscript{174} \textit{Id.} at 294. The appellant claimed that the documents relied upon by the district court did not comply with Rules 56(c) and 56(e) of the Federal Rules of Civil Procedure. \textit{Id.}
\textsuperscript{175} \textit{Id.} at 295.
\textsuperscript{176} \textit{Id.} at 295-96.
\textsuperscript{177} \textit{Id.} at 296.
\textsuperscript{178} \textit{Id.}
Dautremont alleged that he was deprived of a hearing prior to his second hospitalization at Broadlawns and thus, his due process rights were violated by both the commitment and the forced treatment which followed. However, the Eighth Circuit held that the second admission to Broadlawns was merely an extension of the Oklahoma commitment in which Dautremont had received an adequate hearing.

Dautremont then made two separate constitutional claims regarding the forced administration of medication during his third hospitalization at Broadlawns. His first contention was that Iowa commitment laws create liberty interests which are protected by the due process clause of the fourteenth amendment. Dautremont referred to Iowa legislation which grants patients a right to refuse drug therapy during the pre-judicial hearing commitment period unless it is necessary to preserve the patient's life or to prevent physical injury to the patient or others. He alleged that the medication was administered over his refusal despite a lack of evidence indicating that it was necessary to preserve his life or prevent harm to himself or others.

The Eighth Circuit held that even if it assumed that state law created the liberty interest which Dautremont described, the interest had not been violated. The court noted that Dautremont's third hospitalization was precipitated by his threat to assassinate the President and that he had intentionally cut his finger with a juice can prior to his confinement. The court deemed this sufficient evidence indicating that Dautremont presented a danger to himself and others which justified forced medication in accordance with state law.

Dautremont's second contention was that, independent of state law, involuntarily committed mental patients retain an interest in refusing treatment with antipsychotic medication protected by the due process clause of the fourteenth amendment. The Eighth Circuit acknowledged the Supreme Court's recognition of a constitutionally protected liberty interest in being free from unreasonable bodily restraints. Nevertheless, the court was reluctant to accept Dau-

---

179. Id. The Iowa legislation which the court referred to was IOWA CODE ANN. § 229.27 (West 1985). Id. at 296.
180. Id. at 297.
181. Id.
182. Id. at 298. Dautremont cited IOWA CODE ANN. § 229.23.2 (West 1985). Id.
183. Id.
184. Id.
185. Id.
186. Id. at 300.
187. Id.
tremont's assertion that this liberty protection extended to the mental restraint posed by the adverse effects of antipsychotic drugs. The court ruled, however, that even if Dautremont retained the described liberty interest, under the circumstances, it was outweighed by legitimate countervailing state objectives.

In arriving at its conclusion, the Eighth Circuit placed sole reliance on the professional judgment standard articulated by the Supreme Court in Youngberg. The court emphasized that according to Youngberg, freedom from bodily restraint, and therefore, arguably, mental restraint, is "'protected by the [d]ue [p]rocess [c]lause from arbitrary governmental action.'" The court held that in this case, the decisions to forcibly administer antipsychotic drugs to Dautremont were not arbitrary as they were "made by professionals exercising their professional judgment in light of the circumstances precipitating his hospitalization and in light of the evidence of his serious mental impairment presented at the commitment hearing."

The Eighth Circuit found that Dautremont was subject to compelled medication on legitimate police power grounds to "prevent possible injury to himself or others." The court supported its ruling by pointing to Dautremont's threat to assassinate the President and his previous willful injury to himself. In addition, the court held that the state legitimately exercised its parens patriae authority to compel medication "in light of the clear and convincing proof of Dautremont's serious mental impairment."

The Eighth Circuit concluded that Dautremont's liberty interests were outweighed "by the government's legitimate objective to return Dautremont's behavior to that which is acceptable to society and by the professionals' reasonable judgment here that that objective can best be accomplished by the administration of certain types and levels of psychotherapeutic drugs."

The Eighth Circuit's opinion in Dautremont is notable in several respects. First, it is unclear whether the court expressly recognized a constitutionally protected interest on behalf of involuntarily commit-
ted mental patients in refusing antipsychotic drugs. This reluctance is surprising in light of the Supreme Court's language in *Mills v. Rogers* \(^{196}\) and the number of cases recognizing the interest since it emerged in *Rennie* and *Rogers*. Assuming at least an implicit recognition of such an interest in *Dautremont*, the Eighth Circuit equated it with the right to be free from the mere physical restraints at issue in *Youngberg*. \(^{197}\)

Although the Eighth Circuit characterized the protected interest as freedom from mental restraints, it made no mention of the possibility that adverse drug effects on otherwise normal mentation and communicative abilities may infringe upon first amendment values as did the federal district courts in *Rennie* and *Rogers*. \(^{198}\) Nor did the Eighth Circuit address the possible implication of the liberty interest in personal security represented by the potential harmful effects of antipsychotic drugs as did the First and Third Circuits. Finally, unlike the First Circuit, the Eighth Circuit did not address the constitutionally protected privacy interests implicated by compelled drug therapy. In addressing countervailing state objectives, the Eighth Circuit held that the state's police power interest in preventing harm to the patient or others is sufficient to override a patient's interest in refusing medication. The court, by implication, authorized a broad dangerousness standard under which police power authority could be exercised based on predictions of harm. Unlike the First Circuit, it did not limit this predictive discretion by mandating considerations and procedures to assure proper exercise of the authority. The most disturbing aspect of this part of the decision is that the Eighth Circuit took the unprecedented step of allowing such predictions to be based on Dautremont's previous activity in the community setting. The court made no inquiry into whether Dautremont posed a danger to himself once hospitalized or whether he posed a danger to others within the institutional setting. \(^{199}\)


\(^{197}\) *Dautremont*, 827 F.2d at 300.

\(^{198}\) *See id.*

\(^{199}\) *See id.* at 297-300. A finding of a continuing threat of danger within the institutional setting has been held necessary to justify forced medication on police power grounds, even by those courts adopting the dangerousness standard. Although the police power allows the government to commit an individual in order to prevent danger to himself or others within the community setting, that justification does not automatically extend to involuntary treatment of that person once confined. *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir. 1971); *Rogers v. Okin*, 478 F. Supp. 1342, 1369 (D. Mass. 1979); *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978); *Rivers v. Katz*, 67 N.Y.2d 485, 496, 495 N.E.2d 337, 343, 504 N.Y.S.2d 74, 80 (1986); *In re K.K.B.*, 609 P.2d 747, 751 (Okl. 1980). Even when the initial commitment is based on an emergency, that finding alone does not automatically mean that the patient will continue to present a dan-
The Eighth Circuit followed the Third Circuit's lead in departing from the traditional requirement that a patient be determined incompetent to make treatment decisions before the state may exercise its \textit{parens patriae} authority to compel treatment. In addressing the applicability of Iowa's tolling statute, the Eighth Circuit explicitly noted that Dautremont was cognizant and capable of exercising his legal rights.\footnote{Dautremont, 827 F.2d at 296.} This indicates that he may very well have had the capacity to contribute to his treatment decisions as well. Although the court relied on an Iowa statute which states that involuntary hospitalization "does not constitute a finding of nor equate with nor raise a presumption of incompetency, nor cause a person so hospitalized to be deemed a person of unsound mind nor a person under a legal disability for any purpose"\footnote{Id. at 296 (quoting Iowa Code Ann. § 229.27 (West 1985)).} to defeat Dautremont's tolling claim, the court authorized compelled treatment with no prior inquiry into a patient's competency. Instead, the state's objective of returning a patient's behavior "to that which is acceptable to society" is sufficient to allow forced treatment over even a competent patient's refusal.\footnote{Id. at 300.}

Unlike the situation presented to the Third Circuit in \textit{Rennie}, there were no procedures, in-house or otherwise, at issue in \textit{Dautremont}. The Eighth Circuit required no procedural mechanisms assuring the integrity of the medical decisionmaking process. The court, relying on \textit{Youngberg}, mandated only that physicians exercise professional judgment in making treatment decisions. A reviewing court's standard of review is merely to ensure that a treatment decision has not so deviated from accepted professional standards that it can be described only as arbitrarily made.\footnote{Youngberg v. Romeo, 457 U.S. 307, 323 (1981); United States v. Charters, 863 F.2d 302, 313 (4th Cir. 1988).} In addition, the Eighth Circuit made no reference to the least restrictive alternative doctrine and its applicability to medication determinations.

Assuming that the Eighth Circuit did recognize a constitutionally protected interest in refusing antipsychotic medication, its unqualified adoption of the professional judgment doctrine enunciated in \textit{Youngberg} has rendered the right virtually meaningless. Under the Eighth Circuit's standard, there is no absolute right to refuse treatment, even for competent patients. Indeed, a patient does not even have the right to have his refusal reviewed by state professionals before medication is forcibly administered.

\footnotetext[200]{Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983); Jones v. Gerhardstein, 141 Wis. 2d 710, ---, 416 N.W.2d 883, 894 (1987).}
\footnotetext[201]{Id. at 296 (quoting Iowa Code Ann. § 229.27 (West 1985)).}
\footnotetext[202]{Id. at 300.}
\footnotetext[203]{Id. at 300.}
OTHER FEDERAL COURT DECISIONS

Only a few courts facing drug refusal litigation have deferred to professional judgment to the extent displayed by the Eighth Circuit in *Dautremont*. In *Stensvad v. Reivitz*,204 the United States District Court for the Western District of Wisconsin went as far as holding that involuntary commitment itself justifies forced medication decisions if made with professional judgment. However, this ruling was later undercut by a state supreme court decision.205 Under the influence of *Youngberg*, a number of federal courts adopted positions similar, in varying degrees, to that of the Third Circuit in *Rennie*.

Relying on the Supreme Court decisions in both *Parham* and *Youngberg*, the United States Court of Appeals for the Second Circuit has allowed ultimate authority to rest with state officials exercising professional judgment in deciding whether to forcibly medicate even competent patients on either *parens patriae* or police power grounds.206 However, the Second Circuit's deference to professional judgment fell short of that displayed by the Eighth Circuit. The Second Circuit stated that "[w]hile we are aware that deference must be accorded medical judgment in such matters, . . . we are also mindful that '[t]he medical nature of the inquiry . . . does not justify dispensing with due process requirements."207 The court also declared that "in our view, due process requires an opportunity for hearing and review of a decision to administer antipsychotic medication—but such a hearing need not be judicial in nature."208 The Second Circuit upheld a New York three-tiered administrative review procedure in which patients were permitted to be represented by legal counsel as sufficient under due process. However, this case was also undercut by a subsequent state court decision which adopted an approach more protective of patient interests.209

The United States District Court for the Northern District of Texas approved a nonadversarial two-tiered administrative review process for medication refusals.210 Although the procedures included an incompetency determination by the clinical director, patients found competent could, nonetheless, be forcibly medicated after a third-level review by an independent psychiatrist.211

The United States District Court for the District of Columbia

204. 601 F. Supp. 128 (W.D. Wis. 1985).
205. See infra notes 361-64 and accompanying text.
207. Id. at 979 (citations omitted).
208. Id. at 981.
209. See infra notes 357-60 and accompanying text.
211. Id.
also applied the professional judgment standard to drug refusal cases, but in a more limited fashion. In *United States v. Leatherman*, the court strongly implied that competent patients have an absolute right to refuse antipsychotic drugs proposed for treatment purposes. However, the court stated that judicial determinations of incompetency are unnecessary because "[t]o require the courts to pass on such issues would embroil them in a never ending controversy concerning medical judgments for which courts have neither the institutional resources nor the necessary expertise." The court held that the hospital's in-house administrative review procedures for determining incompetency and the necessity of forced medication for those patients found incompetent—which included consideration of available alternative means of treatment—met due process requirements.

Other federal courts have rejected the application of the professional judgment standard to drug refusal cases and have adopted a more protective due process model of review. In *Bee v. Greaves*, the United States Court of Appeals for the Tenth Circuit held that jailed pretrial detainees retain a right to refuse antipsychotic drugs, which is protected by the constitutional privacy interest in making fundamental personal decisions, the liberty interest in remaining free from unjustifiable intrusions on personal security, and the first amendment interest in producing and communicating ideas. The court left police power authority to forcibly medicate based on a dangerousness standard within the discretion of state authorities exercising professional judgment. The court required that these predictive determinations include consideration of all "the relevant circumstances, including the nature and gravity of the safety threat, the characteristics of the individual involved, and the likely effects of particular drugs." Most notably, the court applied the least restrictive alternative principle, requiring the consideration of less restrictive courses of action such as segregation or the use of tranquilizers or sedatives.

In addressing the state's *parens patriae* authority, the Tenth Circuit rejected the professional judgment standard in holding that a pretrial detainee who had not been determined incompetent to make

---

213. *Id.* at 979.
214. *Id.*
215. *Id.* at 980.
217. *Id.* at 1394.
218. *Id.* at 1396.
219. *Id.*
treatment decisions by a court of law retained the absolute right to refuse medication. The court distinguished Youngberg on the grounds that "it involved temporary physical restraints rather than mental restraints with potentially long term effects, and because [the patient] had been certified as severely retarded and unable to care for himself." In 1984, the United States Court of Appeals for the Fourth Circuit, in a rather cryptic opinion, referred to Youngberg’s professional judgment standard in authorizing hospital discretion in forcibly medicating involuntarily committed mental patients. However, in the 1987 panel decision of United States v. Charters ("Charters I"), the Fourth Circuit turned full-circle in adopting a very protective due process model for refusal reviews. The court based a federal pretrial detainee’s constitutional right to refuse antipsychotic drugs on fifth amendment right to privacy and first amendment grounds. In addressing the government’s police power authority, the court invalidated the use of a dangerousness standard as insufficiently compelling to justify the forced administration of antipsychotic drugs. The court stated:

The government may not force an unconsenting individual to hazard the present danger of antipsychotic medication upon a mere supposition that at some future time the individual may become dangerous. Before the government can force an individual to chance such danger, the threat to the government’s interest in safety and security must be manifest.

The Fourth Circuit followed the Tenth Circuit in applying the least restrictive alternative doctrine, stating that “unless it is determined that, without medication, a patient presents an immediate threat of violence that cannot be avoided through the use of less restrictive alternatives, there is no justification for the intrusion into fundamental liberties that forcible medication represents.”

As in Bee, the Fourth Circuit refused to equate a finding of in-

220. Id. at 1395. The court rejected the state’s contention that it was entitled to forcibly medicate the appellant in order to maintain his competency for trial. The court first noted that the prisoner had not been found incompetent. Id. Moreover, the court suggested that due to the potentially dangerous side effects of drugs, the state interest in bringing an accused to trial is not sufficiently compelling to outweigh the individual interest in refusing. Id.

221. Id. at 1396 n.7 (citations omitted).


223. 829 F.2d 479 (4th Cir. 1987), reversed and remanded, 863 F.2d 302 (4th Cir. 1988) (en banc).

224. Id. at 491-92.

225. Id. at 493.

226. Id.
competency to stand trial with incapacity to make treatment decisions. The Fourth Circuit held that absent a prior judicial determination of incompetency to make treatment decisions, an institutionalized individual has an absolute right to refuse antipsychotic medication proposed for treatment purposes. In expressly rejecting the professional judgment standard, the court held that for patients who are adjudicated incompetent, the court is the appropriate body to determine the necessity of compelled medication. The court reasoned that:

The decision here, whether to hazard the substantial risks of a course of antipsychotic medication, is an individual decision, not normally delegated to professionals. Furthermore, the use of antipsychotic medication may present a substantial conflict of interest for institutional professionals because, quite apart from its therapeutic benefits, the medication serves the institutional goals of maintaining control and ameliorating staffing costs.

The Fourth Circuit ruled that the authorizing court is to be guided by the substituted judgment standard, at least to the extent that it is "possible clearly to ascertain what a patient would have done if he were competent." However, when clear evidence of intent is lacking, the court should decide on the basis of the patient’s best interests. The Fourth Circuit distinguished the Supreme Court’s decision in Youngberg on a number of grounds. The court noted that the respondent in Youngberg was profoundly retarded and completely unable to participate in treatment decisions. Thus, the Fourth Circuit stated that the Supreme Court did not address the rights of competent patients. The Fourth Circuit also pointed out that unlike the serious and potentially irreversible side effects posed by antipsychotic drugs, the restraints at issue in Youngberg were only temporary and posed no threat of serious harm. In addition, the Fourth Circuit relied on the fact that “unlike the purely physical restraints considered in [Youngberg], antipsychotic medication has the potential to in-

227. Id. at 495.
228. Id. Like the court in Bee, the Fourth Circuit ruled that the state interest in ensuring a defendant’s competence to stand trial is insufficient to justify the forced administration of potentially dangerous medication. Id. at 494.
229. Id. at 497.
230. Id. at 498. The court reasoned that “[i]t is to deprive the incompetent patient of rights which are afforded competent patients, by ignoring their uniqueness and imposing upon them the views of a hypothetical majority or ‘reasonable man.’” Id. at 497.
231. Id. at 498.
232. Id. at 488.
233. Id. at 489.
fringe upon an individual's freedom of thought."  Finally, the court equated the situation in *Youngberg* to an emergency, as the patient's history unmistakably indicated the need to take some action to prevent further physical injury to the patient and perhaps to others. Thus, as when the government exercises its police power authority in an emergency situation, deference to professional judgment was more appropriate, especially when the preventive measure employed posed no threat of permanent harm.

In a 1988 decision, the United States District Court for the Middle District of North Carolina, in *United States v. Waddell*, rejected the applicability of the professional judgment standard to drug refusal cases. The court adopted the Fourth Circuit's due process model in determining the right of a pretrial detainee to refuse medication which was proposed for treatment purposes. In addition, the United States Court of Appeals for the Seventh Circuit, likewise, favorably cited the approaches adopted by the Fourth and Tenth Circuits in a 1988 decision involving a prisoner's medical malpractice claim against state officials who administered medication over his objection.

With the exception of the Eighth Circuit's 1987 decision in *Dautremont*, it appeared that the impact of the *Youngberg* decision on federal court drug refusal decisions was diminishing. However, in December of 1988, the Fourth Circuit, sitting en banc, reversed its earlier decision in *Charters I*. In *United States v. Charters* ("*Charters II*"), the court shifted from its protective due process model and adopted the Eighth Circuit's approach of unqualified deference to professional judgment.

The Fourth Circuit began its opinion in *Charters II* by recognizing that individuals who are legally confined retain significant constitutionally protected interests. The court looked to the liberty interest in freedom from bodily restraint identified by the Supreme Court in *Youngberg* and held that "the forcible administration of antipsychotic drugs presents a sufficiently analogous intrusion upon bodily security to give rise to such a protectible liberty interest." Thus, the Fourth Circuit shifted its focus from the privacy and first amendment interests relied on in *Charters I*, to a liberty interest in

234. *Id.*
235. *Id.*
237. *Id.* at 209.
238. Chambers v. Ingram, 858 F.2d 351, 359 (7th Cir. 1988).
239. 863 F.2d 302 (4th Cir. 1988) (en banc).
240. *Id.* at 305.
241. *Id.* (quoting *Johnson*, 742 F.2d at 825).
freedom from restraint. In examining the sufficiency of countervailing government objectives, the court stated that the protected interests retained by committed individuals “must yield to the legitimate government interests that are incidental to the basis for legal institutionalization.”242 In determining which such government interests are sufficiently legitimate, the court held that the protected individual interests retained by the involuntarily committed “are only afforded protection against arbitrary and capricious government action.”243

The Fourth Circuit then shifted to a procedural due process analysis to determine the safeguards constitutionally required to protect individual substantive interests from arbitrary government action. Recognizing that procedural due process is a flexible concept, the court looked to the considerations enunciated by the Supreme Court in Mathews to determine the procedures due in this particular situation.244 Referring to the risk of “possibly drastic mental and physical side effects” posed by antipsychotic medication, the court viewed the private interest at stake as “sensitive.”245 However, the Fourth Circuit stated that the government’s process of placing responsibility for medication determinations in the institution’s medical personnel was sufficient protection against the risk of erroneous deprivations of the individual interest.246

The court quoted the Supreme Court’s opinion in Parham, stating that “it has long been recognized that ‘[w]hat process is constitutionally due cannot be divorced from the nature of the ultimate decision that is being made.’”247 Like the Third Circuit in Rennie, the Fourth Circuit characterized the determinations necessary in a forced medication decision as “medical” in nature.248 For example, the court viewed the potential for side effects and the patient’s capacity to make rational treatment decisions as mere factors “in the ultimate [best interests] medical decision to administer the medication involuntarily.”249 Having characterized such determinations as “medical,” the court relied on both Parham and Youngberg in holding that the committing of these decisions to the government’s professionals, subject to judicial review for arbitrariness, comports with due process requirements.250

242. Id.
243. Id.
244. Id. at 306-07.
245. Id. at 307.
246. Id. at 307-08.
247. Id. at 308 (quoting Parham v. J.R., 442 U.S. 584, 608 (1979)).
248. Id.
249. Id. at 311-12.
250. Id. at 307-08.
Relying on Parham, the Fourth Circuit reasoned that "while medical and psychiatric diagnosis obviously was fallible," because the necessary determinations are medical and psychiatric in nature, "there was no reason to suppose that it was more so than would be the comparable diagnosis of a judge or hearing officer." Thus, the role of the court is merely to guarantee that pre-deprivation due process was complied with in that professional judgment in base-line decisionmaking was exercised.

The court criticized the adjudicatory regime envisioned in Charters I as installing "the federal courts as the base-line providers of procedural due process, collapsing their normal review function into this threshold function." Thus, "[d]istrict judges would thereby be cast in the role of making the primary decisions on purely medical and psychiatric questions, rather than reviewers of such decisions made by qualified professionals." The court also criticized the proposed adjudicative regime as imposing heavy burdens on the government in efforts to discharge its duties as a "benign custodian of one legally committed to it for medical care and treatment." The Fourth Circuit thus held that adequate due process protection is found "first, in the general professional competence and integrity of the government's medical personnel, and second, in the availability of judicial review to guard against arbitrariness in making particular decisions."

In addressing how the government's current regime should be properly administered, the Fourth Circuit again relied on Parham in stating that:

Making an acceptable professional judgment of the sort here in issue does not require any internal adversarial hearing. The decision may be based upon accepted medical practices in diagnosis, treatment and prognosis, with the aid of such technical tools and consultative techniques as are appropriate in the profession.

---

251. Id. at 308.
252. Id. at 309.
253. Id.
254. Id.
255. Id. at 312.
256. Id. at 307-08.
257. Charters II, 863 F.2d at 312 (citation omitted). Later, the court seemingly contradicted itself by stating that "under the approved regime such a decision is of a piece with other pre-deprivation governmental decisions such as those leading to job or social benefit terminations, prison transfers, disciplinary sanctions, and the like." Id. at 314. However, many such determinations have been held to require procedural safeguards, often including an adversarial hearing before an impartial decisionmaker, which go far beyond those mandated by the Fourth Circuit's interpretation of the professional judgment standard. See, e.g., Vitek v. Jones, 445 U.S. 480 (1980) (stating that
In reemphasizing the limited scope of judicial review, the Fourth Circuit cited *Youngberg* in stating that only one question is relevant: "[w]as this decision reached by a process so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one."  

**THE APPROPRIATENESS OF APPLYING THE PROFESSIONAL JUDGMENT STANDARD TO DRUG REFUSAL CASES**

**PATIENT INTERESTS**

Whether an involuntarily committed mental patient's right to refuse antipsychotic medication is outweighed by countervailing governmental interests may very well depend on the constitutional source on which the right is based. Generally, the more important the constitutionally protected interest is, the stronger the government's justification must be to override the interest.

Even after legal confinement, individuals retain a constitutionally protected right to remain free from unwarranted government intrusions upon their person. This right has been cast in various terms, often depending on the type of proposed government action, including a liberty interest in bodily integrity, freedom from restraint, personal security or as an aspect of the right to privacy.

A government encroachment on this protected liberty or privacy interest must, at a minimum, be "reasonably related to legitimate government objectives." However, the strength of the government's purpose must increase as its action grows in intrusiveness.

---

the determination to transfer a prisoner to a mental health facility requires an adversarial hearing before an impartial decisionmaker); Morrissey v. Brewer, 408 U.S. 471 (1972) (requiring procedural safeguards, including an adversarial hearing before a neutral and detached hearing body, for parole revocation); Goldberg v. Kelly, 397 U.S. 254 (1970) (stating that a decision to terminate AFDC benefits requires procedural safeguards, including an adversarial hearing before an impartial decisionmaker).

258. *Id.* at 313.


265. *Youngberg*, 457 U.S. at 320; *see also* Bell v. Wolfish, 441 U.S. 520, 539 (1979).

266. *See Price*, 307 Minn. at —, 239 N.W.2d at 910 (stating that the constitutionally protected right to privacy "must give way to certain interests of the state, the balance
A highly intrusive action must be supported by a compelling reason and a showing that there are no less intrusive means available to accomplish the objective.267 Thus, in Schmerber v. California,268 the Supreme Court validated the slight intrusion into "human dignity and privacy" presented by a pin prick for a blood test based on the legitimate state interest in gathering evidence of a crime. The Court qualified its holding by emphasizing a number of factors including the necessity of the test, the fact that it was performed by a physician in a hospital environment and the lack of potential adverse side effects.269 However, in Rochin v. California,270 the Supreme Court invalidated the forced insertion of a stomach pump, even as the only available means of collecting criminal evidence, as not justified by the legitimate state interest due to its extremely intrusive nature.

In Youngberg v. Romeo, the Supreme Court held that the respondent retained a due process liberty interest in remaining free from unreasonable bodily restraints.271 Both the Eighth and Fourth Circuits analogized the bodily restraints at issue in Youngberg to the intrusion presented by the forced administration of antipsychotic drugs. However, the reasoning employed by the Tenth Circuit in Bee v. Greaves and the Fourth Circuit panel in Charters I in distinguishing the individual interest at issue in Youngberg appears sound.

In Youngberg, the government implemented the use of soft arm restraints for short periods of time.272 While these physical restraints are certainly a restriction on liberty, they arguably served only the respondent's best interests by protecting him from his own violence and that of other patients.273 The effects of such physical restraints are predictable and can be easily monitored. Soft arm re-

---

267. Winston, 470 U.S. at 766; Schmerber, 384 U.S. at 768-70; Price, 307 Minn. at —, 239 N.W.2d at 910 (asserting that "[s]ome decisions . . . will be of little consequence to the individual and a showing of a legitimate state interest will justify its intrusion; other decisions, on the other hand, will be of such major consequence that only the most compelling state interest will justify the intrusion"). See generally L. Tribe, supra note 259, § 15-9, at 1329-37.


269. Id. at 772. The Court confined its holding to the particular facts of the case and stated: "The integrity of an individual's person is a cherished value of our society. That we today hold that the Constitution does not forbid the State's minor intrusions into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions." Id.

270. 457 U.S. at 318. The Court also found that the respondent retained a right to safe conditions of confinement based on the liberty interest in personal security as well as the right to minimally adequate training to ensure safety and freedom from undue restraint. Id. at 315-19.

271. Id. at 310, 311 n.8.

272. Id. at 314.
strains pose little threat of injury and the restriction on liberty ceases once they are removed. The intrusion presented by antipsychotic drugs is not comparable to that of temporary physical restraints. Physicians cannot predict the adverse effects drugs may have on a patient.\textsuperscript{274} Indeed, as stated earlier, many side effects may remain undetected during drug therapy. In addition, antipsychotic drugs pose a risk of serious harm—harm which, as evidenced by tardive dyskinesia, may be irreversible. Other adverse effects, although reversible, may afflict the patient for months after termination of drug therapy. Thus, antipsychotic drugs are much more intrusive than temporary physical restraints, encroaching upon bodily integrity and personal security to a far greater degree.

In addition, neither the Eighth nor the Fourth Circuit addressed the possible first amendment implications posed by the forced administration of antipsychotic medication. Unlike temporary physical restraints, drug side effects may adversely impact upon a patient's otherwise normal thought processes. As the court in \textit{Charters I} noted, even if a patient's mental disorder renders him incapable of making rational treatment decisions, he may, nonetheless, be capable of engaging in other activities protected by the first amendment. However, these capabilities may be diminished by drug side effects.\textsuperscript{275}

As noted earlier, patients often experience drowsiness and fatigue at the onset of drug therapy. For some patients, this sedation severely limits the ability to think and function normally.\textsuperscript{276} Neurological side effects, such as akinesia and akithisia, can also impair otherwise normal mental functioning and awareness as well as the ability to concentrate, read and communicate.\textsuperscript{277} Dystonic reactions and the chronic, repetitive movements induced by the dyskinesias are

\begin{itemize}
\item \textsuperscript{275} United States v. Charters, 829 F.2d 479, 489 (4th Cir. 1987) [hereinafter \textit{Charters I}], rev'd, 863 F.2d 302 (4th Cir. 1988) (en banc) [hereinafter \textit{Charters II}].
\item \textsuperscript{276} Kemna, \textit{Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs}, 6 J. LEGAL MED. 107, 111 (1985); Gaughan & LaRue, \textit{The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution}, 4 LAW & PSYCHOLOGY REV. 43, 51 (1978).
often extremely distressing and disruptive to patients.\textsuperscript{278} Although many side effects can be reduced or alleviated by antiparkinsonian agents, a complete cessation of drug therapy is required to eliminate others. The chronic, long-term use of antipsychotic medication poses the threat of irreversible impairment to memory, learning and other reasoning ability.\textsuperscript{279}

Due to their “preferred position” in the hierarchy of constitutional rights,\textsuperscript{280} an infringement of first amendment protections “cannot be justified upon a mere showing of a legitimate state interest.” . . . The interest advanced must [therefore] be paramount, one of vital importance, and the burden is on the government to show the existence of such an interest.”\textsuperscript{281} Moreover, the government’s objective “cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.”\textsuperscript{282} These requirements appear especially warranted in refusal cases, given the degree of intrusiveness on first amendment interests presented by antipsychotic medication. These drugs reach into the mind, the source of all expression, in a manner which we do not yet understand.\textsuperscript{283}

In relying solely on the protected interest at issue in Youngberg, the Eighth and Fourth Circuits also ignored the possibility that compelled drug therapy will implicate the privacy interest in personal decisionmaking. The right to freedom of choice in certain matters affecting a person’s life has been found to be of “fundamental” value and can only be limited by a compelling government interest.\textsuperscript{284} Recognizing that many institutionalized mentally ill individuals retain the capacity to make rational treatment decisions, several courts have extended this privacy interest to the area of forced psychiatric treatment.\textsuperscript{285} As noted in the decisions of Bee and Charters I, the respondent in Youngberg was profoundly retarded and certified incapable of
discouraged about the future; I have no enthusiasm. I can’t type nearly as fast at my job. . . . I want my own personality.” Van Putten, 31 ARCHIVES GEN. PSYCHIATRY at 70.

\textsuperscript{278} Gutheil & Appelbaum, 12 HOFSTRA L. REV. at 108; Comment, Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 1980 WIS. L. REV. 497, 531-32.

\textsuperscript{279} Winick, supra note 92, at 11.


\textsuperscript{283} See supra note 19 and accompanying text.


contributing to his own treatment decisions. Thus, the Supreme Court in *Youngberg* did not address the protected interests in treatment decisionmaking retained by competent patients.

The protected interests implicated by the forced administration of antipsychotic drugs are not, as the Eighth and Fourth Circuits determined, analogous to the liberty interest in freedom from physical restraints addressed in *Youngberg*. Compelled drug therapy poses not only a far greater infringement of constitutionally protected interests than does a purely physical restraint, but the interests threatened are of a more fundamental nature. Thus, the balancing of individual and government interests should be quite different. The rational basis analysis, applied in both *Dautremont v. Broadlawns Hospital* and *Charters II*, is a grossly inadequate standard for protecting the important interests retained by institutionalized mental patients in refusing antipsychotic medication.

**GOVERNMENT INTERESTS**

Given the fundamental nature of the protected interests involved and the degree of intrusion into these interests, the government's justifications for requiring drug therapy must be compelling. As noted earlier, courts have invoked the purposes behind the government's police power and *parens patriae* authority as sufficiently compelling, under certain circumstances, to justify forced medication.

Courts addressing the issue have agreed that an emergency situation, in which the threat of physical harm to the patient or others within the institution is current or imminent, justifies forced medication for a limited time period when no less restrictive alternatives are available.286 However, courts disagree on whether police power authority is sufficiently compelling when based on predictions of future harm if the patient remains unmedicated. The Eighth Circuit, in *Dautremont*, not only authorized compelled medication based on predictions of future dangerousness, but allowed those predictions to be based solely on the patient's previous activities outside the institutional setting.287

Forced medication based on a prediction of future harm is nothing more than preventive chemical restraint.288 The inherent potential for abuse under such a standard has been well documented in

---

286. See supra notes 97-98 and accompanying text.

287. As noted earlier, even those courts which have authorized forced medication based on the dangerousness standard have required a showing of a continuing threat of violence within the institutional setting. See supra note 199 and accompanying text.

litigation and investigations. For example, the Massachusetts Supreme Judicial Court cited substantial evidence of the misuse of medication for purposes of patient management and staff convenience. The court restricted the police power authority to compel medication to situations requiring immediate action. And even in these emergency situations, the court required the consideration of available less restrictive alternatives.

Similarly, the United States District Court for the Northern District of Ohio rejected the dangerousness standard after finding the widespread use of antipsychotic drugs for purposes of staff convenience and punishment. The court noted that in this respect, the Ohio facility appeared to be "little different than any other large institution for the mentally ill." Even when danger is "sufficiently grave and imminent," the court suggested that the medication determination be made at an informal hearing before an independent decisionmaker.

The Arizona Supreme Court likewise rejected the dangerousness standard out of concern that drugs were being used to keep prisoners "docile and manageable regardless of potential serious physical and emotional consequences." The court held that absent true emergencies, legitimate security problems should be handled by less intrusive measures such as incarceration or isolation.

It should also be noted that even most psychiatrists agree that it is virtually impossible to accurately predict future violent behav-

---

289. See supra notes 56-62 and accompanying text.
293. Id. at 926 n.7.
294. Id. at 934.
295. Id. at 938-39.
297. Id. at —, 714 P.2d at 408. The court went on to state that "forcible medication with dangerous drugs should be limited to specific emergencies under procedural safeguards." Id. The court emphasized the urgency required to constitute a true emergency by making the comparison to situations where prison authorities would be justified in shooting the prisoner. Id. at —, 714 P.2d at 409. See also Anderson v. State, 135 Ariz. 578, —, 663 P.2d 570, 573 (Ariz. App. 1982) (determining that drugs may be forcibly administered only when "the patient poses an immediate threat of physical injury to himself or others"); In re Mental Commitment of M.P., 510 N.E.2d 645, 647 (Ind. 1987) (stating that "the fact there is a possibility that the patient might harm himself or another person is not a sufficient justification for permitting forced medication with anti-psychotic drugs. Given the significant risks inherent in the use of these drugs, the propensity for dangerousness is not sufficient to overcome the patient's liberty interest in being free from unreasonable intrusions into his body and mind"); Opinion of the Justices, 465 A.2d 484, 489-90 (1983) (holding that forced medical care on police power grounds is justified only where an immediate and urgent need for treatment is required).
Given this predictive uncertainty, the potential for abuse, and the availability of less intrusive measures to guard against future violence, it would appear that the police power interest, when based on a dangerousness standard, is insufficiently compelling to justify the extensive intrusion into fundamental liberties that compelled medication presents.

The government’s parens patriae authority has also been held, under certain circumstances, to justify the forced treatment of mentally ill patients. However, the beneficent purposes underlying this authority do not exempt it from substantive due process limitations. When the parens patriae authority implicates fundamental interests, the government’s objective must be compelling. In addition, a mere relationship between the government’s intervention and its objective will not suffice; the means implemented must be necessary to achieve its goal.

The exercise of the parens patriae authority to force psychiatric treatment is premised on the compelling need to help individuals who are incapable of making their own treatment decisions. This “incapacity” limitation on government treatment authority is reflected in the common-law doctrine of informed consent. The rationale behind this doctrine is the recognition that treatment decisionmaking is not solely a professional task. Although the health care provider may have more expertise regarding the benefits and risks of a particular medical intervention, the evaluation of this treatment information in light of subjective personal concerns is a right which belongs to the patient.

The values of bodily integrity and self-determination recognized by the informed consent doctrine are the same interests protected by the constitutional right to privacy. As the Massachusetts Supreme Judicial Court stated:

300. See Roe, 410 U.S. at 155.
301. See supra note 104 and accompanying text.
303. See supra note 75 and accompanying text.
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.\textsuperscript{304}

Thus, courts have held that under both the common-law and the constitutional right to privacy doctrine, the \textit{sine qua non} of forced medical treatment based on \textit{parens patriae} grounds is a determination that the patient is incapable of making his own treatment decisions. Without this finding of incompetency, the government’s justification for its exercise of the \textit{parens patriae} power is not sufficiently compelling; indeed, it no longer exists.\textsuperscript{305}

As pointed out above, the Supreme Court did not evaluate the rights of competent patients in \textit{Youngberg}. In relying solely on the liberty interest addressed in that case, the Eighth and Fourth Circuits overlooked the common-law and constitutional privacy interests implicated by the forced administration of antipsychotic drugs. The Eighth and Fourth Circuits allowed professional judgment, supported by the objective of restoring behavior “to that which is acceptable to society,”\textsuperscript{306} to dictate the forced medication of competent patients. Under this broad application of the professional judgment standard, a patient’s competence is, at best, relegated to “simply another factor in the ultimate medical decision to administer the medication involuntarily.”\textsuperscript{307} Such a standard diminishes the value our society has placed in bodily integrity and self-determination, interests long protected by the common law and encompassed within the fundamental constitutional right to privacy.

In addition, as the district court in \textit{Rennie v. Klein} pointed out, determining and honoring competent refusals would have practical medical benefits.\textsuperscript{308} Physicians must depend on their patients for evidence of the subjective effects of medication which requires encour-

\textsuperscript{306} Dautremont v. Broadlawns Hosp., 827 F.2d 291, 300 (8th Cir. 1987). \textit{See infra} note 307 and accompanying text.
\textsuperscript{307} Charters II, 863 F.2d at 311-12.
\textsuperscript{308} Rennie, 462 F. Supp. at 1144-45.
agement and evaluation of patient input. Consultation with the patient encourages cooperation and makes compliance more likely. Studies indicate that forcing treatment on competent patients reduces the therapeutic benefits. Requiring an attempt at obtaining an informed treatment choice will force physicians to thoroughly evaluate the benefits and risks of the proposed treatment and any available alternatives. Concerns which might otherwise go unnoticed will be explored. This open and honest communication will enhance the self-esteem of even incompetent patients, thereby being therapeutic in itself.

**PROCEDURES**

As evidenced by the above case law, several federal courts have applied the professional judgment standard to varying degrees in drug refusal cases. These courts have placed great weight on the Supreme Court's deference to institutional professional decisionmaking displayed in *Parham* and *Youngberg*. Other courts have rejected the professional judgment standard as insufficient under procedural due process requirements. These courts have pointed to the different interests and types of determinations that are involved when a patient refuses antipsychotic medication. The latter approach appears most persuasive.

As described earlier, the Supreme Court in *Mathews v. Eldridge* announced a number of considerations to be balanced in determining the procedures due in any particular case. In *Parham*, the Court addressed the procedural safeguards necessary to protect a minor's liberty interest upon a parental or guardian's request for commitment into a mental hospital. After applying its balancing formula, the Court held that a properly filed application and an informed decision by the admitting physician followed by periodic reviews of the child's condition was sufficient to meet due process requirements.

---

309. Id. at 1145.  
310. Id. at 1144-45. See also Brooks, 8 BULL. AM. ACAD. PSYCHIATRY & L. at 209-10; Sidley, *The Right of Involuntary Patients in Mental Institutions to Refuse Drug Treatment*, 1984 J. PSYCHIATRY & L. 231, 244.  
As exemplified, most notably by the Third Circuit's decision in *Rennie* and the Fourth Circuit's opinion in *Charters II*, courts applying the professional judgment standard in drug refusal cases have relied heavily on the Supreme Court's procedural analysis in *Parham*. However, like the situation in *Youngberg*, the *Parham* case is distinguishable.

The protected interest at issue in a commitment proceeding is the same interest addressed in *Youngberg*, freedom from unreasonable bodily restraint. A decision to commit, although a "massive curtailment of liberty," does not implicate the same fundamental interests involved in a decision to compel treatment with medication posing potentially serious, harmful side effects.

Moreover, in *Parham* the Court stressed that the child's liberty interest is "inextricably linked with the parents' interest in and obligation for the welfare and health of the child, [thus] the private interest at stake is a combination of the child's and parents' concerns." The Court held that the child's individual interest in remaining free from commitment is substantially diminished by the parents' interest in retaining authority to make decisions on what is in the child's best interests. In addition, the Court emphasized the "traditional presumption that the parents act in the best interests of their child" as offering additional protection for the child.

In *Parham*, the Court characterized the questions involved in a child's commitment proceeding as essentially medical in nature. The Court went on to conclude that:

Although we acknowledge the fallibility of medical and psychiatric diagnosis, . . . we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing.

316. *Id.* at 601.
318. The commitment determination does not address such issues as the types of treatments that may be warranted, the benefits and risks of proposed treatments, and the individual's capacity to contribute to treatment decisions. Thus, as one commentator stated, "the commitment order should have no effect whatsoever on the individual's liberty interest regarding treatment decisions. Neither the substantive norms nor the procedural regularity of a commitment hearing can support the legitimacy of a decision never reached in that context." *Zlotnick, First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 409 (1981).
320. *Id.* at 604.
321. *Id.*
322. *Id.* at 609.
323. *Id.* (citations omitted).
Both the Third and Fourth Circuits relied heavily on this reasoning in describing forced medication decisions as medical or psychiatric, thus obviating the need for adversarial type proceedings.

However, unlike the questions involved in a child's commitment proceeding, the issues inherent to a forced medication decision are not solely medical in nature. The potential for adverse drug side effects, although subject to professional evaluation and opinion, is not, as the Fourth Circuit determined, a purely medical issue. That court cited the scientific disagreement as to the severity, duration and prevalence of various side effects in relegating the issue to "an element of the ultimate 'best interests' medical decision" more capable of assessment and review by professionals. However, this risk of harm, which is not at issue in the commitment context, presents a high degree of intrusiveness into fundamental interests in privacy and personal security and thus raises a greater need for legal concern and evaluation. The fact that there is scientific disagreement over the degree (not the presence) of risk would appear to support the need for legal safeguards so that varying medical viewpoints can be adequately assessed. Indeed, the Supreme Court has suggested that this type of uncertainty dictates against allowing the medical intervention.

In *Winston v. Lee*, the Supreme Court denied the government's request to perform minor surgery on a suspect to remove a bullet for evidentiary purposes. The Court pointed to the fundamental interests involved and the dispute between medical experts on the risk of danger presented by the operation and held that this "very uncertainty militates against finding the operation to be 'reasonable.'"

As in *Youngberg*, the Supreme Court did not address the rights of a competent patient in *Parham* but rather the interests of a legally incompetent minor. The commitment determination in *Parham* focused on whether the child suffered from a mental illness which precluded the receipt of care and treatment in the community. However, these essentially medical decisions do not necessarily mean

---

324. *Charters II*, 863 F.2d at 311.
326. *Id.* at 766. *See also* *Vitek v. Jones*, 445 U.S. 480, 495 (1980), wherein the Court addressed the procedural safeguards necessary in the decision to transfer a prisoner to a mental hospital. Even though the decision to commit involved the essentially medical question of whether the prisoner was mentally ill and could not be treated in prison, the Court required an adversarial hearing before an independent institutional decisionmaker. *Id.* at 496. In so doing, the Court stated: "The medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings." *Id.* at 495 (citation omitted).
that once committed, a mentally ill adult patient is incapable of making a rational decision regarding proposed treatments. Thus, unlike the situation in Parham, the threshold question in a forced treatment determination is whether the patient is competent. As even many noted psychiatrists readily admit, "[t]he concept of competency . . . is social and legal and not merely psychiatric or medical."328

Physicians are trained to concentrate on the medical best interests of a patient as reflected by medical standards on which their professional judgments are based.329 This treatment bias was exemplified in the Charters litigation where the attending psychiatrist "took the position that Charters' medical incompetence was evidenced by his refusal to accept antipsychotic medication since refusing the medication was not, in [the psychiatrist's] view, the decision most beneficial to Charters."330

On the other hand, a legal competency evaluation is broader in focus, taking into account not only medical concerns, but the personal interests in self-determination and bodily integrity. With the serious risks accompanying forced medication, these constitutionally protected interests are implicated to a much greater degree than in a decision to commit. Thus, the competency determination should be made by a judicial or quasi-judicial arbitrator who has the experience and aptitude to give due concern to legally protected values while objectively weighing both medical and other evidence.331

329. See Brooks, 8 BULL. AM. ACAD. PSYCHIATRY & LAW at 190-91; Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis. L. REV. 413, 451.
331. In Charters II, the Fourth Circuit feared that requiring adjudications of incompetency would "pose an unavoidable risk of completely anomalous, perhaps flatly inconsistent, determinations of mental competence by different judicial tribunals." Charters II, 863 F.2d at 310. However, clinicians have not yet developed a widely accepted definition of incompetency, and the methods used to make these determinations are rudimentary. See Meisel, 1979 Wis. L. REV. at 440-41; Parry, Psychiatric Care and the Law of Substitute Decision-making, 11 MENTAL & PHYSICAL DISABILITY L. REP. 152, 153 (1987); Roth, Meisel & Lidz, 134 AM. J. PSYCHIATRY at 280-82. As the noted psychiatrist Dr. Loren Roth stated, "[w]e don't know who is competent and who is not competent." Conference Report, Refusing Treatment in Mental Health Institutions: Values in Conflict, 32 Hosp. & COMMUNITY PSYCHIATRY 255, 257 (1981). Dr. Roth went on to admit that "[n]o matter what the law does, we'll always treat all the people we want. I hate to say that, but that's my experience. By hook or by crook, most of the patients will continue to be treated." Id. at 258. This medical uncertainty and treatment bias demonstrates the necessity for adversarial judicial hearings where professional opinions can be objectively weighed in light of the protected individual interests at issue.

The Fourth Circuit also relied on the fact that although the appellee had not been determined incompetent to make treatment decisions, he had been adjudicated incompetent to stand trial. The court stated that "[w]hile in theory there may be a difference
If a patient is adjudicated incompetent, it would seem most appropriate for the court or hearing officer to act as the proxy decisionmaker. Delegation of decisional authority to a guardian presents a number of problems. The guardianship process is dependent upon an available supply of qualified substitute decisionmakers. Frequently, family members are used on the assumption that they are most familiar with the patient's values, preferences and best interests. However, the institutionalized mentally ill often lack close family ties. The objectivity of family members who are available may be compromised by prior conflicts with the patient as well as other psychological and economic factors. Public guardians are in short supply and lack familiarity with the patient. It has also been suggested that guardians are too easily influenced by treating professionals and have neither the time nor ability to examine the relevant concerns at issue. In addition, a guardianship proceeding is a time-consuming process which may unduly delay appropriate treatment between the two mental states, it must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals. However, incompetency is no longer considered as global in nature. Mental illness may render an individual incompetent to make one type of decision while leaving reasoning ability in other areas intact. See supra note 106 and accompanying text. Incompetency is now viewed as situation-specific, with each type of decision-making situation being viewed individually and independently. Macklin, Some Problems in Gaining Informed Consent from Psychiatric Patients, 31 EMORY L.J. 345, 360 (1982). To be deemed competent to stand trial, a defendant must be able to understand the nature of the charges against him and to participate in his defense. Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam). This is wholly different than the capacity to make treatment decisions. Courts do not equate these two types of capabilities. See Bee, 744 F.2d at 1395. See also Charters I, 829 F.2d at 488; United States v. Waddell, 687 F. Supp. 208, 209 (M.D.N.C. 1988). Indeed, competence to stand trial has even been distinguished from competence to waive counsel. See Westbrook v. Arizona, 384 U.S. 150, 150 (1966). It should also be noted that determinations of both competence to stand trial and to waive counsel invoke the protection of a court and are not left to psychiatrists. See Pate v. Robinson, 383 U.S. 375, 385 (1966); Johnson v. Zerbst, 304 U.S. 458, 465 (1938).
for an incompetent individual.\textsuperscript{336} Finally, once a guardian consents to medication, the system does not contain adequate review mechanisms for patients who may eventually regain their competency.\textsuperscript{337}

Likewise, it would seem inappropriate to delegate substitute decisionmaking authority to mental health professionals. Patients are not deprived of their constitutionally protected interests by reason of their incompetency. The decision to risk the hazards posed by drug therapy remains an individual decision, even though exercised by proxy.\textsuperscript{338} Mental health professionals, whether in-house or independent, are socialized in the values of treatment and protection, a bias which dictates against adequate consideration of other legally protected individual interests. In addition, as described earlier, medical decisionmaking authority is vulnerable to compromise by institutional pressures to maintain patient control and to ease administrative and staff burdens through the use of medication.

The standard employed in \textit{Charters I} for guiding proxy decisionmaking appears to strike an appropriate balance between an incompetent patient's constitutionally protected interests and concern for his health and protection. The decisionmaker should look to the patient's previously expressed preferences, values and beliefs in an attempt to exercise a substituted judgment, that is, to decide as would the patient if the patient was competent. However, if clear and convincing evidence on this matter is lacking, as it often is, the decision should be based on the patient's best interests.\textsuperscript{339} Due to the fundamental rights at issue and the degree of infringement posed by the side effects of antipsychotic medication, the least restrictive alternative doctrine should apply to this "best interests" decision. At a minimum, the doctrine would require that the government present sufficient evidence that a cost-benefit analysis from the patient's perspective was included in the determination to propose treatment with antipsychotic drugs.\textsuperscript{340}

\textsuperscript{336} Ford, 137 AM. J. PSYCHIATRY at 336; Guthel, Shapiro & St. Clair, 137 AM. J. PSYCHIATRY at 350; Rhoden, 15 HARV. C.R.-C.L. L. REV. at 404.


\textsuperscript{339} A strict application of the doctrine would require that a reviewing court, after consideration of all the evidence, assure that the correct choice—striking the proper balance between efficacy and intrusiveness—is implemented. See, e.g., \textit{Rennie}, 462 F. Supp. at 1146. Considering the dangers posed by antipsychotic drugs, this application of the standard would appear appropriate. The less stringent approach would require
The judicial or quasi-judicial intervention suggested above will promote consistency, fairness and unbiased objectivity in both the incompetency determination and the resulting forced medication decision. A judge or law-trained hearing officer can evaluate submitted evidence in an unbiased manner, providing adequate concern for individualism as well as society’s interest in protection and health. Due consideration of these interests will be further assured by the visibility of this decisionmaking process, visibility which is lacking when decisions are made behind institutional walls.

While both the Third and Fourth Circuits criticized additional procedural safeguards as unduly interfering with the government’s role as “benign custodian,” their major concerns appear unwarranted. The Fourth Circuit feared that the delays occasioned by necessitating adjudications of incompetency may allow patients to deteriorate to such an extent that treatment will no longer be efficacious. However, this danger can be alleviated by authorizing an emergency exception as envisioned by the First Circuit in Rogers. If immediate administration of medication is necessary to prevent significant and irreversible deterioration in the patient’s mental condition, alternative procedures for determining incompetency could be employed, thus allowing medication until an adjudication could be arranged. It should be noted, however, that immediate and substantial deterioration caused by a delay in treatment is extremely rare. The prognosis for most individuals with untreated schizophrenia is a gradual deterioration, with those patients being medicated after a

the state to present sufficient evidence that appropriate concerns were conscientiously considered. If the state meets this burden, the court would not involve itself in a substantive determination of the correct choice. See Zlotnick, 83 W. VA. L. REV. at 439; Winick, supra note 92, at 21. This diminished standard would at least ensure that the professional choice was not unduly influenced by treatment bias nor the severe administrative, staff, and economic pressures inherent in public institutions.

341. 863 F.2d 302, 312 (4th Cir. 1988). The dissent criticized this characterization of the government’s role, stating:

The prospect that the views of a governmental medical official may be inclined to coincide with those of the federal prosecutor on the desirability of the trial’s proceeding and a resulting conviction leading to lengthy incarceration is not remote. They are, when all is said and done, fellow employees. Nor should we ignore the likelihood that Butner would rather be freed of the concerns such as diversion of experts it would rather detail to other tasks than the care of Charters. It may well be that something other than Charters’ well-being drives the opining medical officials.

Id. at 315 (Murnaghan, J., dissenting) (footnote omitted).

342. Charters II, 863 F.2d at 312.


344. See Roe, 383 Mass. at —, 421 N.E.2d at 54-55.
delay responding just as well as patients medicated immediately.\textsuperscript{345} The Third Circuit cited the Supreme Court's concerns in \textit{Parham} by stating that adversarial-type hearings "are more likely to be counterproductive, adding to the tensions that may have contributed to the patient's initial commitment," thereby interfering with successful long-term treatment.\textsuperscript{346} However, in \textit{Parham} the Court was concerned that a hearing upon an initial parent request for commitment would pit the "parents and child as adversaries," thereby risking an exacerbation of "whatever tensions already exist between the child and parents."\textsuperscript{347} This reasoning is wholly inapplicable to a hearing on the necessity of forced medication of a mentally ill adult patient by institutional authorities following an involuntary commitment. In addition, a hearing on the need for medication, even if decided in the affirmative, instills a sense of fairness in the patient. Not only is this perception of fair procedural treatment therapeutic in itself, but it often leads to greater cooperation in the treatment program which results in increased medical benefit.\textsuperscript{348} Finally, the increased administrative and financial costs inherent in additional procedural safeguards have never, in themselves, been deemed to outweigh fundamental constitutional interests.\textsuperscript{349} In the forced medication context, these costs appear to be more than offset by the benefits resulting from increased procedural protections.

STATE CASES

Since the emergence of the right to refuse medication in 1978, a substantial body of state case law has developed on the issue. No state court has deferred to professional judgment to the same extent as the Eighth and Fourth Circuits. In fact, the great majority of state courts addressing the issue have declined to apply the professional judgment standard to drug refusal cases. These courts have either distinguished \textit{Youngberg} or avoided the question of its precedential

\begin{footnotes}
\textsuperscript{345} Appelbaum & Gutheil, 137 AM. J. PSYCHIATRY at 345; Hassenfeld & Grumet, \textit{A Study of the Right to Refuse Treatment}, 12 BULL. AM. ACAD. PSYCHIATRY & L. 65, 72 (1984).
\textsuperscript{346} \textit{Rennie}, 653 F.2d at 851.
\textsuperscript{347} \textit{Parham}, 442 U.S. at 610.
\textsuperscript{348} \textit{See supra} notes 310-13 and accompanying text.
\textsuperscript{349} \textit{Davis}, 506 F. Supp. at 937-38; Rogers v. O'kin, 478 F. Supp. at 1369-70, 634 F.2d 650 (1st Cir. 1980), vacated and remanded sub nom. \textit{Mills v. Rogers}, 457 U.S. 291 (1982); \textit{Rivers}, 67 N.Y.2d at 495 n.6, 495 N.E.2d at 343 n.6, 504 N.Y.S.2d at 80 n.6; State \textit{ex rel. Jones v. Gerhardstein}, 141 Wis. 2d 710, —, 416 N.W.2d 883, 895 (1987). In \textit{Youngberg}, the Court was concerned with undue judicial interference with the internal operations of public institutions. \textit{Youngberg}, 457 U.S. at 322. However, when the inquiry concerns the constitutionality of institutional practices, it cannot be described as judicial interference. \textit{Jones}, 141 Wis. 2d at —, 416 N.W.2d at 896.
\end{footnotes}
effect by relying on state constitutional, statutory and common law to define the right to refuse antipsychotic medication.

The Oklahoma Supreme Court, in equating antipsychotic medication with such intrusive therapies as psychosurgery and electroshock, relied on the federal constitutional right to privacy as a source for the right to refuse. The court held that absent a police power emergency, competent patients have an absolute right to refuse medication. The court stated that because "competency is not a medical decision," a separate judicial determination is necessary. The court required an appointment of a guardian for those patients adjudicated incompetent and suggested the possible applicability of the substituted judgment standard.

A South Dakota court relied on the federal and state constitutional interest in privacy as well as state statutory law in finding that competent mental patients have an absolute right to refuse antipsychotic medication in nonemergency situations. In refusing to be bound by the professional judgment standard, the court stated that an adversarial judicial hearing "wherein 'professional judgment' testimony can be weighed with other testimony is a better method of determining both competency and necessity of use of antipsychotic drugs . . . ." The court also applied the least restrictive alternative doctrine to forced medication determinations.

The Court of Appeals of New York has held that the administrative review procedures previously affirmed by the Second Circuit in Project Release were not adequate to protect the privacy interests of committed mental patients under the state common law and state constitution. Absent an emergency, the court required a finding of incompetency before a patient could be medicated against his will for treatment purposes as "[o]therwise, the very justification for the state's purported exercise of its parens patriae power—its citizen's inability to care for himself . . . would be missing." The court required an adjudication of incompetency as "[s]uch a determination is uniquely a judicial, not a medical function." If a patient is found

351. Id. at 750.
352. Id. at 749-50.
353. Id. at 751-52 and n.16.
355. Id.
356. Id.
358. Id. at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80 (quoting Rogers v. Okin, 634 F.2d 650, 657 (1st Cir. 1980).
359. Id. (citations omitted).
incompetent, it is the court which is to go on to make the forced medication determination by considering all relevant circumstances, including the availability of any less intrusive alternative treatments.\footnote{360}

The unqualified professional judgment approach adopted by the federal district court in \textit{Stensvad} was nullified by the Wisconsin Supreme Court in \textit{State ex rel. Jones v. Gerhardstein}.\footnote{361} The court avoided the \textit{Youngberg} decision by relying on equal protection in holding that patients who have not been adjudicated incompetent have an absolute right to refuse unless medication is required to prevent serious physical harm to the patient or others.\footnote{362} As the issue of guardian appointments was not presented, court authorization was held necessary before incompetent patients could be forcibly medicated.\footnote{363} The court reasoned that "\textit{[c]onstitutional guarantees may not be replaced by professional judgment, and their protection and enforcement cannot be considered to be judicial interference.}"\footnote{364}

After remand of the \textit{Rogers} case by the Supreme Court, the First Circuit certified questions of state law to the Massachusetts Supreme Judicial Court.\footnote{365} Based on state statutory and common law, the Massachusetts court adopted a protective due process model in defining the scope of the right to refuse antipsychotic drugs.\footnote{366} The court limited the state's police power authority to compel medication to emergency situations requiring immediate action when no less intrusive alternatives are available.\footnote{367} Before medication can be compelled for treatment purposes, the court required a judicial determination of incompetency. For those patients found incompetent, the court must make the medication decision based on a substituted judgment standard.\footnote{368} Only when medication is necessary to prevent the "'immediate, substantial, and irreversible deterioration of a serious mental illness'" can it be forcibly administered for a limited time without a prior adjudication of incompetency.\footnote{369}

The Minnesota Supreme Court, in \textit{Jarvis v. Levine},\footnote{370} distinguished \textit{Youngberg} and stated that the professional judgment standard insufficiently protects the basic human right of privacy as

\footnotesize{\begin{itemize}
\item \textit{Id.} at 497-98, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.
\item 141 Wis. 2d 710, 416 N.W.2d 883 (Wis. 1987).
\item \textit{Id.} at —, 416 N.W.2d at 894-95.
\item \textit{Id.} at —, 416 N.W.2d at 898.
\item \textit{Id.} at —, 416 N.W.2d at 896.
\item Rogers \textit{v. Okin}, 738 F.2d 1, 3 (1st Cir. 1984).
\item \textit{Id.} at —, 458 N.E.2d at 321-22.
\item \textit{Id.} at —, 458 N.E.2d at 314-15.
\item \textit{Id.} at —, 458 N.E.2d at 322 (quoting \textit{In re Guardianship of Roe}, 383 Mass. 415, —, 421 N.E.2d 40, 55 (1981)).
\item 418 N.W.2d 139 (1988).
\end{itemize}}
recognized by the Minnesota constitution.\textsuperscript{371} Absent an emergency, the court required a judicial hearing on the issues of incompetency and the appropriateness of forced medication for patients adjudicated incompetent.\textsuperscript{372} The Colorado Supreme Court issued a similar decision based on state common law and statutory grounds.\textsuperscript{373} Additionally, a Florida appellate court found that under state law, a judicial determination of incompetency is required before medication can be compelled on treatment grounds because:

Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships.\textsuperscript{374}

For a patient adjudicated incompetent, medication may be authorized by the court for up to fourteen days. Thereafter, permission must be granted by an appointed surrogate exercising a substituted judgment.\textsuperscript{375}

Although several other state courts have rejected the professional judgment standard in drug refusal litigation,\textsuperscript{376} one decision is of special interest. In the 1988 case of Harper v. State,\textsuperscript{377} a convicted felon incarcerated in a correctional treatment facility charged that the forced administration of antipsychotic drugs violated his constitutional rights to equal protection, free expression and due process. The Washington Supreme Court held that because "antipsychotic drug treatment is no less intrusive than ECT," prisoners retain a fundamental privacy interest, arising from the due process clause of the fourteenth amendment, in refusing drug therapy.\textsuperscript{378}

An institutional administrative policy allowed forced medication either under the parens patriae authority to treat a gravely disabling mental disorder or on police power grounds after a finding that the prisoner presents a likelihood of serious harm to himself or others.\textsuperscript{379} Procedurally, the policy provided for an informal, in-house, adversarial hearing before a committee composed of a psychiatrist (other

\textsuperscript{371} Id. at 147-48.
372. Id. at 147-48, 148 n.7.
375. Id. at —, 243 Cal. Rptr. at 254.
378. Id. at —, 759 P.2d at 362.
379. Id. at —, 759 P.2d at 362.
than the treating physician), a psychologist and the associate superintendent. The policy also provided for a right to appeal the committee’s majority decision to the facility’s superintendent.380

The State of Washington relied on the Supreme Court decisions in Vitek v. Jones381 and Youngberg in arguing that a forced medication decision based on professional judgment meets due process requirements.382 Vitek involved the transfer of a prisoner to a mental hospital for treatment in a mandatory behavior modification program. In Vitek, the Supreme Court held that procedural due process required an adversarial hearing before an independent institutional decisionmaker (as opposed to a judge).383 The Washington Supreme Court, however, distinguished both Vitek and Youngberg, stating: “Here, we are concerned with the administration of mind altering drugs that have adverse, potentially permanent, side effects. We believe that the highly intrusive nature of antipsychotic drug treatment warrants greater protections than those necessary to protect the interests at issue in Vitek.”384 The court concluded that “a judicial hearing is required before the [state] may administer antipsychotic drugs to a prisoner against his will.”385

The court relied on its previous holding in In re Schouler,386 a case involving compelled electroconvulsive therapy, in defining the criteria for judicial authorization of forced drug therapy. The deciding court must first determine whether the prisoner’s refusal is competently made. If not, the court would then make a substituted judgment for the individual.387 A competent refusal or one arising from the substituted judgment can only be overridden by a compelling state justification.388 The court listed some state interests that are commonly asserted as sufficiently compelling to authorize forced medical treatment in general, but did not address which justifications

380. Id. at —, 759 P.2d at 362. The policy also provided for a 24-hour notice of an involuntary medication hearing; the right to be present and submit evidence; the assistance of a lay advisor; the right to cross-examine; and the right to periodic reviews involving the treating physician. Id. at —, 759 P.2d at 362.
383. Vitek, 445 U.S. at 494-95. The Court also required notice; disclosure of the evidence on which the state is relying; the opportunity to be heard and present documentary evidence; the right to present witnesses and cross-examine except upon finding of good cause for not permitting such presentation and confrontation; a written opinion by the factfinder; availability of legal counsel, furnished by the state to indigent prisoners who are unable to understand or exercise their rights; and notice of the foregoing rights. Id. at 494-97.
385. Id. at —, 759 P.2d at 363.
386. 106 Wash. 2d 500, 723 P.2d 1103 (1986).
388. Id. at —, 759 P.2d at 364.
are compelling enough to permit forced drug therapy. 389 If a compelling state interest is found, the court must then determine whether the proposed treatment is both necessary and effective, considering both the prognosis with and without the treatment as well as other less intrusive measures. 390

*Harper* is especially noteworthy because on March 6, 1989, the Supreme Court granted certiorari. 391 After avoiding the question on two previous occasions, the Supreme Court now appears willing to determine whether a constitutional right to refuse antipsychotic medication exists. The state court based the right on the constitutional privacy interests in freedom from unwarranted government intrusions into the mind and the freedom to make fundamental decisions concerning one's person. 392 Having decided the issue on these grounds, the court did not feel it necessary to reach the equal protection and first amendment claims. 393 Whether the Supreme Court will address these additional claims is uncertain. As explained earlier, the particular constitutional source relied on may determine the sufficiency of the state interest needed to override the right.

Another question raised is whether the Supreme Court will distinguish between the constitutional interests retained by a convicted prisoner and those retained by one subjected to involuntary civil commitment. In *Vitek*, the Supreme Court stated that: "A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the [s]tate to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections." 394 The patient in *Harper* had already been committed to a treatment facility. Unlike the prisoner in *Vitek*, he was not challenging the due process procedures involved in the transfer from prison. Thus, the interests at issue are those implicated by the forced medication of one already confined in a treatment facility, the same interests at issue in the decision to for-

389. *Id.* at —, 759 P.2d at 364 (citing *In re Schouler*, 106 Wash. 2d at —, 723 P.2d at 1108).


392. *Harper*, 110 Wash. 2d at —, 759 P.2d at 361. In declaring that the petitioner retained a liberty interest in refusing antipsychotic drugs, the court cited its previous decisions in *Schouler* and *Ingram*. These cases make it clear that the court was relying on the privacy interests in making fundamental personal decisions and remaining free from unwarranted government intrusions. *Id.* at —, 759 P.2d at 361. See *Schouler*, 106 Wash. 2d at —, 723 P.2d at 1108; *In re Guardianship of Ingram*, 102 Wash. 2d 827, —, 689 P.2d 1363, 1368 (1984).

393. *Harper*, 110 Wash. 2d at —, 759 P.2d at 361 n.2.

cibly treat an involuntary civil patient. These interests are different than the right to freedom from confinement at issue in a criminal conviction and sentence as well as an initial civil commitment determination. Thus, the retained interests of a prisoner in refusing intrusive forms of psychiatric treatment would appear to be no less than those of a civilly committed mental patient. 395

If the Supreme Court finds a constitutional right to refuse medication, it will have to address the state justifications sufficient to outweigh it. However, this determination may be limited by the fact that the patient was medicated because he was deemed to present a danger to others. 396 Thus, the Court's decision may only address the state's police power authority to compel drug therapy for security purposes based on a prediction of violent behavior if the patient is not medicated. If the Court limits its decision in this manner, the issues regarding a patient's competency to make treatment decisions will likely be avoided. Courts authorizing forced medication on police power emergency or dangerousness grounds have not deemed it necessary to address the patient's competence. Whether competent or not, if the patient presents a threat of violence reaching the requisite degree, forced medication has been authorized.

However, if the Court deems it necessary to address the facility's policy authorizing compelled medication under the parens patriae authority to treat a disabling mental disorder, questions concerning competency will be at issue. Either way, it appears the Supreme Court will also have to address the state court's application of the least restrictive alternative doctrine to forced medication decisions. Finally, the procedural mechanisms necessary to protect a patient's interest in refusing antipsychotic drugs will be at issue. It can be expected that the state will continue to assert that a forced medication decision based on professional judgment is adequate under due process requirements, thus eliminating the need for a prior judicial hearing. However, this issue may be limited to whether the facility's in-house, adversarial review process is sufficient when the state's interest is the prevention of violence.

It appears the state will argue that because the patient is a convicted felon incarcerated in a forensic treatment facility, the standard of review adopted by the Supreme Court in Turner v. Safley 397

---

should apply. In *Turner*, the Court addressed an inmate challenge to prison regulations restricting inter-institutional correspondence and inmate marriages. In articulating a standard of review, the Court stated that “when a prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests.” The Court reasoned that “[s]ubjecting the day-to-day judgments of prison officials to an inflexible strict scrutiny analysis would seriously hamper their ability to anticipate security problems and to adopt innovative solutions to the intractable problems of prison administration.”

The Court described a number of factors as relevant in determining the reasonableness of a prison regulation. First, there must be a valid and rational relation between the regulation and the legitimate penological interest. The relation must not be so remote as to render the government action arbitrary or irrational. The second factor is whether there are alternative means for inmates to exercise their asserted right. A third consideration is whether an accommodation of the inmate’s interest will adversely impact on the rights of others within the prison and on the resources available to preserve institutional order. Finally, the existence of ready and easy alternatives may be evidence that the regulation at issue is an exaggerated response to prison concerns. In elaborating on this final consideration, the Court stated that:

This is not a “least restrictive alternative” test: prison officials do not have to set up and then shoot down every conceivable alternative method of accommodating the claimant’s constitutional complaint. But if an inmate claimant can point to an alternative that fully accommodates the prisoner’s rights at de minimis cost to valid penological interests, a court may consider that as evidence that the regulation does not satisfy the reasonable relationship

---

399. *Turner*, 107 S. Ct. at 2261. In adopting this standard, the Supreme Court reversed the strict scrutiny analysis deemed necessary by the Eighth Circuit in the opinion below. *Id.* at 2260-61. See *Saffley v. Turner*, 777 F.2d 1307, 1314 (8th Cir. 1985). It is interesting to note that while the Eighth Circuit was willing to apply strict scrutiny to prison regulations restricting inmate correspondence and marriage, it applied the “reasonableness” standard of review to the forced administration of potentially hazardous drugs to an involuntarily committed mental patient in *Dautremont*.
400. *Id.* at 2262.
401. *Id.*
402. *Id.*
403. *Id.* The Court stated that when the inmate’s asserted rights significantly impact on the rights of fellow inmates, deference should be given to the decision of prison officials. *Id.*
404. *Id.*
The Turner standard, adopted by a five to four majority, is confusing in a number of respects. Because of the emphasis the Court places on prison security, it could be interpreted as a reiteration of the accepted principle that the state's police power interest in preventing violence is, under certain circumstances, sufficiently compelling to override constitutionally protected rights. However, a literal reading of the Court's opinion would indicate that any rational penological objective is sufficient to outweigh a constitutionally protected interest, regardless of the nature of that interest and the degree of intrusiveness presented by the government action. As the dissent indicated, such an application "would seem to permit disregard for inmates' constitutional rights whenever the imagination of the warden produces a plausible security [or any other valid] concern and a deferential trial court is able to discern a logical connection between that concern and the challenged regulation."

Applying the standard from this perspective to the forced psychiatric treatment of incarcerated individuals, it would appear that such intrusive interventions as psychosurgery, electroconvulsive therapy and administration of antipsychotic drugs would warrant the same level of scrutiny as a restriction on reading hours in the prison library. And, as Justice Brennan stated, while "[v]arious 'factors' may be weighed differently in each situation, . . . the message to prison officials is clear: merely act 'reasonably' and your actions will be upheld. . . . [T]he Court deems this single standard adequate to restrain any type of conduct in which prison officials might engage."

This reading of the Turner standard appears to be little different than the professional judgment standard as applied by the Eighth Circuit in Dautremont v. Broadlawns Hospital and the Fourth Circuit in Charters II. In addressing the constitutional rights of an individual incarcerated as incompetent to stand trial, the Charters II court stated that "[t]hese retained interests must yield to the legitimate government interests that are incidental to the basis for legal institutionalization . . . and are only afforded protection against arbitrary and capricious government action." In Dautremont, the Eighth Circuit applied the same standard to an involuntarily commit-
ted civil patient. Both the Fourth and the Eighth Circuits relied on Youngberg in going on to hold that a decision to forcibly medicate is presumptively reasonable if based on the professional judgment of appropriate institutional personnel.

However, despite the inappropriateness of this standard as discussed earlier and reemphasized below, if Turner is applied to patients incarcerated in correctional facilities, the factors enunciated by the Court may nonetheless dictate against a finding that forced medication is a reasonable government action. Under Turner's diluted version of the least restrictive alternative principle, forcible medication with antipsychotic drugs may not even "reasonably relate" to the concededly legitimate goal of prison security. Considering the availability of ready and easy alternatives such as segregation or the use of less intrusive drugs like tranquilizers or sedatives, forced administration of antipsychotic medication with its accompanying potential hazards would appear to be an "exaggerated response" to security concerns. And while the treatment of both serious physical and mental disorders is a legitimate penological objective as well as a constitutional duty:

The premise underlying this duty is that the state may not deliberately fail to provide medical treatment when it is desired by the detainee. . . . This constitutional requirement cannot be turned on its head to mean that if a competent individual chooses not to undertake the risks or pains of a potentially dangerous treatment, the jail may force him to accept it.411

CONCLUSION

A fair reading of the Youngberg v. Romeo opinion indicates that the Court applied its traditional framework for determining whether government action unconstitutionally infringes upon protected individual interests. The Court began its analysis by recognizing that the developmentally disabled patient retained liberty interests in safety and freedom from physical restraint protected by the due process clause of the fourteenth amendment.412 Noting that constitutional rights are not absolute, the Court went on to balance the asserted liberty interests against the state's reasons for infringement.413 As

410. See Bee v. Greaves, 744 F.2d 1387, 1396 (10th Cir. 1984), cert. denied, 105 S. Ct. 1187 (1985); see also supra notes 288-98 and accompanying text. Nor would the use of these less restrictive approaches adversely impact on the interests of others within the institution or on the allocation of prison resources for preserving institutional order.
411. Bee, 744 F.2d at 1395.
413. Id. at 319-20.
stated earlier, a government encroachment on interests of this nature must, at a minimum, be reasonably related to legitimate government objectives. However, as the intrusiveness of the infringement rises, the sufficiency of the state's justification must also increase. In *Youngberg*, the Court noted that the protected interests at issue were to some extent in conflict, as physical restraint was often necessary to assure the respondent's personal safety. In addition, the type of restraint was mild in character. In considering the nature of the interests at stake and the level of intrusiveness presented, the Court concluded that the restrictions should be upheld upon the minimal showing of a reasonable relation to legitimate objectives. The Court then articulated the professional judgment standard as a method for a reviewing court to determine whether the state's showing is sufficient.

Under this interpretation of the *Youngberg* opinion, the professional judgment doctrine is nothing more than a standard of review which simply "denotes the degree of deference that a reviewing court gives to the actions or decisions under review." As Justice Brennan stated: "A standard of review frames the terms in which justification may be offered, and thus delineates the boundaries within which argument may take place. The use of differing levels of scrutiny proclaims that on some occasions official power must justify itself in a way that otherwise it need not."

However, by automatically applying *Youngberg's* professional judgment standard to drug refusal cases, courts such as the Eighth and Fourth Circuits are misusing a standard of review to define constitutional rights, as opposed to assuring that these rights are appropriately implemented. Under the rubric of "professional judgment," the protected interests implicated by the forced administration of potentially hazardous drugs are automatically equated to the interests at issue in *Youngberg*. As a result of this blind extension of *Youngberg*, any retained interests of an involuntarily committed individual "must yield to the legitimate government interests that are incidental to the basis for legal institutionalization . . . and are only afforded protection against arbitrary and capricious government

\[\footnotesize{414. \text{Id. at 320.}}\]
\[\footnotesize{415. \text{Id. at 320-22.}}\]
action."419 This appears to remain true regardless of the nature of the interests at stake and the extent of the intrusion presented.

What is most frightening is that a literal reading of the Turner v. Safley decision would indicate that a majority of the Supreme Court is willing to utilize this inverted framework for constitutional analysis, at least in the context of penal facilities. Extending this approach to the involuntarily committed would serve to justify any type of psychiatric intervention as long as it can be logically connected to a plausible institutional concern.420 As a result, the substantive constitutional rights of mental patients become "no more than an entitlement to a professional judgment... and the constitutional guarantee of due process is deemed satisfied by whatever medical judgment happens to be recognized in the psychiatric science of the day."421

Psychiatry is, as of yet, an imprecise science which has not been free of serious and tragic error.422 Indeed, the use of psychosurgery was once an accepted therapy that has since fallen into disrepute because of its irreversible and dangerous consequences.423 Psychopharmacology is still in an early stage of development. Antipsychotic drugs affect the essence of humanness—the chemical structure of the mind—in a manner which is not yet understood. There is not even a consensus on the cause of the illness which the drugs are used to control.424 Moreover, all antipsychotic drugs are capable of


420. As Justice Brennan stated: "Once we provide such an elastic and deferential principle of justification, '[t]he principle... lies about like a loaded weapon ready for the hand of any authority that can bring forth a plausible claim of an urgent need. Every repetition imbeds that principle more deeply in our law and thinking and expands it to new purposes." O'Lone, 107 S. Ct. at 2409 (citation omitted).


422. As one commentator stated: "Psychiatry is handicapped by its subject matter. Not only has human behavior thus far resisted scientific understanding, but its study is notoriously subject to passing political tides and cultural fashions." Gelman, 72 GEO. L.J. at 1762. See also 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, 1161 (1976) (stating that "[t]he biases built into the clinical observations of psychiatrists have led to a tendency toward 'faddishness' in psychiatric treatment").

423. See, e.g., DuBose, 60 MINN. L. REV. at 1161. A 1969 study of 134 lobotomized patients revealed that 50 percent of these individuals suffered disabling seizures and 25 percent were severely intellectually impaired. See Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 NW. U.L. REV. 461, 469 (1978). One doctor was involved in performing over 3,500 lobotomies during his career. Id. at 468. See also Gelman, 72 GEO. L.J. at 1761 (asserting that "there is no reason to think that psychiatry's internal processes—its capacity to detect the harms it inflicts and its willingness to deal with those harms meaningfully—have changed in any fundamental way since lobotomy's heyday").

424. See supra notes 19-20 and accompanying text.
producing serious and sometimes irreversible side effects. The prevalence of these side effects is alarming, with the most dangerous, tardive dyskinesia, recently being labeled a national health concern.425

And yet, many institutional psychiatrists remain unskilled and ill-trained in psychopharmacology despite almost total reliance on this form of treatment.426 High dosages of antipsychotic medication continue to be prescribed over prolonged periods for an expanding variety of conditions, although the efficacy of drug therapy for many of those conditions has not been established.427 It has been reported that even today, seven out of ten psychoactive prescriptions are written by nonpsychiatric physicians.428

To exacerbate matters, public mental health facilities continue to be plagued by overcrowded, understaffed and poorly financed conditions. A recent legislative investigation revealed that state mental institutions are staffed by some of the health care profession's most undertrained personnel.429 Patients continue to be subjected to abuse, physical injury, intimidation, harassment and substandard living conditions. Medication is the predominant form of treatment, often administered for the purpose of control as determined by direct-care staff.430 Despite the growing awareness of the dangers and limits of drug therapy by the academic branch of the psychiatric profession, institutional clinicians continue to be governed by the mindset that "drugs can do no wrong."431

Given this continuing state of affairs, it is inappropriate to shift concern for the protection of the constitutional rights of institutionalized patients to state mental health officials through a virtually un-

425. See supra notes 50-51 and accompanying text.
426. See R. SOVNER, ASSESSING THE QUALITY OF A PSYCHOTROPIC DRUG REGIMEN IN THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 48 (1986); Brooks, supra note 16, at 251.
428. Id.
429. Staff Report on the Institutionalized Mentally Ill Disabled, summarized in 9 MENTAL & PHYSICAL DISABILITY L. REP. 154 (1985) [hereinafter Staff Report]; see also Brooks, supra note 16, at 210-11 (stating that “[m]any 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”); Dix, Realism and Drug Refusal: A Reply to Appelbaum and Gutheil, 9 BULL. AM. ACAD. PSYCHIATRY & L. 180, 182 (1981) (citing American Psychiatric Association President Dr. Donald Langley, who stated, “[m]any, if not most, of the medical staff [of state mental hospitals] turn out to be poorly trained in comparison with psychiatrists from other settings”) (citation omitted).
430. Staff Report, supra note 429, at 154.
431. Dix, 9 BULL. AM. ACAD. PSYCHIATRY & L. at 182.
qualified deference to professional judgment. Even when appropriately applied as a standard of review, the professional judgment doctrine offers woefully inadequate protection for the important constitutional interests implicated by intrusive forms of psychiatric treatment. Such a standard renders any right to refuse illusory and, in reality, merely provides an after-the-fact remedy for patently arbitrary interventions, a remedy which may be meaningless to a patient afflicted with irreversible adverse side effects. The institutionalized mentally disabled represent a long-ignored segment of our population. The positive reforms in this country's public mental health system over the past fifteen years are, in large part, attributable to the judiciary's willingness to actively intervene in protecting the constitutional rights of the mentally disabled. The professional judgment standard is a step back to the days when patients' constitutional rights were subject to unfettered psychiatric discretion practiced behind institutional walls.