

1998

Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs

William M. Brooks
Touro Law Center

Follow this and additional works at: <https://digitalcommons.tourolaw.edu/scholarlyworks>



Part of the [Civil Rights and Discrimination Commons](#), [Constitutional Law Commons](#), [Disability Law Commons](#), and the [Other Law Commons](#)

Recommended Citation

31 *Indiana L. Rev.* 937 (1998)

This Article is brought to you for free and open access by the Faculty Scholarship at Digital Commons @ Touro Law Center. It has been accepted for inclusion in Scholarly Works by an authorized administrator of Digital Commons @ Touro Law Center. For more information, please contact lross@tourolaw.edu.

REEVALUATING SUBSTANTIVE DUE PROCESS AS A SOURCE OF PROTECTION FOR PSYCHIATRIC PATIENTS TO REFUSE DRUGS

WILLIAM M. BROOKS*

My medical regimen during my hospital stays usually didn't consist of much more than doses of drugs—usually Thorazine. When I took the prescribed amount, I was usually out of Bellevue in three or four days. But I hated the effect of the drug. It was like putting my head in a vise; it cut off the free flow of ideas; it stifled imagination; it literally killed inspiration.¹

INTRODUCTION

The right of psychiatrically hospitalized patients to refuse drugs has been characterized as arguably the most important subject in the area of mental health law.² Thus, it is hardly surprising that this issue has generated much controversy and heated discussion.³ Every state takes action to involuntarily hospitalize mentally ill individuals deemed dangerous to self or others and numerous states

* Associate Professor of Law, Touro College, Jacob D. Fuchsberg Law Center. B.A., 1976, Ohio Wesleyan University; J.D., 1979, State University of New York at Buffalo School of Law. The author would like to thank Professors Martin Schwartz and Eileen Kaufman of Touro Law Center for their helpful comments and suggestions on this article.

1. Richard Kopperdahl, *Bettervue Hospital*, THE VILLAGE VOICE, Oct. 3, 1995, at 33.
2. Michael L. Perlin, *Reading the Supreme Court's Tea Leaves: Predicting the Judicial Behavior in Civil and Criminal Right to Refuse Treatment Cases*, 12 AM. J. FORENSIC PSYCHIATRY 37, 40 (1991).
3. See Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 286 (1992) (commenting that shortly after the filing of the initial right to refuse cases, "[t]he right to refuse antipsychotic drugs soon became the most controversial and divisive issue between the medical and legal professions"); Franklin J. Hickman et al., *Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal*, 6 MENTAL DISABILITY L. REP. 122, 122 (1982). See also Catherine E. Blackburn, *The "Therapeutic Orgy" "and the 'Right to Rot'" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 447 (1990) (discussing the heated controversy over the right to refuse drugs). Professor Blackburn highlighted the emotional tenor of this dispute in the title of her article by incorporating two of the more perjorative descriptions of the impact of antipsychotic medication and the consequences of permitting patients to refuse such treatment. These pejorative descriptions came from two sources: (1) a lawyer characterized institutional psychiatrists as subjecting patients to an "orgy" of drug treatment, Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461, 461 (1978); and (2) shortly thereafter, two leading psychiatrists maintained that granting patients the right to refuse medication provided them with the opportunity to "rot with their rights on," Paul S. Appelbaum & Thomas G. Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 AM. ACAD. PSYCHIATRY & L. 306, 306-07 (1979) [hereinafter "*Rotting With Their Rights On*"].

grant such authority to persons in the medical profession.⁴ Indeed, seventeen states authorize confinement for the express purpose of providing treatment to mentally ill patients.⁵ Under these circumstances, numerous psychiatrists have questioned and assailed the propriety of permitting a psychiatric patient who theoretically fails to understand the need for treatment to refuse the very medication a psychiatrist has prescribed to treat the patient's mental illness.⁶ The psychiatric profession has accused the legal system of failing to take into account "clinical realities" when it broadly defines the right to refuse medication.⁷ The psychiatric profession further believes that the right of patients to refuse medication destroys physicians' ability to manage patients, disrupts ward milieu, and exacerbates the refuser's illness.⁸

In contrast, both the legal and medical professions recognize that psychotropic medication in general, and antipsychotic medication in particular,⁹ often produce side effects ranging in nature from short-term and merely discomforting to permanent and life-threatening.¹⁰ Furthermore, the common law has long recognized that competent adults may determine their own course of treatment.¹¹ In addition, virtually every state provides that notwithstanding involuntary commitment, patients remain competent as a matter of law absent a specific finding to the contrary.¹² Thus, it is not surprising that mental patients, their lawyers and legal scholars have challenged any unbridled authority to administer medication in the best interests of the patient without consent.¹³ Such challenges are particularly understandable when one recognizes that institutional considerations and not the well-being of patients may motivate the treatment

4. See SAMUEL J. BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 101-09, 159-60 (1985).

5. *Id.* at 114, 159-60. Indeed, as the Constitution prohibits the commitment of any individual who does not suffer from mental illness, *Foucha v. Louisiana*, 504 U.S. 71, 77-78 (1992), the commitment of everyone, at least implicitly, involves the provision of treatment.

6. See, e.g., Paul S. Appelbaum, *The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect*, 145 AM. J. PSYCHIATRY 413, 417 (1988); Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1049 (1988).

7. See, e.g., Paul S. Appelbaum & Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 345 (1980); "Rotting With Their Rights On", *supra* note 3, at 315; Schwartz et al., *supra* note 6, at 1049.

8. Blackburn, *supra* note 3, at 485.

9. See *infra* notes 55-57 and accompanying text for a discussion of the difference between psychotropic and antipsychotic medication.

10. See *infra* notes 76-126 and accompanying text.

11. See, e.g., *Schloendorff v. Society of N.Y. Hospital*, 211 N.Y. 125 (1917), *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960). See generally Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1736 (1982) [hereinafter *Common Law Remedy*].

12. See *infra* note 507 and accompanying text.

13. See generally Cichon, *supra* note 3.

decisions of psychiatrists.¹⁴

Litigation over the right to refuse medication began in a New Jersey court with an anonymous patient.¹⁵ Challenges commenced in earnest a few years later with the filing of two class action lawsuits in United States district courts: *Rogers v. Okin*¹⁶ and *Rennie v. Klein*.¹⁷ However, the willingness of federal courts to provide protection to patients who sought to refuse medication abruptly halted after 1980 when the Supreme Court remanded one of these cases, *Rennie v. Klein*,¹⁸ in light of its decision in *Youngberg v. Romeo*,¹⁹ a case that addressed the issue of a mentally retarded person's right to treatment, not the right to refuse treatment. In *Youngberg*, the Supreme Court held that treatment decisions by professionals in an institution for individuals with mental retardation are presumptively valid and such decisions will not violate an individual's right to treatment unless they constitute "a substantial departure from accepted professional judgment, practice or standards."²⁰ As a result, between 1980 and 1990, federal courts that addressed the issue of the right of civilly committed patients to refuse medication invariably applied the *Youngberg* professional judgment standard. Those courts held that patients could not refuse medication unless the decision to administer drugs constituted a substantial departure from accepted judgment, practice or standards.²¹

However, during the same time period, many state courts issued decisions broadly defining the right to refuse drugs.²² State court decisions such as *Rivers*

14. See Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 665 (1992).

15. *In re B.*, 383 A.2d 760 (N.J. Super. Ct. Law Div. 1977).

16. 478 F. Supp. 1342 (D. Mass. 1979) [hereinafter *Rogers I*], *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980) [hereinafter *Rogers II*], *vacated sub nom.*, *Mills v. Rogers*, 457 U.S. 291 (1982) [hereinafter *Rogers III*], *opinion on remand sub nom.*, *Rogers v. Okin* 738 F.2d 1 (1st Cir. 1984) [hereinafter *Rogers IV*].

17. 476 F. Supp. 1294 (D.N.J. 1979) [hereinafter *Rennie II*], *stay granted by* 481 F. Supp. 552 (D.N.J. 1979), *vacated en banc*, 653 F.2d 836 (3d Cir. 1981) [hereinafter *Rennie III*], *vacated and remanded*, 458 U.S. 1119 (1982) [hereinafter *Rennie IV*], *opinion on remand*, 720 F.2d 266 (3d Cir. 1983) (en banc) [hereinafter *Rennie V*].

18. *Rennie IV*, 458 U.S. at 1119.

19. 457 U.S. 307 (1982).

20. *Id.* at 323.

21. See, e.g., *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960, 980-81 (2d Cir. 1983); *Rennie V*, 720 F.2d at 269-79; *R.A.J. v. Miller*, 590 F. Supp. 1319, 1321-22 (N.D. Tex. 1984).

22. See, e.g., *Anderson v. State*, 663 P.2d 570, 575 (Ariz. Ct. App. 1982); *Riese v. Saint Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 208-09 (Cal. Ct. App. 1987); *People v. Medina*, 705 P.2d 961, 967-68 (Colo. 1985); *Goedecke v. Department of Insts.*, 603 P.2d 123, 125 (Colo. 1979) (per curiam); *In re M.P.*, 510 N.E.2d 645, 646 (Ind. 1987); *Rogers v. Department of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983); *Jarvis v. Levine*, 418 N.W.2d 139, 148 (Minn. 1988); *Opinion of the Justices*, 465 A.2d 484, 488-89 (N.H. 1983); *Rivers v. Katz*, 495 N.E.2d 337, 342-43 (N.Y.

*v. Katz*²³ and *Riese v. Saint Mary's Hospital*,²⁴ supporting the right of patients to refuse drugs contrasted with the willingness of federal courts to defer to clinical professionals' judgment in similar cases, led many authorities to dismiss federal courts as a forum for protecting individuals from forcible administration of medication. Accordingly, mentally ill individuals would have to turn to state courts as a source of protection.²⁵

However, since 1990, the Supreme Court has addressed the right to refuse medication in two other contexts: when a psychiatric patient is in a prison setting,²⁶ and when a state seeks to forcibly administer medication to induce a criminal defendant's competency.²⁷ In each case, the Supreme Court issued opinions that clearly support a far broader reading of the right to refuse under the Federal Constitution than the professional judgment standard of *Youngberg*.²⁸ These decisions have led to a re-evaluation of whether the post-*Rennie IV* cases warranted rejection of the Federal Constitution as a source of protection for a patient's right to refuse drugs.²⁹

Even prior to these recent Supreme Court decisions, the dismissal of the Federal Constitution as a source of the right to refuse drugs was troubling. Since the passage of the post-Civil War era legislation, including the Fourteenth Amendment, "the role of the Federal Government as a guarantor of basic federal rights against state power was clearly established."³⁰ As such, the Federal Constitution has historically served as a shield against intrusive governmental behavior and a sword to uphold individual liberty in many different contexts.³¹

1986); *In re K.K.B.*, 609 P.2d 747, 749-50 (Okla. 1980); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 892-93 (Wisc. 1987).

23. *Rivers*, 495 N.E.2d at 337.

24. 271 Cal. Rptr. 199 (Cal. Ct. App. 1987).

25. Perlín, *supra* note 2, at 43; Ellen Wright Clayton, *From Rogers to Rivers: The Rights of the Mentally Ill to Refuse Medication*, 13 AM. J.L. & MED. 7, 9 (1987).

26. *Washington v. Harper*, 494 U.S. 210 (1990).

27. *Riggins v. Nevada*, 504 U.S. 127 (1992).

28. 457 U.S. 307 (1982). For a discussion of *Harper* and *Riggins*, see *infra* notes 195-212 and accompanying text.

29. See, e.g., MICHAEL L. PERLIN, 2 MENTAL DISABILITY LAW § 5.65A at 90 (Supp. 1996).

30. *Mitchum v. Foster*, 407 U.S. 225, 239 (1972) (citations omitted). As one federal court noted, "If federal courts have any overriding reason for being, it is a source of protection to any person who believes there is a serious violation of his or her federal constitutional rights—particularly by government officials. The institutionalized mentally disabled are especially prone to abuse unless they can turn to the federal courts for protection." *Society for Good Will to Retarded Children v. Cuomo*, 652 F. Supp. 515, 518 (E.D.N.Y. 1987) (citations omitted).

31. See, e.g., *Roe v. Wade*, 410 U.S. 113, 153 (right to abortion), *reh'g denied*, 410 U.S. 459 (1973); *Shapiro v. Thompson*, 394 U.S. 618, 629 (1969) (right to travel); *Reynolds v. Sims*, 377 U.S. 533, 551 (right to vote), *reh'g denied*, 379 U.S. 870 (1964). Beyond the historical role of the federal courts, the Eleventh Amendment bars federal courts from enjoining state officials based upon state law. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 117 (1984). Hence, any attempts to invoke the protection of the federal courts must rely upon federal law.

Moreover, even in jurisdictions where state law affords significant protection against forced drugging, the existence of a broad right to refuse medication under the Federal Constitution has a number of practical consequences. First, for those patients who wish to seek damages for the unlawful administration of medication, the statute of limitations for a federal cause of action pursuant to 42 U.S.C. § 1983³² may well be longer than the state statute of limitations for intentional torts.³³ Second, a party who prevails in a lawsuit pursuant to 42 U.S.C. § 1983 is entitled to attorney fees.³⁴ Common sense suggests that the threat of paying fees may well serve to induce recalcitrant government officials to settle disputes with patients that they might not otherwise settle in the absence of this statutory fee shifting provision. Furthermore, many individuals who have been forcibly and unlawfully drugged do not suffer any long-term, and perhaps, even short-term, physical harm.³⁵ Moreover, it is difficult to measure the loss of dignity that a patient suffers when hospital staff hold him down so that a nurse may inject medication. This absence of measurable harm limits the ability of patients to secure legal assistance on a contingency basis as it will be a rare member of the private bar who agrees to represent a patient on a contingency basis with only non-pecuniary interests at stake.³⁶ The availability of attorney

32. 42 U.S.C. § 1983 (1994). Section 1983 creates causes of action for violations of rights under the Federal Constitution or federal statutes, but not state law. *See, e.g., Baker v. McCollan*, 443 U.S. 137, 146-47 (1979).

33. A state's "general or residual limitation's statute for personal injury actions" governs lawsuits filed pursuant to 42 U.S.C. § 1983. *Owens v. Okure*, 488 U.S. 235, 249-50 (1989). For example, in New York, the general limitations period is three years. *Id.* However, New York's limitations period for intentional torts, such as assault and battery, is one year. N.Y. CIV. PRAC. L. & RULES § 215 (McKinney 1990). *Compare James v. Sadler*, 909 F.2d 834, 836 (5th Cir. 1990) (three year limitations period in Mississippi for § 1983 actions), *with MISS. CODE ANN. § 15-1-35* (West 1972) (one year limitations period for assault and battery); *Bauers v. City of Lincoln*, 514 N.W.2d 625, 634 (1994) (four year limitations period in Nebraska for § 1983 actions) *with NEB. REV. STAT. § 25-208* (1996) (one year limitation period for assault and battery); *Gray v. Lacke*, 885 F.2d 399, 408-09 (7th Cir. 1989) (six year limitations period in Wisconsin for § 1983 actions) *with WIS. STAT. ANN. § 893.57* (West 1996) (two-year limitations period for assault and battery). For an illustration of the various limitations periods for state causes of action that may also prompt a § 1983 lawsuit, see *Owens*, 488 U.S. at 244 n.8.

34. 42 U.S.C. § 1988 (1994).

35. See *infra* notes 78-92 and accompanying text for a discussion of temporary side effects that medication produces.

36. The Protection and Advocacy for Mentally Ill Individuals Amendments Act of 1991 authorizes federally funded advocacy programs to provide legal representation to institutionalized mentally ill individuals. 42 U.S.C. § 10805(a)(1)(C) (1994). However, Protection and Advocacy programs, as well as other government programs that provide legal services to civilly committed patients, have limited resources. *See Steven J. Schwartz et al., Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 RUTGERS L.J. 541, 550-53 (1983). Little question exists that Protection and Advocacy offices by themselves do not have the ability to address all the legal needs of institutionalized mentally ill

fees may well enhance a patient's ability to secure legal assistance.³⁷

Finally, availability of a federal remedy may make it easier for a plaintiff or his attorney to obtain injunctive relief to prevent unlawful medication practices. The short-term nature of many psychiatric hospitalizations creates a substantial risk that claims involving unlawful medication practices will become moot before a court rules on the legality of the particular practice.³⁸ However, in the federal courts, certification of a class action will defeat any mootness claim as long as a legal controversy exists between any plaintiff class member and a defendant.³⁹ For this reason it may be advantageous for a plaintiff or his attorney to seek relief in federal court.⁴⁰

individuals.

37. A statement by a leading psychiatrist illustrates the need for an effective damages remedy: "No matter what the law does, we'll always [d]rug 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 [drugged]." Cichon, *supra* note 3, at 387 (quoting Dr. Loren Roth in *Conference Report, Refusing Treatment in Mental Health Institutions: Values in Conflict*, 32 HOSP. & COMMUNITY PSYCHIATRY 255, 257 (1981)).

38. See *Goetz v. Crosson*, 728 F. Supp. 995, 1000-01 (S.D.N.Y. 1990) (recognizing transitory nature of claims of involuntarily hospitalized patients).

39. See, e.g., *Sosna v. Iowa*, 419 U.S. 393, 402 (1975); *United States Parole Comm'n v. Geraghty*, 445 U.S. 399, 404 (1980).

40. For instance, generally, a court may certify a lawsuit as a class action only if a ripe claim exists at the time of certification. *Sosna*, 419 U.S. at 403. However, when a claim is of such transitory nature that it is not likely to remain ripe until class certification, federal courts will invoke the "relation-back" doctrine to certify the class. Criteria for the "relation-back" doctrine includes: (1) a ripe controversy existed when the named plaintiff filed the lawsuit; and (2) there is a "constant existence of a class of persons suffering the deprivation." *Gerstein v. Pugh*, 420 U.S. 103, 110-11 n.11 (1975).

Furthermore, federal courts may be more willing to certify class actions than some state courts. For example, in New York, the government operations rule holds that a court should not certify a lawsuit against a state agency because the doctrine of *stare decisis* will adequately protect similarly situated class members. See, e.g., *Jones v. Berman*, 332 N.E.2d 303, 311 (N.Y. 1975) (citations omitted); *Martin v. Lavine*, 346 N.E.2d 794, 796 (N.Y. 1976) (citations omitted). Even if such premise is correct (and there is some question about whether it is, see Daan Braveman, *Class Certification in State Court Welfare Litigation: A Request for Procedural Justice*, 28 BUFFALO L. REV. 57, 79-81 (1979)), it fails to consider the role class actions play in maintaining justiciable controversies enabling courts to address claims that are short-lived in nature but impact upon many individuals. See, e.g., *Alston v. Coughlin*, 109 F.R.D. 609, 612 (S.D.N.Y. 1976); *Mendoza v. Lavine*, 72 F.R.D. 520, 523 (S.D.N.Y. 1976).

In *Ruiz v. Acrish*, 89 Civ. 2935 (S.D.N.Y. October 25, 1989), the court certified a class of patients challenging a medication practice on the ground that certification eliminated the "very real possibility of the plaintiff's claims becoming moot prior to a determination on the merits." Slip. op. at 6. The lawsuit resulted in a state-wide settlement that eliminated the practice of physicians authorizing medication over objection on a PRN, i.e., as needed, basis for agitation even if a patient was not dangerous.

The right to refuse medication has two components.

‘The substantive issue involves a definition of th[e] protected constitutional interest, as well as the identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual’s liberty interest is actually outweighed in a particular instance.’⁴¹

This Article will address the scope of a civilly committed patient’s right to refuse medication under the substantive component of the Due Process Clause. It will first examine how federal courts, including the Supreme Court, have addressed an individual’s substantive right to refuse medication. This Article will then establish that even prior to *Harper* and *Riggins*, there was ample authority to support a broad right to refuse medication under the substantive component of the Due Process Clause of the Fourteenth Amendment. *Harper* is particularly significant because it reaffirms the notion that state law can, and will, define the scope of protections under the Federal Constitution.⁴² This Article will then examine Supreme Court case pertaining to the scope of substantive protections accorded by the Due Process Clause and those cases’ impact on the right to refuse. The analysis will include how the least restrictive alternative theory is appropriately applied in the refusal of treatment context.

An analysis of the Fourteenth Amendment right to refuse drugs requires an analysis of the textual source of this right and a determination of whether it is a fundamental right that would result in the greatest protection for patients. Regardless of whether the right to refuse is fundamental, this analysis also requires an examination of what state interests will override a patient’s interest in refusing medication and what standard of review courts should apply when examining the government’s efforts to override a patient’s attempt to refuse drugs. It is also necessary to explore the interrelationship between right to refuse cases with other cases involving decisions to decline treatment such as the right to refuse civil commitment and the right to die. Those cases detail the balance of relevant state interests that a court must weigh against a patient’s decision to refuse drugs. Finally, the Supreme Court’s remand in *Rennie IV* must be reconciled with its remand of *Rogers III*.⁴³

Finally, one must examine how the doctrine of state-created liberty interests impacts the right to refuse medication. Such an examination details that existing law in most states creates a broad right that the Federal Constitution protects. These considerations reveal that the right to refuse medication under the Fourteenth Amendment is far broader than has been recognized and affords patients the right to refuse except when they create an emergency within a hospital setting or are found to be incompetent to make decisions about the

41. *Washington v. Harper*, 494 U.S. 210, 220 (quoting *Rogers III*, 457 U.S. at 299).

42. *Id.*

43. *Compare Rennie IV*, 458 U.S. at 1119, with *Rogers III*, 457 U.S. at 291.

administration of medication.⁴⁴

I. THE NATURE OF PSYCHOTROPIC MEDICATION⁴⁵

In state-operated psychiatric hospitals, psychotropic drug treatment is the primary form of treatment.⁴⁶ In many mental health facilities, for all intents and purposes, medication is the only treatment patients receive.⁴⁷ It is estimated that up to three million people each year receive antipsychotic medication.⁴⁸

The forcible administration of medication involves injecting medication into

44. While ample authority supports the proposition that the Federal Constitution provides broader substantive protections to civil patients, one cannot say the same for the procedural component of the Due Process Clause. The Supreme Court has often recognized that the Constitution provides less procedural protections to individuals when interests other than one's physical liberty are at stake than when physical liberty itself is at risk. *See, e.g., Lassiter v. Department of Social Servs.*, 452 U.S. 18, 26-27 (1981); *Scott v. Illinois*, 440 U.S. 367, 373 (1979). Second, the Supreme Court has shown a willingness to interpret the Fourteenth Amendment as requiring only informal professional review when liberty interests are at stake in psychiatric settings. *See Harper*, 494 U.S. at 231 (finding that in a prison setting "an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge"); *Parham v. J.R.*, 442 U.S. 584, 613-17 (1979) (approving informal medical procedures for the admission of juveniles to psychiatric hospitals pursuant to a state statute authorizing the admission of minors upon the approval of their parents or guardians).

Indeed, the Supreme Court in *Rogers III* addressed in dicta the scope of procedural protections that accompany the right to refuse. Recognizing that judges and juries are not better qualified than appropriate medical professionals to make treatment decisions, the Court strongly suggested that because the State of Massachusetts evinced a judicial preference for resolution of patients' attempts to refuse medication, state law may afford greater procedural protection than did the Fourteenth Amendment. *Rogers IV*, 457 U.S. at 303-04. In contrast, while the Supreme Court has emphasized that courts should defer to professionals when clinical decisions must be made in individual situations, such deference to professional expertise is unnecessary when defining substantive rights such as privacy where there are no experts on such matters. *See Sheldon Gelman, The Biological Alteration Cases*, 36 WM. & MARY L. REV. 1203, 1246 (1995).

45. In addressing the nature of psychotropic medication, the author drew in part from a prior work. *See William M. Brooks, A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York State Constitutions*, 8 TOURO L. REV. 1 (1991).

46. Donald J. Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. LEGAL MED. 107, 109 (1985); Dennis E. Cichon, *The Eighth Circuit and Professional Judgment: Retrenchment of the Constitutional Right to Refuse Medication*, 22 CREIGHTON L. REV. 889, 952 (1989).

47. Alexander D. Brooks, *The Right to Refuse Antipsychotic Medication: Law and Policy*, 39 RUTGERS L. REV. 339, 342 (1987).

48. Cichon, *supra* note 3, at 309.

one's body.⁴⁹ Psychotropic medication also produces numerous debilitating side effects, some of which may be permanent in nature.⁵⁰ No less an authority than the U.S. Supreme Court has recognized that the drugs psychiatric patients receive are "mind altering."⁵¹ No one can seriously dispute that the injection of such an intrusive treatment regimen constitutes a significant infringement on bodily autonomy,⁵² one of this Nation's most cherished rights under the Constitution,⁵³ which requires the most stringent due process protection that the Constitution provides.⁵⁴

A. Characteristics of Antipsychotic Drugs and Other Psychotropic Drugs

Psychotropic drugs include all medications that affect one's mental processes.⁵⁵ They include antipsychotics, sedatives, tranquilizers, and hypnotics.⁵⁶ Antipsychotic drugs, also known as neuroleptics or major tranquilizers, aim to reduce symptoms of psychosis,⁵⁷ which is a mental disorder characterized by a loss of contact with reality.⁵⁸ Antipsychotic medication alters the chemical balance in an individual's brain, leading to changes in one's cognitive processes that are intended to be beneficial.⁵⁹ Although it is unknown exactly how this medication works, some medical professionals believe that the drugs impact upon the levels of dopamine that the brain produces.⁶⁰

Antipsychotic medication does not cure mental illness.⁶¹ Rather, antipsychotic drugs suppress psychotic symptoms such as hallucinations, delusions and paranoid ideation.⁶² Furthermore, antipsychotic drugs will not

49. Many, although not all, antipsychotic medications can be administered by injection. *See, e.g.,* PHYSICIAN'S DESK REFERENCE 510, 1585 (51 ed. 1997). The author previously worked for a patients' rights organization that represented patients at hearings to administer medication over objection pursuant to *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986), and has observed many medication hearings. Invariably, doctors will testify of the need to prescribe a drug that can be administered over objection because resort to injection is necessary if a patient refuses oral medication.

50. *See infra* notes 78-128 and accompanying text.

51. *Rogers III*, 457 U.S. 291, 293 n.1 (1982).

52. *See infra* notes 351-70 and accompanying text; *see also infra* note 376.

53. *See infra* notes 359-63 and accompanying text.

54. *See infra* notes 329 and 351-57 and accompanying text.

55. *See* Thomas G. Gutheil & Paul S. Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication, 12 HOFTSTRA L. REV. 77, 79 (1983) [hereinafter "Mind Control"].

56. *Id.*

57. *Id.*

58. WEBSTER'S MEDICAL DESK DICTIONARY 423 (1986).

59. *Harper*, 494 U.S. at 229.

60. Cichon, *supra* note 3, at 291 n.38.

61. *See* "Mind Control", *supra* note 55, at 101; Kemna, *supra* note 46, at 110.

62. Kemna, *supra* note 46, at 110.

alleviate many of the disabling aspects of schizophrenia, such as a lack of goal-directed behavior, profound asociality and absence of affectual drive.⁶³ These symptoms of schizophrenia are "more significant for prognosis and over-all outcome [than] the symptoms of schizophrenia that are amendable to a pharmacological approach."⁶⁴ Moreover, antipsychotic drugs will fail to benefit twenty per cent of the patients for whom the medication has been prescribed.⁶⁵ Physicians must prescribe antipsychotic drugs on a trial and error basis as there is no accurate method of determining how a patient will respond to a particular drug.⁶⁶ Since some patients who fail to respond to one particular antipsychotic drug may respond to another, a physician may have to prescribe several drugs before the most effective one is found for the patient.⁶⁷ Furthermore, because in most cases schizophrenia is a chronic disorder, never fully going into remission, drug therapy must continue indefinitely.⁶⁸ Finally not only will antipsychotic medication provide no benefit to some patients, but almost all patients fail to completely respond to the drugs.⁶⁹

Notwithstanding its limitations, "[p]sychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia."⁷⁰ Antipsychotic medication remains "the primary modality in the treatment of an acute episode or an acute exacerbation of schizophrenic illness."⁷¹ Indeed, one authority has argued that "[t]he available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis."⁷² Others have asserted that "there is still no single substitute for [antipsychotic drugs] for control of symptoms and prevention of relapse in the majority of chronic schizophrenic patients. Denying these patients the benefit of [antipsychotic drugs] without offering any suitable alternative may be

63. Samuel J. Keith, *Drugs: Not the Only Treatment*, 33 HOSP. & COMMUNITY PSYCHIATRY 793, 793 (1982) (Commentary); Leo E. Hollister, *Antipsychotic and Antimanic Drugs*, in REVIEW OF GENERAL PSYCHIATRY 590, 595 (Goldman ed. 1984).

64. Keith, *supra* note 63, at 793.

65. Ross J. Baldessarini & Frances R. Frankenburg, *Clozapine: A Novel Antipsychotic Agent*, 324 NEW ENG. J. MED. 746, 746 (1991); Walter A. Brown & Lawrence R. Herz, *Response to Neuroleptic Drugs as a Device for Classifying Schizophrenia*, 15 SCHIZOPHRENIA BULL. 123, 123 (1989).

66. Cichon, *supra* note 3, at 296; Kemna, *supra* note 46, at 110-11; see also Philip R. A. May et al., *Predicting Individual Responses to Drug Treatment in Schizophrenia: A Test Dosage Model*, 162 J. NERVOUS & MENTAL DISEASE 177, 177-78 (1976).

67. Hollister, *supra* note 63, at 595.

68. *Id.*

69. *Id.* at 593.

70. *Harper*, 494 U.S. at 226 n.9 (quoting Brief for American Psychiatric Association as *amicus curiae* at 10-11).

71. John M. Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133, 134 (1987).

72. *Id.* at 142.

considered a clinical error."⁷³

However, the uncertainty and fallibility of psychiatric diagnosis further limits the potential benefits of antipsychotic drugs.⁷⁴ It has been estimated that psychiatrists misdiagnosed patients as schizophrenic as much as forty per cent of the time.⁷⁵ To the extent that antipsychotic medication is the treatment of choice for schizophrenia,⁷⁶ both the frequent misdiagnoses of patients, together with the numerous well-recognized side effects of drug treatment,⁷⁷ present a troubling situation.

B. Side Effects of Psychotropic Medication

Both antipsychotic drugs and other psychotropic drugs produce numerous debilitating side effects that range from unpleasant to life threatening and even fatal.⁷⁸ Many side effects fall within the category of extrapyramidal symptoms.⁷⁹ Akathisia is one of the most common extrapyramidal symptoms.⁸⁰ Uncontrollable physical restlessness, agitation, pacing, anxiety and panic characterize this syndrome.⁸¹ Other symptoms of akathisia "include a constant tapping of feet, alteration of posture . . . and an inability to feel comfortable in any position."⁸² Psychiatrists often fail to diagnose akathisia as it may be impossible to distinguish between akathisia and psychotic excitement.⁸³ Because

73. Dilip V. Jeste & Richard Jed Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 AM. J. PSYCHIATRY 297, 306 (1981).

74. See ROBERT M. LEVY & LEONARD S. RUBENSTEIN, THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES 111 (1996); see also *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985); *Addington v. Texas*, 441 U.S. 418, 429 (1979); Brooks, *supra* note 47, at 352 (stating "[m]any non-schizophrenic patients are incorrectly diagnosed as schizophrenic and forced to take harmful medications that provide no benefit whatsoever"); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 711-19 (1974) (discussing many reasons to question the validity of psychiatrists' diagnoses of schizophrenia); Alan A. Lipton & Franklin S. Simon, *Psychiatric Diagnosis in a State Hospital: Manhattan State Revisited*, 36 HOSP. & COMMUNITY PSYCHIATRY 368, 370 (1985) (reporting 73 out of 89 patients misdiagnosed as schizophrenic).

75. Cichon, *supra* note 3, at 296.

76. See *supra* notes 70-73 and accompanying text; see also Sheldon Gelman, *Mental Hospital Drugs, Professionalism and the Constitution*, 72 GEO. L.J. 1725, 1727 & n.20 (1984) (detailing near universal use of drugs in state psychiatric hospitals).

77. See *supra* notes 74-75 and accompanying text; see also *infra* notes 78-128 and accompanying text.

78. *Harper*, 494 U.S. at 229.

79. Extrapyramidal side effects involve an impairment of the motor system which controls muscular movement. Kemna, *supra* note 46, at 112; Cichon, *supra* note 3, at 300.

80. Brooks, *supra* note 47, at 348.

81. *Id.*

82. Cichon, *supra* note 3, at 301.

83. Theodore Van Putten & Stephan R. Marder, *Behavioral Toxicity of Antipsychotic Drugs*,

psychiatrists often misinterpret symptoms of akathisia as a worsening of a patient's psychiatric condition, physicians will react by increasing the dosage level of medication.⁸⁴ Over twenty per cent of the patients who receive antipsychotic drugs suffer from akathisia.⁸⁵

Akinesia is another extrapyramidal side effect that antipsychotic medication produces. Akinesia is a behavioral state of diminished capacity that is characterized by unspontaneous speech, apathy and a difficulty in initiating activities.⁸⁶ For patients who suffer from akinesia, "reading and talking become virtually impossible."⁸⁷

Dystonic reactions are another type of extrapyramidal symptom. They are characterized by muscle spasms, particularly in the eyes, neck, face and arms.⁸⁸ Dystonic reactions are temporary and will disappear when patients end their regimen of antipsychotic medication.⁸⁹

Antipsychotic drugs also produce extrapyramidal symptoms known as parkinsonism, whose symptoms mimic those of Parkinson's disease.⁹⁰ An individual who manifests parkinsonism manifests a "mask-like face, drooling, muscle stiffness and rigidity."⁹¹ Studies indicate that anywhere from "five to ninety percent of patients treated with antipsychotic drugs" suffer from parkinsonism.⁹²

The most damaging extrapyramidal symptom, and the one that has generated the most scrutiny and disagreement is tardive dyskinesia. Tardive dyskinesia is a syndrome associated with the long-term use of antipsychotic drugs,⁹³ and has been described as a significant public health hazard.⁹⁴ Tardive dyskinesia involves the involuntary movements of facial, arm, leg, or truncal musculature.⁹⁵ Such movements involve the sucking or smacking of lips and, at the very least, are grotesque and humiliating.⁹⁶ In more serious cases, individuals may have

48 J. CLINICAL PSYCHIATRY 13, 13 (1987).

84. Peter J. Weiden et al., *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 AM. J. PSYCHIATRY 1148, 1151 (1987); May et al., *supra* note 66, at 178.

85. Brooks, *supra* note 47, at 350 (citing TASK FORCE ON LATE NEUROLOGICAL EFFECTS OF ANTIPSYCHOTIC DRUGS: TARDIVE DYSKINESIA (Am. Psychiatric Ass'n ed., 1980), summarized in *Task Force Report of the American Psychiatric Association*, 137 AM. J. PSYCHIATRY 1163 (1980) [hereinafter NEUROLOGICAL EFFECTS OF ANTIPSYCHOTIC DRUGS]).

86. Van Putten & Marder, *supra* note 83, at 15.

87. Cichon, *supra* note 3, at 301.

88. *Id.* at 303.

89. See Plotkin, *supra* note 3, at 475.

90. Cichon, *supra* note 3, at 300.

91. Plotkin, *supra* note 3, at 475; Kemna, *supra* note 46, at 112.

92. Cichon, *supra* note 3, at 300.

93. *Id.* at 304.

94. Jeste & Wyatt, *supra* note 73, at 297.

95. See "Mind Control", *supra* note 55, at 109.

96. Brooks, *supra* note 47, at 349; Dilip V. Jeste et al., *The Biology and Experimental*

difficulty swallowing, talking and breathing.⁹⁷

There is substantial disagreement about the ability of the medical profession to detect and control the disorder. Some authorities believe that although the symptoms of tardive dyskinesia appear while a patient is taking medication, because antipsychotic drugs often mask the onset of the disorder, the symptoms "may not become clinically evident until the drug is either decreased or discontinued."⁹⁸ Furthermore, psychiatrists often fail to diagnose symptoms of tardive dyskinesia.⁹⁹ For example, one study found that psychiatrists failed to recognize symptoms of tardive dyskinesia ninety per cent of the time.¹⁰⁰ Perhaps because many psychiatrists believe that antipsychotic medication can do no wrong,¹⁰¹ when confronted with patients who suffer from the disorder, many psychiatrists accuse patients of faking their symptoms.¹⁰² Significantly, it is impossible to predict which patients will suffer from the disorder and the disorder is irreversible.¹⁰³ However, some authorities believe that at least milder forms of tardive dyskinesia may abate when a physician discontinues or reduces a patient's medication.¹⁰⁴

There has frequently been disagreement about the incidence of tardive dyskinesia.¹⁰⁵ Some studies place the incidence of tardive dyskinesia at over fifty per cent.¹⁰⁶ In contrast, the American Psychiatric Association places the

Treatment of Tardive Dyskinesia and Other Related Movement Disorders, in 8 AMERICAN HANDBOOK OF PSYCHIATRY 536, 537 (Berger & Brodie eds., 2d ed. 1986).

97. Cichon, *supra* 3 note, at 304; *see also* Jeste et al., *supra* note 96, at 538 (reporting that physical complications include respiratory irregularities and/or speech abnormalities, retching and vomiting).

98. *See* Kenneth A. Kessler & Jeremy P. Waletzky, *Clinical Use of Antipsychotic*, 138 AM. J. PSYCHIATRY 202, 205 (1981); Jeste et al., *supra* note 96, at 560.

99. *See, e.g.*, Cichon, *supra* note 3, at 306; LEVY & RUBENSTEIN, *supra* note 74, at 112.

100. Weiden et al., *supra* note 84, at 1150; *see also* Gelman, *supra* note 76, at 1755 (detailing substantial failure of physicians employed by state hospitals to diagnose tardive dyskinesia).

101. Gelman, *supra* note 76, at 1759.

102. *Id.* at 1756.

103. *See* Jeste et al., *supra* note 96, at 560 ("We estimate in approximately one-third of these patient in whom neuroleptics are stopped, TD will disappear. The remaining two-thirds of these patients will have persistent TD. . . . To date, there is no specific curative treatment for persistent TD."); Brooks, *supra* note 47 at 349; Gelman, *supra* note 76, at 1752.

104. Philip V. Jeste & Richard Jed Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature*, 5 SCHIZOPHRENIA BULL. 251, 269, 275 (1979); *see also* Mary Ann Richardson & Daniel E. Casey, *Tardive Dyskinesia Status: Stability or Change*, 24 PSYCHOPHARMACOLOGY BULL. 471, 474 (1988); "Mind Control", *supra* note 55, at 109; Daniel E. Casey et al., *Neuroleptic Induced Tardive Dyskinesia and Parkinsonism: Changes During Several Years of Continuing Treatment*, 22 PSYCHOPHARMACOLOGY BULL. 250, 251 (1986).

105. *See* Cichon, *supra* note 3, at 306.

106. *See, e.g.*, Cichon, *supra* note 3, at 306 (citing, *inter alia*, ALAN F. SCHATZBERG & JONATHAN O. COLE, *MANUAL OF CLINICAL PSYCHOPHARMACOLOGY* 99 (1986) (reporting incidence of tardive dyskinesia at 56%); Robert Sovner et al., *Tardive Dyskinesia and Informed Consent*, 19

prevalence of tardive dyskinesia at the significantly lower rate of ten to twenty percent of patients.¹⁰⁷ Even the federal judiciary has been unable to agree on the incidence of tardive dyskinesia. The district court in *Rogers I*¹⁰⁸ placed the incidence of tardive dyskinesia at fifty and fifty-six percent.¹⁰⁹ However, the Supreme Court concluded that a "fair reading of the evidence" places the incidence of tardive dyskinesia at ten to twenty-five percent.¹¹⁰ In terms of total numbers, one authority estimates that one to two million individuals suffer from tardive dyskinesia in any given year.¹¹¹

Another potentially devastating side effect is neuroleptic malignant syndrome. Neuroleptic malignant syndrome produces fever skeletal rigidity, elevated blood pressure, delirium, mutism, stupor and coma.¹¹² It is estimated that approximately two per cent of patients who use neuroleptic medication will suffer from neuroleptic malignant syndrome.¹¹³ Accordingly, because of the large numbers of patients for whom a regimen of antipsychotic medication has been prescribed, "even a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases, a significant number of which may have fatal consequences."¹¹⁴ Indeed, it is estimated that neuroleptic malignant syndrome produces death twenty to thirty per cent of the time.¹¹⁵

Antipsychotic drugs produce many other side effects. Blurred vision, dry mouth and interference with sexual functioning are common.¹¹⁶ Weight gain is also common.¹¹⁷ The medication can also produce agranulocytosis which is a hematological side effect characterized by sore throat, fever, fatigue, lethargy and other signs of infection, jaundice, skin discoloration, and eye lesions.¹¹⁸

While antipsychotic medication is the treatment of choice for psychosis,

PSYCHOSOMATICS 172, 173 (1978) (reporting incidence of tardive dyskinesia at 56 %); *see also* LEVY & RUBENSTEIN, *supra* note 74, at 113.

107. NEUROLOGICAL EFFECTS OF ANTIPSYCHOTIC DRUGS, *supra* note 85, at 1165.

108. 478 F. Supp. 1342 (D. Mass. 1979).

109. *Id.* at 1360.

110. *Washington v. Harper*, 494 U.S. 210 (1990).

111. Cichon, *supra* note 3, at 307.

112. *Id.* at 308.

113. *See* Gerald Addonizio et al., *Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients*, 143 AM. J. PSYCHIATRY 1587, 1588 (1986); *see also* Harrison G. Pope et al., *Frequency and Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital*, 143 AM. J. PSYCHIATRY 1227, 1231 (1986) (finding incidence of neuroleptic malignant syndrome of 1.4%).

114. Pope et al., *supra* note 113, at 1232.

115. Cichon, *supra* note 3, at 308.

116. Gelman, *supra* note 76, at 1745.

117. Hollister, *supra* note 63, at 596.

118. *People v. Medina*, 705 P.2d 961, 968 n.3 (Colo. 1985); THE MERCK MANUAL 1174 (Robert Berkow ed., 15th ed. 1987).

lithium is the indicated treatment for manic episodes of bipolar disorder,¹¹⁹ otherwise characterized as manic-depressive illness.¹²⁰ Like antipsychotic drugs, lithium also produces debilitating side effects. Lithium's impact on the central nervous system range from commonly observed side effects to life-threatening irreversible brain damage in rare instances of lithium toxicity.¹²¹ Patients whose lithium levels are within ordinary therapeutic ranges can suffer from lithium toxicity.¹²² Toxic effects of lithium are initially manifested by gross tremors, persistent headache, vomiting, and mental confusion.¹²³ They "may progress to stupor, seizures, and cardiac arrhythmias."¹²⁴ Lithium can harm the body's immunological system¹²⁵ and contribute to cardiac failure of patients who have a familial history of heart disease.¹²⁶

Like antipsychotic drugs, lithium can produce extrapyramidal symptoms.¹²⁷ In fact, the use of lithium and antipsychotic medication together increases both the risk and severity of extrapyramidal symptoms.¹²⁸

In sum, the drugs that patients receive, particularly antipsychotic medications, are nothing short of hazardous.¹²⁹ Indeed, "antipsychotic drug[s] cause[] severe harms . . . on a far broader scale than lobotomy ever did."¹³⁰ The nature of antipsychotic medication is such that one court has concluded that "[e]ven acutely disturbed patients might have good reason to refuse these drugs."¹³¹

119. See PHYSICIAN'S DESK REFERENCE 1923 (45th ed. 1991). A manic episode is a distinct period of an elevated, expansive mood, and associated symptoms of, *inter alia*, increased activity, a flight of ideas, inflated self esteem, decreased need for sleep, and an "excessive involvement in activities without recognition of the high potential for painful consequences." COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 765 (Harold I. Kaplan & Benjamin J. Sadeck ed., 4th ed. 1985) [hereinafter TEXTBOOK OF PSYCHIATRY].

120. TEXTBOOK OF PSYCHIATRY, *supra* note 119, at 765.

121. Barry Reisberg & Samuel Gershon, *Side Effects Associated with Lithium Therapy*, 36 AM. J. PSYCHIATRY 879, 879 (1979).

122. *Id.* at 880.

123. See MERCK MANUAL, *supra* note 118, at 1530.

124. *Id.*

125. See Vikram R. Shukla & Richard L. Borison, *Lithium and Lupuslike Syndrome*, 248 JAMA 921, 921 (1982) (Letter to the Editor).

126. See Reisberg & Gershon, *supra* note 121, at 882.

127. See John Kane et al., *Extrapyramidal Side Effects with Lithium Treatment*, 135 AM. J. PSYCHIATRY 851, 852 (1978).

128. See D. Thomas Blair, *Risk Management for Extrapyramidal Symptoms*, 16 JOINT COMM'N ON ACCREDITATION OF HOSPITALS: QUALITY REVIEW BULL. 116, 121 (1990); Hollister, *supra* note 63, at 598.

129. See *Stone v. Smith, Kline & French Labs.*, 731 F.2d 1575, 1578 (11th Cir. 1984) (concluding that the lower court correctly found that the antipsychotic drug Thorazine is "unavoidably unsafe").

130. Gelman, *supra* note 44, at 1265.

131. *Rennie II*, 476 F. Supp. at 1299.

II. AN HISTORIC OVERVIEW OF THE RIGHT OF REFUSE DRUGS UNDER FEDERAL LAW

A. *The Initial Federal Litigation*

1. *Rogers v. Okin*.¹³²—*Rogers I* involved a challenge to medication and seclusion practices at Boston State Hospital.¹³³ The district court concluded that the right to accept or refuse medication is part of the right to privacy and is “fundamental” to any concept of ordered liberty.¹³⁴ However, compelling state interests may override the right to refuse.¹³⁵ The safety of the community is one such interest, although the civil commitment of individuals mentally ill and dangerous satisfies this interest.¹³⁶ Hence, members of the hospital community are at risk only in emergency situations and consequently, the state may forcibly administer medication only when an emergency exists within the hospital.¹³⁷

On appeal, the First Circuit concluded that as part of any right to privacy, bodily integrity or personal security, an individual has a right to decide for himself whether or not to submit to a potentially harmful regimen of antipsychotic medication.¹³⁸ A decision to override a patient’s choice to refuse drugs, according to the court, requires a determination that the need to prevent violence in a particular situation outweighs the possibility of harm to the medicated patient, and reasonable alternatives to medication have been ruled out.¹³⁹ Further, a court should leave this assessment to hospital doctors and limit its role to designing procedures that would protect patients’ interests.¹⁴⁰

132. 478 F. Supp. 1342, 1353 (D. Mass. 1979).

133. The seclusion practices of the hospital were not subject to appellate review. *See Rogers II*, 634 F.2d at 653.

134. *Rogers I*, 478 F. Supp. at 1366.

135. *Id.* at 1368.

136. *Id.* at 1368-69.

137. *Id.* at 1365, 1369. The court defined “emergency” as a situation in which a failure to medicate “would result in a substantial likelihood of physical harm” to the patient himself, other patients or hospital staff. *Id.* at 1365. In so holding the court concluded that the government’s interest in providing needed treatment simply did not override the patient’s right to refuse. *Id.* at 1369.

138. *Rogers II*, 634 F.2d at 653.

139. *Id.* at 655-56.

140. *Id.* at 656-57. The First Circuit recognized further that the state’s *parens patriae* power authorized the forcible administration of medication to patients who lacked the ability to make treatment decisions. However, if a hospital sought to medicate over objection only for treatment purposes, the facility must obtain a determination that the patient lacked the capacity to decide for himself whether or not to accept the medication. *Id.* at 657. The court of appeals further held that the district court erred when it defined an emergency as a situation that requires immediate action to prevent physical harm. *Id.* at 659-60. Rather, situations existed in which the need to administer medication to prevent further deterioration of a patient also rose to the level of an emergency.

When the case reached the Supreme Court, the Court framed the substantive issue of the right to refuse by defining the constitutional interest involved and then identifying conditions under which competing state interests might outweigh an individual's right.¹⁴¹ The Court articulated further that the substantive protections arising directly from the Constitution detail only a minimum and state law may recognize liberty interests broader than those directly protected within the Constitution.¹⁴² Because the Due Process Clause protects state-created liberty interests, "the full scope of a patient's due process rights may depend in part on the substantive liberty interests created by state as well as federal law."¹⁴³ Analysis of state law is particularly important "[t]o identify the nature and scope of state interests that are to be balanced against an individual liberty interest."¹⁴⁴ Since the Massachusetts Supreme Court's disposition in *Guardianship of Roe*¹⁴⁵ may have "put into doubt, if not altered" the underlying state-law predicate for the weighing of the state interests,¹⁴⁶ the Supreme Court remanded *Rogers III* to the court of appeals.

2. *Rennie v. Klein*.¹⁴⁷—*Rennie I* involved a challenge to the forcible administration of medication by a patient confined at Aurora Psychiatric Hospital

Accordingly, the First Circuit vacated the district court's definition of emergency and remanded the case for "consideration of alternative means for making incompetency determinations in situations where any delay could result in significant deterioration of a patient's health." *Id.* at 660.

141. *Rogers III*, 457 U.S. at 299. In engaging in this substantive due process analysis, the Supreme Court assumed for purposes of this case that involuntarily hospitalized patients retain liberty interests protected directly by the Constitution and the forcible administration of antipsychotic drugs implicates these interests. *Id.* at 299 n.16.

142. *Id.* at 300. The Court's citations to *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 7, 12 (1979), and subsequently, *Vitek v. Jones*, 445 U.S. 480 (1980), are particularly relevant in determining the meaning and scope of *Rogers III*. If one reads the Court's discussion of interests under state law as simply a precursor to a remand for an examination of state law because protections created by state law are broader than those arising directly from the Constitution then this decision has little significance when evaluating Supreme Court discussion on the right to refuse. Both the court of appeals on remand and a district court interpreted *Rogers III* in this manner. See *Rogers IV*, 738 F.2d at 4; *R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Texas 1984). However, *Vitek* and *Greenholtz* focused on the issue of state-created liberty interests that the Federal Constitution protects. The Court's citation to these cases and its recognition that the Due Process Clause of the Fourteenth Amendment protects rights created by both state and federal law strongly suggests that the Court remanded *Rogers III* not to determine whether state law rendered moot the patients' federal claims, but whether intervening state law identified state interests that might outweigh the patients' liberty interests. See *Rogers III*, 457 U.S. at 299. For a full discussion of the significance of this aspect of *Rogers III*, see *infra* notes 404-18 and accompanying text.

143. *Rogers III*, 457 U.S. at 300.

144. *Id.* at 304.

145. 421 N.E.2d 40 (Mass. 1981).

146. *Rogers III*, 457 U.S. at 304.

147. 462 F. Supp. 1131 (D.N.J. 1978) [hereinafter *Rennie I*].

in New Jersey. Ruling on a preliminary injunction motion, the district court held that the right of privacy included the right to refuse psychotropic medication.¹⁴⁸ Accordingly, the court held that a patient “may challenge the forced administration of drugs on the basis that alternative treatment methods should be tried before a more intrusive technique like psychotropic medication is used.”¹⁴⁹ However, while the right of privacy encompassed the right to refuse drugs, the government’s interest in protecting other patients and hospital staff was sufficiently compelling to override the plaintiff’s right to refuse.¹⁵⁰ Although the court never definitively detailed other state interests that would compel the forced administration of medication, the court recognized that some patients lacked sufficient insight into their illness warranting the forced administration of medication.¹⁵¹ In sum, the *Rennie I* court held that a decision to administer medication required an assessment of four factors when evaluating a patient’s refusal: (1) the physical threat to other patients and staff; (2) the patient’s capacity to decide on his course of treatment; (3) the existence of any less restrictive alternatives; and (4) the risk of permanent side effects from the medication.¹⁵² Subsequently, the plaintiff moved to amend his complaint to contain class allegations and the court certified the lawsuit as a class action.¹⁵³ The court then issued a class-wide decision enjoining the forced administration of medication in non-emergency situations.¹⁵⁴

The court of appeals, sitting *en banc*, recognized that while state law gives rise to a liberty interest when it creates a right or expectation rooted in state law,¹⁵⁵ no such state created interest existed in New Jersey as state law only permitted voluntary patients to refuse medication.¹⁵⁶ The court reasoned that by implication, “involuntarily committed patients do not have this right and a [state

148. *Id.* at 1144.

149. *Id.* at 1146 (quoting Bruce J. Winick, *Psychotropic Drugs and Competence to Stand Trial*, 1977 AM. B. FOUND RES. J. 769, 813). The court also recognized procedural due process concerns arising from the state’s attempt to administer medication over objection. To address these concerns, for all non-emergency situations the court required: a hearing to address the need for medication, a lawyer for the patient and an independent psychiatrist to evaluate a hospital’s decision to medicate. Finally, the hospital must provide the patients’ counsel and independent psychiatrist with access to the hospital record. *Id.* at 1147-48.

150. *Id.* at 1145.

151. *Id.* at 1146.

152. *Id.* at 1148.

153. *Rennie II*, 476 F. Supp. 1294, 1297-98 (D.N.J. 1979).

154. *Id.* at 1313-14. Most of the injunction addressed procedural rights of patients who sought to refuse medication. *Id.* at 1313-15. For instance when a hospital sought to forcibly medicate a patient, the court directed an independent psychiatrist to conduct a hearing in which the factfinder was to evaluate both the four factors detailed in *Rennie I* and the existence of any possible First or Eighth Amendment violations. *Id.* at 1314-15.

155. *Rennie III*, 653 F.2d at 841-42.

156. *Id.* at 842.

court] had so held.”¹⁵⁷ Notwithstanding the absence of a state created liberty interest in refusing medication, involuntarily hospitalized patients retained a “residuum of liberty”¹⁵⁸ infringed by forced drugging since compulsory medication with antipsychotic drugs amounted to a “major change in the conditions of confinement.”¹⁵⁹ The court concluded that forced drugging implicated the right to remain free from “unjustified intrusions on personal security.”¹⁶⁰

A majority of the *Rennie III* court adopted a least intrusive means standard for detailing circumstances when government interests will override a patient’s interest in refusing medication.¹⁶¹ The least intrusive means standard did not prohibit all unwanted intrusions produced by medication. Rather, this criteria prohibited forced druggings “which are unnecessary or whose cost benefit ratios, weighed from the patient’s standpoint, are unacceptable.”¹⁶²

On July 2, 1982, two weeks after the Supreme Court remanded *Rogers III*, the Court rendered a decision in *Rennie IV*.¹⁶³ In a summary order, the Court remanded *Rennie IV* for further consideration in light of *Youngberg*,¹⁶⁴ which the Court decided on June 18, 1982, the same day it decided *Rogers III*.¹⁶⁵

157. *Id.* (citing *In re B.*, 383 A.2d 760 (N.J. Super. Ct. Law. Div. 1977)).

158. *Id.* at 843 (quoting *Vitek v. Jones*, 445 U.S. 480, 491 (1980)).

159. *Id.* (quoting *Wolff v. McDonnell*, 418 U.S. 539, 571-72 n.19 (1974)).

160. *Id.* at 844 (citing *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)).

161. *Id.* at 845.

162. *Id.* at 847. In an appendix the Court ordered that medication is considered necessary when either (1) the party is incapable, without medication, of participating in any treatment plan that will provide the patient with a realistic opportunity of improving his condition; or (2) although the hospital can devise a plan that will give the patient a realistic opportunity of improving his condition, (a) the provision of medication would probably improve the patient’s condition in a significantly shorter time, or (b) a significant possibility exists that the patient will harm himself or others before his condition improves in the absence of medication. *Id.* at 853.

Eight of the judges held that administrative regulations promulgated after the filing of *Rennie III* satisfied substantive standards. *Id.* at 851-52. The regulations permitted the forcible administration of medication under the following circumstances: (1) when a patient was incapable, without medication, of participating in a treatment plan that would provide him with a realistic opportunity of improving his condition; (2) the administration of medication would probably improve the patient’s condition in a significantly shorter period of time; or (3) there was a significant possibility that, in the absence of the provision of medication, the patient would harm himself or others before improvement of his condition is realized; and (4) the existence of an emergency. *Id.* at 852-53.

163. 458 U.S. 1119 (1982).

164. 457 U.S. 307 (1982).

165. See *Rogers III*, 457 U.S. at 291; *Youngberg*, 457 U.S. at 307.

*B. Case Law Subsequent to the Supreme Court's Decisions
in Rogers III and Rennie IV*

After the Supreme Court's remand of *Rennie IV* in light of *Youngberg* the federal courts adopted the professional judgment standard of *Youngberg* and denied civil commitment patients the right to refuse medication unless a physician's authorization decision failed to satisfy the professional judgment standard.¹⁶⁶ Cases arose in a number of different contexts; federal courts' reliance upon the *Youngberg* standard ranged from blind adherence, without any examination as to the appropriateness of adopting the professional judgment standard, to an *en banc* reconsideration of the issue in *Rennie V* in which seven out of ten judges in three different opinions adopted the professional judgment test in one form or another.¹⁶⁷

On remand in *Rennie V*, the Third Circuit became the first federal court to re-evaluate the scope of the right to refuse after the Supreme Court's dispositions of *Rogers III* and *Rennie IV*. The court examined the scope of the right to refuse by evaluating the constitutionality of the substantive standards within the New Jersey regulations authorizing forcible administration of medication.¹⁶⁸ Five judges held that physicians may administer medication over objection when in the exercise of professional judgment the physician determined that a patient poses a threat of harm to himself or others.¹⁶⁹ Chief Judge Seitz, in concurrence,

166. See, e.g., *Walters v. Western State Hosp.*, 864 F.2d 695, 698-99 (10th Cir. 1988); *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *Rennie V*, 720 F.2d 266, 269-74 (3d Cir. 1983) (en banc); *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960, 977-81 (2d Cir. 1983); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1321 (N.D. Tex. 1984).

167. *Rennie V*, 720 F.2d at 269, 272, 274.

168. *Id.* at 270 & n.9. See *supra* note 162 for the standards set forth in the administrative provisions in question.

169. *Rennie V*, 720 F.2d at 269-70. Comparing the opinion of the court, written by Judge Garth, and joined by Judges Aldisert and Hunter, with the concurring opinion of Judge Adams, joined by Judge Becker, indicates that members of the court had difficulty understanding each other. Although all five judges concluded that a hospital could override a patient's decision to refuse medication when a physician, in the exercise of professional judgment deems that the patient poses a danger to himself or others, Judge Adams refused to join the opinion by Judge Garth. Judge Adams noted that under New Jersey law, the state could not involuntarily hospitalize a patient unless he posed a danger to himself or others. Judge Adams then interpreted Judge Garth's opinion to hold that the determination of dangerousness in the context of civil commitment justified a determination of dangerousness within a hospital setting that would permit the forcible administration of medication. This, Judge Adams believed, did not afford sufficient protection to patients. *Id.* at 272.

However, Judge Garth's opinion reveals that he never clarified what he meant by danger to oneself or others. At no time did Judge Garth define the phrase as either posing a danger within a hospital setting or posing a threat outside of a hospital that would justify civil commitment. Notwithstanding Judge Adams' attempt to distinguish his opinion from that of the Court, Judge

concluded that the professional judgment standard of *Youngberg* governed the administration of medication over objection, although a physician must consider the patient's welfare and society's interests.¹⁷⁰ Accordingly, the Chief Judge continued, any forced drugging must be part of an effort to treat mental illness "or in response to, or in anticipation of, [a] patient's violent outbreaks."¹⁷¹

In an opinion written by Judge Weis, four judges rejected application of the *Youngberg* standard in the refusal of treatment context.¹⁷² These judges further concluded that the administration of medication must satisfy the "least intrusive means" test.¹⁷³ Nevertheless, these judges permitted the professional judgment standard to govern this case as long as the decision to administer medication included a least intrusive means consideration, namely, "a cost-benefit analysis viewed from the patient's perspective."¹⁷⁴ In sum, nine of the ten judges concluded that the regulations promulgated by the State of New Jersey satisfied due process because they required physicians to exercise professional judgment, in one form or another, when administering medication.¹⁷⁵

In *Project Release v. Prevost*,¹⁷⁶ the Second Circuit became the second court after the Supreme Court's remand of *Rennie IV* to examine the scope of the right to refuse. Like the Third Circuit, the Second Circuit evaluated the right to refuse in light of administrative regulations that governed the forcible administration of medication and upheld the regulations because the regulations required the exercise of professional judgment.¹⁷⁷

In a rather convoluted opinion, the *Project Release* court recognized how the Supreme Court observed in *Rogers III* that state law could create an interest in refusing medication.¹⁷⁸ The Second Circuit determined that New York's administrative regulations served as a source of such a state created interest.¹⁷⁹

Garth noted that the standard set forth by Judge Adams did not differ from his. *Id.* at 269 n.6.

170. *Id.* at 274.

171. *Id.*

172. *Id.* at 275.

173. *Id.* at 276. For a full discussion of the least intrusive means/least restrictive alternative test, see *infra* notes 454-72 and accompanying text.

174. *Id.* at 276. Judge Weis reconciled the least intrusive means test with the professional judgment standard by noting that the least intrusive means test requires professionals to give greater consideration to the potential harmful effects of medication than any administrative or economic concerns arising out the administration of medication. *Id.*

175. Judge Gibbons dissented from the court's opinion, believing that, for the reasons given in his dissent to the original Third Circuit opinion, the court of appeals should not have modified the issuance of the preliminary injunction issued by the district court. *Id.* at 277. In his original dissent, Judge Gibbons concluded that the findings of rights violations by the district court were not clearly erroneous. *Rennie III*, 653 F.2d at 865-70.

176. 722 F.2d 960 (2d Cir. 1983).

177. *Id.*

178. *Id.* at 979 (citing *Rogers III*, 457 U.S. at 300).

179. *Id.* (citing N.Y. COMP. CODES R. & REGS. tit. 14, §§ 27.8 and 27.9 (1983)). The court also noted that state statutory law encompassed any substantive right to refuse medication that

However, a court had to weigh any right to refuse against relevant state interests. The court then noted that the Supreme Court remanded *Rennie IV* in light of *Youngberg*.¹⁸⁰ As such, *Youngberg* provided guidance for evaluating the standards for objecting to treatment. Without examining the content of any standards, the court concluded that because the regulations afforded an opportunity for the exercise of professional judgment, the regulations satisfied due process.¹⁸¹

Regardless of the merits of utilizing the professional judgment standard to govern the right to refuse,¹⁸² other courts soon applied the professional judgment standard in the refusal of treatment context.¹⁸³

might exist. The statute in question, Mental Hygiene Law § 33.03(a), provided that “[e]ach patient in a facility and each person receiving services for mental disability shall receive care and treatment that is suited to his needs and skillfully, safely and humanely administered *with full respect for his dignity and personal integrity*.” *Id.* (emphasis in opinion).

180. *Id.* at 980.

181. *Id.* at 980-81.

182. For a discussion of the appropriateness of utilizing the professional judgment standard in the refusal of treatment context, see *infra* notes 213-69 and accompanying text.

183. For example, two circuit courts and two district courts expressed a willingness to adopt the professional judgment standard within a year of the Supreme Court’s remand of *Rennie IV*. *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984), involved a determination governing the sufficiency of a *pro se* complaint in which a civilly committed patient sought damages. Although the court of appeals overturned the dismissal of the complaint by the district court, the appellate court held that the professional judgment standard controlled. In order for the patient to prevail, he would have to establish that the physician who directed him to take medication failed to exercise professional judgment. *Id.* at 825.

In *Dautremont v. Broadlawns Hospital*, 827 F.2d 291 (8th Cir. 1987), a psychiatrically hospitalized patient sought damages for a number of purported violations including the administration of medication over objection. In assessing the scope of the patient’s right to refuse drugs, the Eighth Circuit applied the professional judgment standard. The court of appeals then held that the government’s legitimate objective of restoring the patient’s behavior to acceptable societal standards and the doctors’ reasonable professional judgment that the administration of medication could best accomplish this goal outweighed the patient’s liberty interest in refusing medication. *Id.* at 300.

The patient in *Dautremont* also argued that Iowa law created a liberty interest in refusing medication unless the administration of drugs was necessary to preserve life or control behavior that was likely to result in physical injury to himself or others. The court of appeals did not squarely address this issue; the court held that assuming state law created such a liberty interest, because the patient posed a danger to himself and others, the administration of medication was justified. *Id.* at 298.

In *R.A.J. v. Miller*, 590 F. Supp. 1319 (N.D. Tex. 1984), a district court relied upon *Rennie IV* and *Project Release* and applied the *Youngberg* standard in evaluating a putative settlement agreement after the parties acknowledged that they could not agree upon a standard. In so doing, the district court explicitly set forth what amounted to the assumption underlying all post-*Rennie* decisions: “The [Supreme] Court’s action in vacating and remanding the *Rennie* decision for

Only in *Walters v. Western State Hospital*¹⁸⁴ did a federal court begin to retreat from the *Youngberg* standard. In the context of a damages action, the court examined the scope of the right to refuse and addressed the defendants' contention that they were shielded from liability pursuant to the qualified immunity defense. The court first noted that case law granted patients the right to refuse drugs except in emergency situations.¹⁸⁵ The defendants did not directly dispute that an emergency standard governed the scope of the plaintiff's right to refuse. Rather, they asserted that they were immune from suit because their decision to administer medication was the product of professional judgment. In denying the defendants' motion for summary judgment, the court failed to detail what standards governed the right to refuse. First, in adopting an approach similar to that set forth by the Third Circuit in *Rennie V*, the court in *Walters* concluded that disputed issues of fact existed concerning whether a reasonable person exercising professional judgment would have believed that an emergency existed.¹⁸⁶ The court also held that there was a question of fact whether the decision to forcibly administer medication was consistent with the exercise of professional judgment.¹⁸⁷ The court left to readers the unenviable task of determining whether the court believed that the *Youngberg* standard controlled or if relying upon the professional judgment standard when examining qualified immunity was simply a way to determine whether a reasonable defendant could have acted in the same manner as the defendant.

More recently, in *Noble v. Schmitt*,¹⁸⁸ the court addressed a civilly committed

further consideration in light of *Youngberg*, moreover, evidences an intent to apply the guidelines of *Youngberg* to the right of an involuntarily committed *mentally ill* patient to refuse *administration of psychotropic drugs*." *Id.* at 1321 (emphasis in original). As such, the court's decree authorized the forcible administration of medication after patients were afforded a two tier medical review of any decision to administer medication over objection. *Id.* at 1320, 1322.

Stensvad v. Reivitz, 601 F. Supp. 128 (W.D. Wisc. 1985), involved a challenge to a Wisconsin statute that provided that "[f]ollowing a final commitment order, the subject individual does not have the right to refuse medication and treatment except as provided in this section." *Id.* at 129 (quoting Wis. Stats. § 51.61(1)(g) (1985)). While the statute authorized the forcible administration of medication, it provided patients with a right to remain free from unnecessary or excessive medication. The statute also proscribed the use of medication for purposes of punishment or the convenience of staff. *Id.* Although an insanity acquittee challenged the statute, the court recognized that because the state subjected criminal and civil patients to the same statutory provisions, the plaintiff's status had no bearing on the litigation. *Id.* at 130 n.2.

The court first upheld the challenged provisions on the ground that under state law, commitment was for "custody, care and treatment." Hence, involuntary commitment was tantamount to a finding of incompetence in regard to treatment decisions. *Id.* at 130-31.

184. 864 F.2d 695 (10th Cir. 1988).

185. *Id.* at 697-98 (citing, *inter alia*, *In re K.K.B.*, 609 P.2d 747 (Okla. 1980); *Davis v. Hubbard*, 506 F. Supp. 915, 929 (N.D. Ohio 1980)).

186. *Id.* at 699.

187. *Id.*

188. 87 F.3d 157 (6th Cir. 1996).

patient's right to refuse medication in the context of a motion to dismiss a damages claim on qualified immunity grounds. In an unclear opinion, the Court concluded that a state may administer involuntary medical treatment if a patient poses a danger to himself or others or if the treatment is in the patient's medical interest.¹⁸⁹ The court then noted the plaintiff's allegation that an emergency did not initially exist and that the defendant provoked him (plaintiff) to act out so that she could justify forcibly administering medication under the pretext of an emergency. After concluding that if these allegations were true a reasonable defendant would understand that such conduct would be unlawful, the court denied defendant's motion to dismiss.¹⁹⁰

In a different context, the professional judgment standard was applied when the Fourth Circuit examined the right of an incompetent defendant to refuse medication.¹⁹¹ In *Charters*, the Fourth Circuit took perhaps the most charitable view of administering medication over objection by holding that such a decision simply constituted a base-line decision that the Constitution permitted a person of the medical professional to make.¹⁹²

In contrast, when evaluating the right of a pretrial detainee to refuse drugs, one court explicitly rejected the applicability of the *Youngberg* standard.¹⁹³ The court distinguished *Youngberg* on the grounds that it involved temporary physical restraints as opposed to potentially long-term mental restraints and because the patient in *Youngberg* had been certified severely retarded and unable to care for himself.¹⁹⁴

C. The Supreme Court Examines the Issue in Other Contexts

Eight years after *Rennie IV*, in *Washington v. Harper*¹⁹⁵ the Supreme Court examined both the substantive and procedural rights of a prisoner to refuse antipsychotic medication. The Court framed the substantive issue as "what factual circumstances must exist before the State may administer antipsychotic drugs to the prisoner against his will."¹⁹⁶

Beginning its analysis, the Court noted that state law created a federally

189. *Id.* at 162 (citing *Washington v. Harper*, 494 U.S. 210, 227 (1990)).

190. *Id.*

191. *See* *United States v. Charters*, 863 F.2d 302, 313 (4th Cir. 1988) (en banc).

192. *Id.* at 308.

193. *See* *Bee v. Greaves*, 744 F.2d 1387, 1396 n.7 (10th Cir. 1984).

194. *Id.*; *see also* *United States v. Watson*, 893 F.2d 970, 980 (8th Cir. 1990) (interpreting *Youngberg* as meaning that the state may forcibly administer antipsychotic medication to prisoner when it becomes necessary to protect the patient and those around him from physical harm).

195. 494 U.S. 210 (1990).

196. *Id.* at 220. In defining a prisoner's substantive right in this fashion, the Court quoted *Rogers III* and reiterated that the substantive contours of an individual's right to refuse "involves a definition of th[e] protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it." *Id.* (quoting *Rogers III*, 457 U.S. 291, 299 (1982)) (citations omitted).

protected liberty interest in refusing medication.¹⁹⁷ Because state law expressly prohibited a prison psychiatrist from forcibly administering medication unless the inmate was found to be “(1) mentally ill and (2) gravely disabled or dangerous,” state law created “a justifiable expectation on the part of the inmate that the drugs will not be administered unless those conditions exist.”¹⁹⁸

The Court also found that the Due Process Clause itself created a liberty interest in avoiding the unwanted administration of antipsychotic medication.¹⁹⁹ However, the Court rejected the prisoner’s contention that the Fourteenth Amendment require a finding of incompetence before a prison doctor can forcibly drug an inmate.²⁰⁰ Rather, the court determined a prison regulation governing the administration of medication is constitutional if the regulation is “reasonably related to legitimate penological interests.”²⁰¹ This standard governed prison regulations “even when the constitutional right claimed to have been infringed is fundamental, and the State under other circumstances would have been required to satisfy a more rigorous standard of review.”²⁰² The Court then found that by limiting the forcible administration of medication to patients who were mentally ill and either dangerous or gravely disabled, the state law was reasonably related to legitimate penological interests.²⁰³

Two years after the Court decided *Harper*, it decided *Riggins v. Nevada*.²⁰⁴ In *Riggins*, a defendant challenged his convictions on the ground that the state subjected him to a regimen of forced medication during his trial that violated his rights under the Sixth and Fourteenth Amendments.²⁰⁵

197. *Id.* at 221.

198. *Id.*

199. *Id.* at 221-22.

200. *Id.* at 222.

201. *Id.* at 223 (quoting *Turner v. Safley*, 482 U.S. 78, 89 (1987)).

202. *Id.* (citing *O’Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987)).

203. *Id.* at 225. In determining the reasonableness of the regulation, the Court examined three factors: (1) whether there was a rational connection between the prison regulation and the legitimate government interest that justified the regulation; (2) the impact that the accommodation of the asserted constitutional right would have upon guards, other inmates and prison resources in general; and (3) the existence of ready alternatives, the absence of which is evidence of the reasonableness of the regulation. *Id.* at 224-25.

In *Harper*, the regulations satisfied the State’s interest in providing needed medical treatment and maintaining prison safety. The regulation in question furthered legitimate State objectives since proper use of antipsychotic medication is one of the most effective means of treating a mental illness that is likely to cause violent behavior. *Id.* at 226. The Court also rejected other possible alternatives, including physical restraints, which the Court noted, provided only short-term relief. Moreover, the Court found that the prisoner failed to demonstrate how physical restraints or seclusion were acceptable substitutes for antipsychotic medication, in terms of either their medical effectiveness or their impact on limited prison resources. *Id.* at 226-27.

204. 504 U.S. 127 (1992).

205. *Id.* at 132-33. Although the petitioner in *Riggins* raised the right to refuse issue in an appeal of his murder conviction, the context in which the issue was raised has little bearing upon

The Court first presumed that the administration of antipsychotic medication (Mellaril) was medically appropriate.²⁰⁶ It then interpreted *Harper* as requiring not only a determination of medical appropriateness, but also a finding of an overriding justification before a state may forcibly administer medication to a convicted prisoner.²⁰⁷ By noting that prison regulations are subject to a reasonableness test, which is “less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights,”²⁰⁸ the Court distinguished the present case of a trial setting from the prison setting in *Harper*.

The Court then held that Nevada would have satisfied substantive due process if the administration of medication was medically appropriate and “considering less intrusive alternatives, essential for the sake of Riggins’ own safety or the safety of others.”²⁰⁹ Nevada also would have satisfied due process if it established that it could not obtain an adjudication of guilt or innocence by using means less intrusive than an involuntary but medically appropriate regimen of antipsychotic drugs.²¹⁰ However, the Supreme Court noted that the trial court failed to make any findings when it denied Riggins’ application to discontinue the medication. As such, the trial court failed to address the necessity of medication to satisfy safety considerations, other compelling state concerns, or the availability of reasonable alternatives.²¹¹ In light of the trial court’s failure to determine the availability of alternatives to antipsychotic drugs and the necessity of such treatment to satisfy compelling state interests, the Supreme Court held that this failure may well have impaired Riggins’ Sixth and Fourteenth Amendment rights.²¹²

III. REEVALUATING THE APPLICABILITY OF THE PROFESSIONAL JUDGMENT STANDARD OF *YOUNGBERG* TO THE REFUSAL OF TREATMENT CONTEXT

The failure of the Supreme Court in *Harper* and *Riggins* to rely upon the professional judgment standard of *Youngberg* as part of constitutional analysis amounts to a clear signal that the professional judgment standard does not

the impact of *Riggins* on a civil patient’s right to refuse. Just as when an individual seeks damages for, or an injunction to halt an illegal regimen of forced drugging, the Court in *Riggins* addressed whether state conduct violated the Constitution. Although the Court framed the chief issue for review as whether the involuntary administration of antipsychotic medication denied the petitioner a full and fair trial, the Court based its decision on not only cases that addressed the issue of prejudice in a criminal proceeding, but also the circumstances when the state may infringe upon the liberty interests of an individual through the forcible administration of medication. *See id.* at 135.

206. *Id.* at 133.

207. *Id.* at 135.

208. *Id.* (quoting *O’Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987)).

209. *Id.*

210. *Id.*

211. *Id.* at 136.

212. *Id.* at 136-37. The Court reversed the conviction without requiring the defendant to establish actual prejudice as attempts to prove or disprove prejudice would be futile. *Id.* at 137.

necessarily govern a civilly committed individual's right to refuse treatment under the Fourteenth Amendment.²¹³ However, upon analysis, it might be more accurate to say that *Harper* and *Riggins* simply clarified what should have been clear since the Supreme Court's remand in *Rennie IV*: that application of the professional judgment standard in the refusal of treatment context has always been a dubious proposition at best.

First, when assessing the applicability of the professional judgment standard in the refusal of treatment context, one must attempt to reconcile the Supreme Court's decision in *Rogers III* with its decision to remand *Rennie IV* in light of *Youngberg*. Indeed, it is very surprising that no court has ever questioned why the Supreme Court remanded *Rogers III*, directing the court of appeals to examine the degree to which state law created protectable liberty interests, and then two weeks later apparently adopted a standard far more deferential to clinicians when it remanded *Rennie IV* in light of *Youngberg*.²¹⁴ The question requires scrutiny as the Supreme Court decided *Rogers III* the same day it decided *Youngberg* and two weeks later remanded *Rennie IV*. However, the Court did not remand *Rennie IV* in light of *Rogers III*—the other right to refuse case—but rather *Youngberg*, a case with little factual similarity to *Rennie IV*. Unless one believes that the Supreme Court began to question its decision in *Rogers III* within two weeks of the opinion, any decision addressing the right to refuse requires a reconciliation of the different dispositions in *Rogers III* and *Rennie IV*. When one reconciles *Rogers III* and *Rennie IV*, it becomes clear that at the very least, courts should not apply the professional judgment standard until they determine: 1) whether any relevant state law exists to guide the balancing process between the individual and the state; and 2) whether state law creates a liberty interest in refusing medication.²¹⁵

In *Rogers III*, the Court recognized that not only may state law serve as a source of a federally protected liberty interest,²¹⁶ a concept that the Supreme Court reiterated in *Harper*,²¹⁷ but state law can also serve as a guide in determining how much weight to accord the competing interests of the individual

213. Admittedly, one can assert that neither *Harper* nor *Riggins* addressed the right of a civil patient as did *Rennie IV*. However, because “[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish,” *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982), it is highly unlikely that the more onerous professional judgment standard governs civilly committed patients' right to refuse when prisoners and pretrial detainees are not subject to this standard.

214. The Supreme Court decided *Rogers III* on June 18, 1982 and remanded *Rennie IV* in light of *Youngberg* on July 2, 1982.

215. See *Rogers III*, 457 U.S. at 300; see also *Washington v. Harper*, 494 U.S. 210, 221 (1990). For discussion of the impact of state created liberty interests on the right to refuse medication, see *infra* notes 492-514 and accompanying text.

216. *Rogers III*, 457 U.S. at 300.

217. *Harper*, 494 U.S. at 221.

and the state.²¹⁸ Because recent state law may have altered the balance between the competing interests,²¹⁹ the Court remanded *Rogers III* so that the lower court could assess the impact of new state law.²²⁰ There was no need to examine relevant state law in *Rennie IV* because the Third Circuit had explicitly held that state law did not create any protected liberty interests.²²¹ Because state law provided that only voluntary patients could refuse medication,

the implication of the statute is that involuntarily committed patients do not have this right and a New Jersey trial court has so held. Research has not disclosed any New Jersey appellate opinions interpreting the statute, nor has the Supreme Court of that state had occasion to determine the application of the New Jersey constitution or the common law in this situation.²²²

Accordingly, in *Rennie IV* there existed no state law to guide a court when it weighed the competing interests of the patient and the state. However, as the Court in *Youngberg* recognized, the balancing of an individual's liberty interest against relevant state interests "cannot be left to the unguided discretion of the judge or jury."²²³ When evaluating the rights of patients in New Jersey where there was no state law to guide the balancing process and no independent interest in refusing medication, the Court in *Youngberg*, resorted to a relevant standard under federal law in order to avoid ad hoc balancing. Resort to any such uniform standard, including the *Youngberg* professional judgment test, was both unnecessary and inappropriate in *Rogers III*. The Court recognized that because of the recently decided state law case of *Guardianship of Roe*, relevant state law may have existed and should serve to balance the competing interests of the individual and the State.²²⁴

Even prior to *Harper*, further support for this analysis existed. The Court in *Rogers III* went so far as to cite *Youngberg* when it noted that substantive due process involved defining protected constitutional interest as well as the conditions under which competing state interests might outweigh it.²²⁵ The Court in *Rogers III* cited *Youngberg* in recognizing that a court should weigh a patient's constitutional interest against the state's competing interest. Yet, the Court also remanded *Rogers III* in light of *Guardianship of Roe*. Therefore, resort to an independent federal standard is appropriate only in the absence of independent state law that (1) creates a protectable interest in refusing medication and (2) serves to guide the balancing of the competing interests of the individual and the

218. *Rogers III*, 457 U.S. at 304.

219. *Id.*

220. *Id.* at 306.

221. *Rennie III*, 653 F.2d 836, 842 (1980).

222. *Id.* (citing *In re B.*, 383 A.2d 760 (N.J. Super. 1977)).

223. *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982).

224. *Rogers III*, 457 U.S. at 300-04.

225. *Id.* at 299.

state.²²⁶

226. See *Rennie*, 653 F.2d at 842. In most jurisdictions, resort to an independent federal standard will not be appropriate because there is state law that limits the forcible administration of medication. See *infra* notes 504-08 and accompanying text.

If the author is correct when asserting that the Supreme Court remanded *Rennie IV* because of the absence of relevant state law, the Third Circuit's reliance upon *In re B.* to conclude that no state created interest existed is particularly ironic because the state court probably decided *In re B.* incorrectly. In *In re B.*, the court examined New Jersey statutory law and noted that state law deemed experimental research, shock treatment, psychosurgery and sterilization intrusive forms of treatment that required the consent of the patient or his guardian. *Id.* at 763. On the other hand, the Legislature failed to delineate medication as intrusive treatment. *Id.* The court then ruled that by implication, the administration of medication did not require the informed consent of a patient and hospital staff could administer medication over objection. *Id.*

However, at the time the court decided *In re B.*, New Jersey law recognized the right of all patients to make informed treatment decisions. See *Kaplan v. Haines*, 232 A.2d 840, 847 (N.J. Super. 1967), *overruled on other grounds by* *Largey v. Rothman*, 540 A.2d 504 (N.J. 1988). Furthermore, state law provided that (1) no patient shall be deprived of any civil right as a result of the receipt of treatment under the state's commitment laws, N.J. STAT. ANN. § 30:4-24.2(a), and (2) all patients, even those involuntarily hospitalized, shall be presumed competent. *Id.* § 30:4-24.2(c). These statutory provisions, together with the common law right to make informed treatment decisions, which included the right to determine one's treatment, see *Kaplan*, 232 A.2d at 840; *Common Law Remedy*, *supra* note 11, at 1743, provided all New Jersey patients with a right to determine one's course of treatment, which necessarily included the right to refuse medication.

An examination of New Jersey law at the time of *In re B.* reveals that the court in *In re B.* incorrectly concluded that because some forms of treatment, but not the administration of medication, required the provision of informed consent, hospital staff could administer medication in the absence of informed consent, i.e., over objection. Admittedly, under New Jersey law, a general provision should yield when it conflicts with a specific statutory provision. *Sheeran v. Nationwide Mut. Ins. Co., Inc.*, 388 A.2d 272, 275 (N.J. Super. 1978). Hence, if the laws pertaining to competence and the forfeiture of civil rights conflicted with laws governing the right to refuse medication, the latter would prevail. However, the legal axiom *expressio unius est exclusio alterius*, the express mention of one thing implies the exclusion of another is simply an interpretative aid and not the rule of law. *Gangemi v. Berry*, 134 A.2d 1, 6 (N.J. 1957). Any implication from the mention of some things in a statute and the exclusion of others "must be clear and compelling . . . not a conjectural or purely theoretical concept." *Id.* More importantly, under New Jersey law, any change limiting a patient's common law right to determine his own course of treatment would have had to have been expressly stated. See *State v. Western Union Tel. Co.*, 97 A.2d 480, 489 (N.J. 1953); *Fivehouse v. Passaic Valley Water Comm'n*, 317 A.2d 755, 757 (N.J. Super. 1974); *Township of Wayne v. Ricmin, Inc.*, 308 A.2d 27, 30 (N.J. Super. 1973). Accordingly, the court in *In re B.* should not have read into the statutory scheme in question a right to override a patient's common law right to make informed treatment decisions. There was no express intent to overrule a patient's common law right. Hence, the court could, and should, have interpreted the New Jersey provisions regarding treatment as (1) requiring affirmative consent when hospital staff sought to administer experimental treatment, shock therapy or psychosurgery, while (2) permitting a patient to refuse medication while authorizing hospital staff to administer

Moreover, a recognition that the absence of state law requires resort to a federal standard does not mean that the professional judgment standard is the appropriate standard to govern the right to refuse medication in any instance. Rather, the Supreme Court's remand in *Rennie IV* amounted to a suggestion that the professional judgment standard may be appropriate in the refusal of treatment context.²²⁷ *Youngberg* and *Rogers III* were the first Supreme Court cases

medication in the absence of an informed decision to accept drugs.

Not only did the court err in deciding *In re B.* in the manner that it did, but the circumstances surrounding the court's opinion, as related by the patient's counsel, are particularly troubling. The issue before the court was whether a patient who was a management problem in the hospital, i.e., posing a danger in the hospital setting, could be medicated over objection. Counsel, to the best of his recollection, is "almost sure" there were no briefs on this issue. Conversation with Donald Smith, respondent's counsel (Sept. 16, 1996). As this was a routine case in the state's mental hygiene court calendar, on the day the matter was on the court calendar the court issued a ruling from the bench that authorized the forcible administration of medication. *Id.* Only a few months later did the court issue, *sua sponte*, a written opinion that was published and which eventually served as authority for the Third Circuit's conclusion that involuntary patients could not refuse medication under state law. *Id.*

Ironically, a California appellate court looking at very similar case law to that which existed in New Jersey at the time of *In re B.*, reached the opposite conclusion and held that state law afforded patients a right to refuse medication. *See Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Cal. App. 1st Dist. 1987). California law provided that people with mental illness have the same legal rights as others under both federal and state law and no person may be presumed competent as a result of involuntary treatment for mental illness. *Id.* at 205, 206 (citing CAL. WELF. & INST. CODE §§ 5325.1; 5331 (West 1987)). State law also explicitly guaranteed patients the right to refuse convulsive therapy, i.e., shock treatment and psychosurgery. *Id.* at 207. The treating hospital argued that under *expressio unius est exclusio alterius*, all omissions under the statute should be regarded as exclusions, which would mean that the legislature intended to deny patients the right to refuse antipsychotic drugs. *Riese*, 271 Cal. Rptr. at 207. The court rejected this contention.

Recognizing that the inference embodied in the maxim *inclusio unius est exclusio alterius* is not to be drawn when it frustrates a legislative purpose, the court rejected the hospital's argument. Since state law clearly spelled out that unless specifically set forth, patients retain all their rights, and under common law individuals have the right to withhold their consent to treatment, "[t]he fact that [a statute] expressly authorizes patients to refuse psychosurgery and electroconvulsive treatment does not, as the defendants assert, exclude by implication the patients' rights to make treatment decisions as to antipsychotic drugs." *Id.* at 208 (quoting *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 313 (Mass. 1983)).

227. *See Zant v. Moore*, 489 U.S. 836, 837 (1989) (Backmun, J., dissenting) (commenting that vacated and remanded in light of another Supreme Court case does not mean a prejudgment of the issue a lower court must address on remand); *Busby v. Louisiana*, 474 U.S. 873, 875 (1985) (Marshall, J., dissenting) (commenting that generally, the Supreme Court will vacate and remand when an intervening decision "may" affect a lower court's decision); *see also Grant H. Morris, Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 351-352 (1995) (noting Supreme Court's remand of *Rennie IV* in light of

involving the treatment of institutionalized mentally disabled patients. Understandably, the Court believed the *Youngberg* standard might provide some guidance to the lower court addressing the treatment of the institutionalized mentally disabled. However, this does not mean that the Court necessarily believed that *Youngberg* controlled in the refusal of medication context. If the Court did, it is more likely that it would have issued an opinion so holding.²²⁸ The Court's remand in light of *Youngberg* was simply a recognition that the lower court decided the case without the benefit of *Youngberg* and hence it was appropriate to re-consider the issue of the right to refuse in light of the newly decided case.

The unusually deferential professional judgment standard also should not control the right to refuse issue even in the absence of relevant state law because the standard was designed for the unique situation presented in *Youngberg*. The considerations inherent in *Youngberg* do not exist in the refusal of treatment context.²²⁹

First, the right to treatment raises a distinct analysis under the Due Process Clause not applicable to the right to refuse.²³⁰ The right to treatment, which requires the government to provide an affirmative benefit to institutionalized mentally disabled individuals, is an exception to general constitutional jurisprudence.²³¹ Generally, the Constitution has been described as a "charter of negative rather than positive liberties."²³² The Due Process Clause declares that

Youngberg constituted a suggestion that professional judgment standard might be a usable standard in right to refuse cases).

228. When the Supreme Court believes that an intervening Supreme Court decision necessarily controlled another case on its docket, the Court decides this second case on the merits, relying on the intervening case as authority. It has not remanded the subsequent case. *See, e.g.,* *Wainwright v. Goode*, 464 U.S. 78, 86 (1983) (reversing court of appeals' decision relying upon *Barclay v. Florida*, 463 U.S. 939 (1983)).

229. Admittedly, courts have applied the professional judgment standard in numerous other situations. *See generally* Stefan, *supra* note 14, at 699-715. However, Professor Stefan persuasively argues that the adoption of the professional judgment standard in contexts other than the right to treatment is frequently incorrect. *See id.* at 672, 706.

230. *See Youngberg*, 457 U.S. at 315 (framing issues at hand as whether rights to be afforded are "protected substantively by the Due Process Clause").

231. *See Collins v. City of Harker Heights*, 503 U.S. 115, 127 n.10 (1992) ("[h]istorically, this guarantee of due process has been applied to *deliberate* decisions of government officials to *deprive* a person of life, liberty or property") ("deliberate" emphasized in original) ("deprive" emphasized by author).

232. *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983). In characterizing the Constitution in this manner, the Seventh Circuit noted that "[t]he men who wrote the Bill of Rights were not concerned that government might do too little for the people but that it might do too much to them. The Fourteenth Amendment, adopted in 1868 at the height of laissez-faire thinking, sought to protect Americans from oppression by state government, not to secure them basic governmental services." *Id.* at 1203. For a discussion of positive and negative rights under the Constitution, see Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271

a state may not “deprive any person of life, liberty or property without due process of law.”²³³ However, it “generally does not impose any affirmative ‘duty to provide substantive services.’”²³⁴

However, when a state restrains the liberty of a mentally disabled person so as to render him incapable of meeting such basic needs as food, clothing, shelter, medical care and reasonable safety, the Fourteenth Amendment imposes a “duty to assume some responsibility for his safety and general well-being.”²³⁵ Such a responsibility exists because the state has limited the person’s ability to act on his own behalf.²³⁶ In other words,

[i]n the substantive due process analysis, it is the State’s affirmative act of restraining the individual’s freedom to act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the ‘deprivation of liberty’ triggering the protections of the Due Process Clause, not its failure to act to protect his liberty interests against harms inflicted by other means.²³⁷

This reasoning supports the right to food, clothing, shelter, and safety that was set forth in *Youngberg*. It does not explain why the Constitution imposes an affirmative obligation upon a state already addressing the basic needs of an institutionalized individual to also provide treatment.²³⁸ The Court in *Youngberg*

(1990); David P. Currie, *Positive and Negative Rights*, 53 U. CHI. L. REV. 864 (1986).

233. U.S. CONST. amend XIV, § 1 (emphasis added).

234. *Fialkowski v. Greenwich Home for Children, Inc.*, 921 F.2d 459, 465 (3d Cir. 1990) (emphasis in original) (quoting *Youngberg*, 457 U.S. at 317).

235. *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 198, 200 (1989).

236. *Id.*

237. *Id.*

238. There have been numerous bases put forth to justify a right to treatment for institutionalized mentally disabled individuals. See, e.g., Roy G. Spece, Jr., *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 ARIZ. L. REV. 1 (1978) (discussing such legal bases for the right to treatment as the *quid pro quo* theory; a requirement of providing treatment to avoid commitment that is tantamount to punishment; and the least restrictive alternative theory). Perhaps the soundest foundation for the right to treatment rests with *Jackson v. Indiana*, 406 U.S. 715 (1972) and *Jones v. United States*, 463 U.S. 354 (1983). *Jackson* requires the “nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.” *Jackson*, 406 U.S. at 738. *Jones* established that the protection against harm caused by a mentally disabled person and treatment are both constitutionally acceptable and required purposes of commitment. In *Jones*, which was decided a year after *Youngberg*, the Court held that both civil commitment and confinement following a verdict of not guilty by reason of insanity serve to “treat the individual’s mental illness and protect him and society from his potential dangerousness.” *Jones*, 463 U.S. at 368. Accordingly, an insanity acquittee (and presumably, a civilly committed patient) “is entitled to release when he has recovered his sanity or is no longer dangerous.” *Id.* (emphasis added). Another Supreme Court case affirms the provision of treatment as a constitutional prerequisite for

provided little basis for the right to training,²³⁹ which it held to be among the protected liberty interests of the plaintiff,²⁴⁰ other than to note that involuntarily committed individuals “are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”²⁴¹

Having concluded that the Due Process Clause confers a right to training, the Court addressed two concerns. First, the Court wanted to limit judicial review of day-to-day treatment decisions,²⁴² particularly interference with institutional operations by the federal judiciary.²⁴³ Presumably this included a concern about excessive federal court intervention arising out of lawsuits for injunctive relief. Such a concern is understandable, considering that the constitutional requirement of a right to treatment means every treatment plan for every involuntarily hospitalized patient raises potential constitutional considerations.

Second, the Court believed that hospital clinicians should not have to make clinical decisions in the shadow of damages actions for wrongful or inappropriate treatment.²⁴⁴ This concern is also understandable in light of the evolving nature of the qualified immunity defense that was occurring at the time of the Court’s decision in *Youngberg*. At that time, the Court had not yet issued its opinion in *Harlow v. Fitzgerald*²⁴⁵ modifying the qualified immunity defense from a subjective to an objective standard.²⁴⁶ To further complicate the issue of damages, the plaintiff in *Youngberg* did not challenge the lower court’s jury

confinement. See *Foucha v. Louisiana*, 504 U.S. 71 (1992). In *Foucha*, the Court held that a state must release an insanity acquittee if he is no longer mentally ill, notwithstanding any potential harm he may cause. *Id.* at 77-79. Ironically, in *Youngberg*, the majority rejected *Jackson* as a basis for the substantive right to treatment, holding that *Jackson* was a procedural due process case that simply addressed the validity of an involuntary commitment. *Youngberg*, 457 U.S. at 320 n.27.

239. In *Youngberg*, the Supreme Court referred to the provision of treatment as “training” because the subject of the lawsuit was a mentally retarded individual and retardation is a training impairment as opposed to an illness. *Youngberg*, 457 U.S. at 309 n.1. Since *Youngberg*, courts have equated the issue of training of a retarded individual with the provision of treatment to a mentally ill person. See, e.g., *Woe v. Como*, 729 F.2d 96, 104-07 (2d Cir. 1984).

240. *Youngberg*, 457 U.S. at 319.

241. *Id.* at 322. In *Youngberg*, the mentally retarded resident’s representative sought only training related to safety and freedom from restraints and the court limited the right to training to that which was minimally adequate to ensure safety and freedom from restraint. *Id.* at 318-19. Without citing any authority, the Court adopted the concurring opinion of Chief Judge Seitz of the Third Circuit which noted that “the plaintiff has a constitutional right to minimally adequate care and treatment. The existence of a constitutional right to care and treatment is no longer a novel legal proposition.” *Id.* (quoting *Romeo v. Youngberg*, 644 F.2d 147, 176 (3d Cir. 1980) (Seitz, C.J., concurring)).

242. *Id.* at 322-23 & n.29.

243. See *id.* at 322.

244. *Id.* at 324-25.

245. 457 U.S. 800 (1982) (issued a week after *Youngberg*).

246. *Id.* at 815-19.

instructions on the qualified immunity defense that relied upon *Pierson v. Ray*²⁴⁷ and *Scheuer v. Rhodes*,²⁴⁸ neither of which would constitute good law in light of *Harlow*.²⁴⁹ As such, the professional judgment standard can be viewed as a legal standard that, in this period of legal flux, attempted to address a concern that liability should be imposed only on those government defendants whose conduct was not objectively reasonable.²⁵⁰

Understanding the Court's concerns about judicial scrutiny of treatment decisions and the imposition of excessive legal obligations upon clinicians helps to explain why the professional judgment standard should not govern the right to refuse. Seen in this light, the professional judgment standard is simply a standard of judicial review when reviewing decisions impacting protected liberty interests historically not under the substantive component of the Due Process Clause, such as the right to receive treatment.²⁵¹

These considerations have little relevance when examining individual decisions to refuse medication with debilitating, and, at times, life threatening consequences. The right to refuse involves scrutiny of deliberate decisions by physicians that interfere with the right of bodily autonomy, a right that has been historically ingrained within this nation's constitutional jurisprudence.²⁵² Indeed, the Supreme Court has explicitly recognized the constitutional differences between positive and negative rights when it concluded that "[c]onstitutional concerns are greatest. . .when the State attempts to impose its will by the force

247. 386 U.S. 547 (1967).

248. 416 U.S. 232 (1974).

249. *Youngberg*, 457 U.S. at 313 n.13.

250. Since 1982, the Supreme Court has clearly noted that 42 U.S.C. § 1983 (1994) does not subject government officials to liability unless they have acted in a manner in which no reasonable official would have acted. See *Anderson v. Creighton*, 483 U.S. 635, 641 (1987); *Malley v. Briggs*, 475 U.S. 335, 341 (1986).

251. Indeed, the Supreme Court took pains to "emphasize" that courts must defer to clinical decisions of qualified professionals and added that the professional judgment standard limits "judicial review" of treatment decisions in a manner that facilitates this deference. *Youngberg*, 457 U.S. at 322; see also *Regents of the Univ. of Mich. v. Ewing*, 474 U.S. 214, 225 (1985) (stating that the professional judgment standard governs review of decisions of academic professionals since courts must show great respect for the judgment of academic professionals). In this context, the professional judgment standard prohibits government conduct that so exceeds professional standards that it amounts to an arbitrary exercise of governmental power, which the Due Process Clause prohibits. See *Collins v. City of Harker Heights*, 503 U.S. 115, 127 n.10 (1992). For a more detailed discussion of this concept of due process protection, see *infra* notes 302-05 and accompanying text. See also *infra* notes 384-86 and accompanying text (concern for excessive judicial intervention justifies a "reasonably related to penological interests" standard of review in prison setting).

252. See *infra* notes 358-60 and accompanying text. For a general discussion of the difference between positive and negative rights and how this difference pertains to the right to refuse medication, see Stefan, *supra* note 14, at 642-43, 670-72.

of law. . . .”²⁵³

Indeed, if the *Youngberg* standard constitutes a balance between “‘the liberty of the individual’ and ‘the demands of an organized society[.]’”²⁵⁴ then the professional judgment standard is simply unworkable in the refusal of treatment context. No one can seriously dispute that historically, institutions for the mentally disabled have been fraught with abuse.²⁵⁵ Nor can anyone seriously dispute the need to ensure that the interests and desires of the institution and its employees do not *unfairly* override those of the psychiatric patient. A combination of factors, including the need to ensure the safety of staff and current staffing levels in a hospital, creates enormous incentives for government psychiatrists to prescribe medication.²⁵⁶ Furthermore, because institutional considerations often drive treatment decisions,²⁵⁷ not only is there an incentive to prescribe drugs, but also in very high doses. A docile patient who suffers from side effects, such as akinesia, makes life easier for hospital staff, and psychiatrists. Hence, whether on a conscious or unconscious level, there is incentive to err on the side of overmedication or even to overtly overmedicate patients.²⁵⁸

The Constitution requires that any decision to medicate satisfy a “medical appropriateness” standard.²⁵⁹ However, a professional judgment standard that governs the right to refuse not only results in decisions to medicate over objection but permits doctors to administer dosages of medication in excess of those acceptable, even if the treatment would otherwise constitute malpractice.²⁶⁰ Accordingly, drugs can be used for behavior control as long as the decision to medicate does not constitute a *substantial* departure from accepted practices. The line between medically appropriate treatment and behavior control becomes indecipherable.²⁶¹ Because use of the professional judgment standard to assess a decision to forcibly administer medication is neither “objective” nor “manageable,” but rather relies upon subjective appraisals of clinicians, use of such a standard is troubling.²⁶² Accordingly, while the professional judgment

253. *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 510 (1989) (quoting *Maher v. Roe*, 432 U.S. 464, 476 (1977)).

254. *Youngberg*, 457 U.S. at 320 (quoting *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting)).

255. *See, e.g., Stefan, supra* note 14, at 663.

256. *Gelman, supra* note 44, at 1228-29.

257. *See Stefan, supra* note 14, at 661.

258. As one authority has noted, while most jurisdictions prohibit the use of medication for staff convenience, “the practice of over-medicating patients persists, while other patients, staff, and administrators look the other way.” *Brooks, supra* note 47, at 507.

259. *See Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

260. *See Shaw v. Strackhouse*, 920 F.2d 1135, 1143, 1144-47 (3d Cir. 1990) (recognizing that traditional malpractice does not rise to the level of a professional judgment violation); *Estate of Porter v. Illinois*, 36 F.3d 684, 688 (7th Cir. 1994).

261. *See Brooks, supra* note 47, at 347.

262. *See Riggins*, 504 U.S. at 140-41 (Kennedy, J. concurring).

standard might strike the appropriate balance between individual and societal demands in the context of the provision of treatment, the standard is far too deferential to govern the forcible administration of medication because of the institutional abuses that can, and have, resulted from forced medication.²⁶³

Other significant differences between the situation presented in *Youngberg* and the right to refuse militate against application of the professional judgment standard when addressing the right to refuse medication. In *Youngberg*, in addition to the issue of treatment, the Court addressed the provision of temporary physical restraints as opposed to psychotropic drugs with their potentially short and long-term side effects.²⁶⁴ Forcing, by injection if necessary, a person to accept mind-altering medication unquestionably implicates a person's right to bodily integrity. However, when an institutionalized person, whose liberty has already been significantly diminished,²⁶⁵ has been placed in temporary restraint, such action simply amounts to a *de minimus* interference with a person's liberty, particularly when such action was to protect the patient. Indeed, as one authority has pointed out, the Supreme Court in *Youngberg* reserved judgment on whether the professional judgment standard governs the right to refuse, as the Court noted that issues of severe intrusions on individual dignity were not present in the case.²⁶⁶

Moreover, there was no question in *Youngberg* that the patient was severely retarded and lacked the capacity to make any treatment decisions.²⁶⁷ On the other hand, most civilly committed patients remain competent as a matter of law.²⁶⁸ Simply put, the government has a far greater interest in making treatment decisions for people who lack the capacity to care for themselves than they do for people whose decision-making skills are not so diminished that they are

263. See, e.g., Stefan, *supra* note 14, at 664-64. The potential for institutional abuse can be illustrated by the statement of Dr. Loren Roth, detailed at *supra* note 37. Another example is the abysmally poor response by the psychiatric profession when it was becoming abundantly clear that antipsychotic medication produced significant harm. Gelman, *supra* note 76, at 1755-56. Furthermore, mental hospitals in New Jersey once considered the administration of medication "voluntary" if a patient acquiesced after staff threatened with force." Gelman, *supra* note 44, at 1228 n.93.

264. See *Youngberg*, 457 U.S. 307, 319-23 (1982); see also *Bee v. Greaves*, 744 F.2d 1387, 1396 n.7 (9th Cir. 1984).

265. See, e.g., *Vitek v. Jones*, 445 U.S. 480, 493 (1980) (commenting that for an ordinary citizen, civil commitment entails a massive curtailment of liberty).

266. Gelman, *supra* note 44, at 1267 n.325 (citing *Youngberg*, 457 U.S. at 313 n.14.)

267. See *Bee*, 744 F.2d at 1396 n.7. Indeed, the court in *Bee v. Greaves* appears to understate the magnitude of the disability of the person upon whose behalf the lawsuit was brought. Nicholas Romeo was profoundly retarded (a level of retardation more pronounced than severe retardation) and had the mental capacity of an eighteen month old child and an I.Q. of between eight and ten. *Youngberg*, 457 U.S. at 309.

268. See *infra* note 507 and accompanying text; see also BRAKEL ET AL., *supra* note 4, at 406-09.

incompetent.²⁶⁹

In sum, the Supreme Court's remand of *Rennie IV* in light of *Youngberg* did not warrant application of the professional judgment standard in the refusal of treatment context. If the professional judgment standard does not govern the right to refuse medication, then one can begin to scrutinize the scope of Fourteenth Amendment protection by examining the source of any right to refuse, the weight of competing individual and state interests, and the standard of judicial review triggered by a decision to administer medication over objection. *Washington v. Harper*²⁷⁰ further establishes that constitutional analysis requires an evaluation of whether state law creates constitutionally protected liberty interests that the substantive component of the Fourteenth Amendment protects.

IV. THE SCOPE OF SUBSTANTIVE PROTECTION UNDER THE DUE PROCESS CLAUSE

A. *The Concept of Fundamental Rights and Other Protectable Liberty*

No provision of the Constitution explicitly protects against the unwanted administration of medication or any other forcible intrusions of the body. However, while the language of the Fourteenth Amendment "appears to focus only on the processes by which life, liberty, or property is taken,"²⁷¹ it is well-settled that the Due Process Clause contains a substantive component that protects rights that have no textual support within the Constitution.²⁷² This substantive component prohibits the government from taking action under certain circumstances regardless of the fairness of the procedures used.²⁷³

It is equally well-settled that the "liberty" that the Fourteenth Amendment protects "extends beyond freedom from physical restraint."²⁷⁴ Rather,

269. See *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 313-14 (Mass. 1983) (recognizing that a state's interest in providing necessary treatment overrides a patient's liberty interest in refusing medication only when the patient is legally incompetent to refuse medication); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (agreeing that a state's interest in providing necessary treatment overrides a patient's liberty interest in refusing medication only when the patient is legally incompetent to refuse medication); see also *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 287 n.12 (1990) (finding decisions made by competent patient and for incompetent patient are "so obviously different"); cf. also *Addington v. Texas*, 441 U.S. 418, 426 (1979) (stating that the "state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable . . . to care for themselves"); *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972) (finding that the state's *parens patriae* authority evolved from its role as the "general guardian of all infants, idiots, and lunatics") (citation omitted).

270. 494 U.S. 210 (1990).

271. *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986).

272. *Id.*; *Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992).

273. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2267 (1997); *Daniels v. Williams*, 474 U.S. 327, 331 (1986).

274. *Michael H. v. Gerald D.*, 491 U.S. 110, 121 (1985).

it denotes . . . also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness.²⁷⁵

Notwithstanding this seemingly broad concept of liberty, the Supreme Court has been reluctant to extend substantive protections of the Due Process Clause.²⁷⁶

In determining whether substantive due process protects a particular liberty interest in question, the Supreme Court has two seemingly related, but different standards. The Court will look at whether the liberty sought to be protected is “implicit in the concept of ordered liberty”²⁷⁷ or “deeply rooted in this Nation’s history and tradition.”²⁷⁸ Put another way, the latter standard examines whether the interest in question is “so rooted in the traditions and conscience of our people as to be ranked as fundamental.”²⁷⁹

However, the historical protection of certain interests will not ensure

275. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

276. *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992); *Regents of Univ. of Mich. v. Ewing*, 474 U.S. 214, 225-26 (1985).

277. *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)); *see also Glucksberg*, 117 S. Ct. at 2268.

278. *Bowers*, 478 U.S. at 191 (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977); *Glucksberg*, 117 S. Ct. at 2268. In *Moore v. City of East Cleveland*, the Supreme Court invalidated a housing ordinance that prohibited a grandmother from living with two grandchildren. *Moore*, 431 U.S. at 505-06. The Court concluded that the statute in question violated the appellant’s liberty protected by the substantive component of the Due Process Clause because the institution of family is deeply rooted in this Nation’s history and tradition. *Id.* at 503. In *Washington v. Glucksberg*, the Court upheld the State of Washington’s statute that prohibited the causing or aiding of a suicide. *Glucksberg*, 117 S. Ct. at 2275. The Court found that historically, suicide had been, and generally remains, prohibited. Hence, there is no right to physician assisted suicide under the substantive component of the Due Process Clause. *Id.* at 2271, 2275.

279. *Michael H. v. Gerald D.*, 491 U.S. 110, 122 (1985) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)). Determining whether the “history and tradition” standard is a more, less, or equally appropriate test as compared to the “ordered liberty” standard to determine the existence of protected liberty has generated a fair amount of discussion. *See, e.g.*, David Crump, *How Do the Courts Really Discover Unenumerated Fundamental Rights? Cataloguing the Methods of Judicial Alchemy*, 19 HARV. J.L. & PUB. POL’Y 795 (1996); Robin L. West, *The Ideal of Liberty: A Comment on Michael H. v. Gerald D.*, 139 U. PA. L. REV. 1373 (1991). However, because the history and tradition test has been adopted by both the liberal, conservative and moderate wings of the Supreme Court (*see, e.g., Glucksberg*, 117 S. Ct. at 2268; *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 305 (1990) (Brennan, J. dissenting); *Bowers*, 478 U.S. at 194; *Michael H.*, 491 U.S. at 123-24), and the right to refuse drugs is based in substantial part on the history and tradition of protecting an individual’s right to refuse unwanted medical care (*see infra* notes 358-63 and accompanying text), this Article will focus on this standard.

substantive due process protection. While history is an important factor in determining whether or not a particular practice is rooted in the concept of ordered liberty, it is not the sole factor. First, *Michael H. v. Gerald D.*²⁸⁰ establishes that such interests must be intensely personal and rest upon an historic “sanctity.”²⁸¹ Furthermore, while history is important, the Supreme Court also considers “the basic values that underlie our society.”²⁸² Fundamental

280. 491 U.S. 110 (1985).

281. *Id.* at 123-24. The Court in *Michael H.* never explained what it meant when it concluded that substantive due process protects those interests that rest upon an historic sanctity. *See id.* However, case law indicates that it involves matters relating to the most personal and private aspects of individual and family life. *See Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992); *see also Glucksberg*, 117 S. Ct. at 2271 n.19 (detailing instances in which Supreme Court found substantive due process protection). Hence, although one’s interest in reputation has been historically protected, the Supreme Court distinguished one’s interest in reputation from matters relating to “marriage, procreation, contraception, family relationships, and child rearing and education.” *Paul v. Davis*, 424 U.S. 693, 713 (1976). Substantive due process does not protect an individual’s interest in reputation. *Id.*

However, the Court in *Washington v. Glucksberg* made clear that substantive due process does not protect all important intimate and personal decisions. *Glucksberg*, 117 S. Ct. at 2269. Rather the Nation’s history, legal tradition and practices serve as “guideposts” for the delineating of substantive due process protections. *Id.* at 2268. Hence, it appears that only in rare instances will conduct that has not been historically protected receive substantive due process protection.

282. *Michael H.*, 491 U.S. at 122-123 (quoting *Griswold v. Connecticut*, 381 U.S. 479, 501 (1965) (Harlan, J. concurring)). A respect for basic values explains the decision in *Loving v. Virginia*, 388 U.S. 1 (1967). At one time, 41 states passed anti-miscegenation statutes. *Compassion in Dying v. Washington*, 79 F.3d 790, 806 n.20 (9th Cir. 1996) (citing Harvey M. Appelbaum, *Miscegenation Statutes: A Constitutional and Social Problem*, 53 GEO. L.J. 49, 50 & n.9 (1964)), *rev’d on other grounds, Glucksberg*, 117 S. Ct. at 2258. However, by the time *Loving* reached the Supreme Court, the Court had decided *Brown v. Board of Education*, 347 U.S. 483 (1954), which overturned *Plessy v. Ferguson*, 163 U.S. 537 (1896), and ended the constitutional sanctioning of the separation of races through the “separate but equal” doctrine. *See Brown*, 347 U.S. at 495. In addition, Congress has passed numerous civil rights statutes, such as the Civil Rights Act of 1964, 42 U.S.C. §§ 1971, 1975a-1975d, 2000a-2000h-g (1964), all of which evinced a rather significant change in societal attitudes towards the separation of races.

Within history, tradition and societal values, what is implicit within ordered liberty involves “the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.” *Planned Parenthood*, 505 U.S. at 851. While one would have thought that the Court in *Planned Parenthood* recognized that certain intimate decisions were simply beyond the reach of government interference regardless of whether such decisions have been historically and traditionally protected, this is not the case. Rather, the Court has interpreted this language within *Planned Parenthood* as a recognition that substantive due process protects highly personal and intimate decisions as long as such decisions are “deeply rooted in our history and traditions, or . . . fundamental to our concept of constitutionally ordered liberty.” *Glucksberg*, 117 S. Ct. at 2271.

rights deserving of substantive protection are those that relate to “freedom of action in a sphere contended to be ‘private.’”²⁸³ Such “private” rights include marriage, procreation, and family relationships.²⁸⁴ Bodily integrity²⁸⁵ is also part of this substantive protection.²⁸⁶

A determination of whether a particular type of liberty is deeply rooted in this Nation’s history and tradition requires a definition of the liberty in question. In his now famous footnote six in *Michael H. v. Gerald D.*,²⁸⁷ Justice Scalia concluded that a court should focus upon “the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified.”²⁸⁸ On the other hand, Justice Brennan would ask whether the specific interest in question is close enough to any interest previously deemed to be protected by the Fourteenth Amendment as to also be considered an aspect of “liberty.”²⁸⁹

Justices O’Connor and Kennedy joined all but footnote six of Justice Scalia’s

283. *Paul*, 424 U.S. at 713. In this way, unlike anti-abortion, anti-miscegenation and compulsory education laws, any harm to one’s reputation does not compartmentalize lives into highly confined institutional layers. See Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 784 (1989). Put another way, maintaining one’s reputation does not impact on the core decisions bearing on how one chooses to live his or her life.

284. *Roe v. Wade*, 410 U.S. 113, 152-53 (1973).

285. “Bodily integrity” involves the right to control one’s body, i.e., the physical aspect of one’s person. *Planned Parenthood*, 505 U.S. at 915-16 (Stevens, J., concurring in part, dissenting in part).

286. *Glucksberg*, 117 S. Ct. at 2267; *Albright v. Oliver*, 510 U.S. 266, 272 (1994). Because the Supreme Court has been willing to recognize substantive due process protections in areas not deemed fundamental, see *infra* notes 298-303 and accompanying text, when the Supreme Court has noted that substantive due process protects matters relating to bodily integrity, marriage, procreation and family, as it did in *Albright v. Oliver*, the Court was not setting forth an inclusive list of those aspects of liberty that substantive due process protects. Rather, the Court was delineating those fundamental rights that deserve the highest protection.

287. *Michael H.*, 491 U.S. at 127 n.6. This footnote has generated much heated debate. See generally Laurence H. Tribe & Michael C. Dorf, *Levels of Generality in the Definition of Rights*, 57 U. CHI. L. REV. 1057 (1990); West, *supra* note 279; L. Benjamin Young, Jr., *Justice Scalia’s History and Tradition: The Chief Nightmare in Professor Tribe’s Anxiety Closet*, 78 VA. L. REV. 581 (1992). Tribe and Dorf have noted that footnote six “seems destined to take its place alongside Justice Stone’s famous footnote [four] as one of constitutional laws most provocative asides.” *Id.* at 622 n.20 (quoting LAURENCE H. TRIBE AND MICHAEL C. DORF, ON READING THE CONSTITUTION 97-98 (1991)).

288. *Michael H.*, 491 U.S. at 127 n.6. Justice Thomas, who joined the Court after the decision in *Michael H.*, subscribes to the same substantive due process analysis as Chief Justice Rehnquist. See *Planned Parenthood*, 505 U.S. at 951-55 (Rehnquist, C.J. dissenting). Under this analysis, the substantive component of the Fourteenth Amendment does not protect a parent-child relationship that resulted from an adulterous relationship as historic practices did not treat such a relationship as a protected family unit. *Michael H.*, 491 U.S. at 124.

289. *Michael H.*, 491 U.S. at 142 (Brennan, J., dissenting).

opinion in *Michael H.*, and noted in a concurring opinion that characterizing rights at “the most specific level available” will not necessarily be the single mode of analysis.²⁹⁰ More significantly, Justices O’Connor and Kennedy have now rejected the Scalia approach to measuring the scope of substantive due process protection. These Justices, together with Justices Souter and Stevens, believe that Justice Scalia’s approach is “inconsistent with our law.”²⁹¹ Rather, they apparently adopted, in substantial part, the views of Justice Brennan.²⁹² The views of Justice O’Connor are particularly important, and Justice Kennedy only slightly less so, because to a significant degree, Justice O’Connor has shaped substantive due process since *Bowers v. Hardwick*.²⁹³

290. *Id.* at 132 (O’Connor, J., concurring).

291. *Planned Parenthood*, 505 U.S. at 847. As the Supreme Court itself recognized, if history were the sole guide, the Court would have decided *Loving v. Virginia*, 388 U.S. 1 (1967), differently. See *Planned Parenthood*, 505 U.S. at 847-48. In *Loving*, the Supreme Court found that substantive due process protected interracial marriage even though interracial marriage was illegal in most states in the 19th century. *Loving*, 388 U.S. at 12.

292. Justice Brennan’s concept of protected liberty within the Constitution has been described as “precedential.” West, *supra* note 279, at 1373. As Tribe and Dorf point out, this view rejects societal traditions as the defining mechanism for determining whether liberty is protected by the Due Process Clause and instead requires a court to rationally connect both judicial precedent and the different clauses within the Constitution. TRIBE & DORF, *supra* note 287, at 1065-69. This approach is illustrated by Justice Harlan’s concept of liberty, which he defines as “‘is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgement.’” *Id.* at 1068 (quoting *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)). This quote was relied upon by Justices O’Connor, Kennedy, and Souter in explaining what liberty entails in their opinion in *Planned Parenthood*. 505 U.S. at 848. Accordingly, these Justices believe that a woman’s right to choose an abortion is an example of both “*Griswold* liberty” while also fitting in within the right to bodily integrity. *Id.* at 857; see also *Washington v. Glucksberg*, 117 S. Ct. 2258, 2285 n.11 (1997) (Souter, J., concurring). See *infra* note 353 for a discussion of the liberty in question in *Griswold v. Connecticut*, 381 U.S. 479 (1965).

293. 478 U.S. 186 (1986). Justice O’Connor was in the five-person majority in *Bowers*. *Id.* at 187. She and Justice Kennedy joined all of the plurality opinion of Justice Scalia in *Michael H.* except for footnote six. *Michael H.*, 491 U.S. at 132. Justice O’Connor wrote the Court’s opinion in *Planned Parenthood* that commanded a majority of justices. See *Planned Parenthood*, 505 U.S. at 841-42. Justices O’Connor and Kennedy were part of the five person majority in *Cruzan*, but Justice O’Connor wrote a concurring opinion in which she emphasized that the substantive due process protects the right to refuse life sustaining medical treatment. See *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 287 (1990). Justice O’Connor wrote the opinion in *Riggins v. Nevada*, with which Justice Kennedy concurred in a separate opinion, 504 U.S. 127, 128 (1992), and both Justices were in the majority in *Washington v. Harper*, 494 U.S. 210, 212 (1990).

Reading *Bowers*, *Michael H.*, *Cruzan* and *Planned Parenthood* together suggests that Justice O’Connor believes that any assessment of whether a particular type of liberty is fundamental as to attain substantive due process protection requires an examination of a number of factors that may

As a result of the Supreme Court's reluctance to expand substantive due process protections, lower courts have concluded that substantive due process protects only those rights deemed fundamental.²⁹⁴ Although in some instances the Supreme Court has found no substantive protection when the liberty interests claimed were not deemed fundamental by the Court,²⁹⁵ this appears to be an overstatement. If substantive due process protected only fundamental constitutional rights, then the Supreme Court would subject all infringements of protected substantive liberty interests to the same scrutiny as it does the infringement of fundamental rights.²⁹⁶ However, this is not the case. Rather,

at times conflict. These include the degree to which the interest has been historically protected, *Michael H.*, 491 U.S. at 123-24, whether there has been societal approval or disapproval of the interest asserted, *Bowers*, 478 U.S. at 192, and, beyond these considerations, the extent that liberty is related to the physical and mental being of a person, *Planned Parenthood*, 505 U.S. at 851; *Cruzan*, 497 U.S. at 287-88.

Michael H. illustrates the Court's (including Justice O'Connor's) attempt to reconcile competing substantive due process considerations. The Court first recognized that history and tradition protected the "unitary family." *Michael H.*, 491 U.S. at 123. The Court further recognized that "[i]n some circumstances" the interests of an unwed father may be "comparable to those of the married father." *Id.* at 129 (quoting *Lehr v. Robertson*, 463 U.S. 248, 260 n.16 (1983) (quoting *Caban v. Mohammed*, 441 U.S. 380, 397 (1979) (Stewart, J., dissenting))). However, societal traditions place limits on the rights of an unwed father in this case in which the mother was cohabitating with, and married to, another man. *Id.* Hence, while substantive due process generally "places limits on a State's right to interfere with a person's most basic decisions about family and parenthood," *Planned Parenthood*, 505 U.S. at 849, under the facts of *Michael H.*, substantive due process did not require the state to permit the unwed father to rebut a presumption of parenthood by the paternal father. *Michael H.*, 491 U.S. at 129-30.

Hence, *Michael H.* can be viewed not so much as a dispute between the state and the natural father as it is the Court's attempt to reconcile competing constitutional considerations since the conferring of rights upon the natural father would have resulted in the loss of rights by the paternal father and impacted upon his liberty interest in parenthood and family. *Id.* at 126. Indeed, a different holding may occur in the situation when the marital parents did not wish to raise the child as their own. *Id.* at 130 n.7.

Admittedly it is difficult to reconcile Justice O'Connor's willingness to join the majority in *Bowers* with her opinion in *Planned Parenthood*. Perhaps because of the pervasive imposition of criminal penalties for sodomy, see *Bowers*, 478 U.S. at 193-94, on the "rational continuum" that Justice O'Connor recognizes governs substantive due process analysis, see *supra* note 292, homosexual activity falls closer to "adultery, incest, and other sexual crimes," *Bowers*, 478 U.S. at 196, than it does to family, marriage, or procreation. See *id.* at 191.

294. See, e.g., *Wooten v. Campbell*, 49 F.3d 696, 699 (11th Cir. 1995); *National Paint & Coatings Ass'n v. City of Chicago*, 45 F.3d 1124, 1129 (7th Cir. 1995); *Wright v. Lovin*, 32 F.3d 538, 540 (11th Cir. 1994); *Local 342, Long Island Pub. Serv. Employees v. Town Board*, 31 F.3d 1191, 1196 (2d Cir. 1994).

295. See *Bowers*, 478 U.S. at 192-94; *Michael H.*, 491 U.S. at 122-27.

296. In order to justify an infringement of a fundamental right, the state must demonstrate a compelling governmental interest. See, e.g., *Simon & Schuster, Inc. v. Members of the New York*

while the Supreme Court has recognized that substantive due process protects interests that fall within a certain private sphere that make them fundamental,²⁹⁷ the Court has also, at least implicitly, recognized that substantive due process protects certain liberty interests, without concluding that such interests are fundamental.²⁹⁸ In these instances, the Court has failed to scrutinize the abridgement of protected liberty in the manner that it does fundamental rights.²⁹⁹

A number of explanations exist for the Supreme Court's willingness to recognize that substantive due process protects some liberty interests without a concomitant determination that such interests are fundamental. First, there are aspects of liberty, such as a desire to pursue career opportunities or to wear one's hair at a particular length, that simply do not fall within a private realm because they do not involve "a substantial claim of infringement on the individual's freedom of choice with respect to certain basic matters of procreation, marriage, and family life."³⁰⁰ In other words, some government action does not unduly burden an interest that rests on an historic sanctity or involves an intrusion on the innermost being of the person.³⁰¹ Perhaps because these cases involved only qualified abridgement of liberty interests since those aggrieved sought inclusion

State Crime Victims Bd., 502 U.S. 105, 118 (1991); *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969). Any state or local government action must be narrowly tailored to further only the compelling interest in question. *See, e.g., Washington v. Glucksberg*, 117 S. Ct. 2258, 2268 (1997); *Reno v. Flores*, 507 U.S. 292, 302 (1993); *Simon & Schuster*, 502 U.S. at 118; *Zablocki v. Redhail*, 434 U.S. 373, 388 (1978). For a discussion of the appropriate standard governing an infringement of the right to refuse, see *infra* notes 380-417 and accompanying text.

297. *See, e.g., Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977); *Roe*, 410 U.S. at 152-53.

298. For example, the Supreme Court recognized that a confined mentally ill person's interest in refusing medication is protected by substantive due process without asking whether the right to refuse medication is fundamental. *See Washington v. Harper*, 494 U.S. 210, 221-22 (1990); *Rogers III*, 457 U.S. 291, 299 (1982). Likewise, the Court concluded that mentally ill individuals have a liberty interest in avoiding unwanted hospitalization, and thus that the circumstances in which a state may civilly commit people suffering from mental illness are limited. *See O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *see also infra* notes 300-03 and accompanying text.

299. Depending upon the liberty interest involved, the Court has either balanced the competing interests of the individual and the government or applied an arbitrariness standard to governmental action. *See supra* note 298 and *infra* notes 264-70 and accompanying text.

300. *Kelley v. Johnson*, 425 U.S. 238, 244 (1976); *see also Regents of Univ. of Mich. v. Ewing*, 474 U.S. 214, 225 (1985) (desire for continuation in joint undergraduate-medical school program); *Board of Curators of Univ. of Mo. v. Horowitz*, 435 U.S. 78, 91-92 (1978) (desire to continue participation in medical school program).

301. Governmental actions that amount to incidental infringements of liberty do not impermissibly conflict with a persons' liberty. Rather, liberty is violated when state regulations impose an undue burden on the exercise of a right. *See Planned Parenthood v. Casey*, 505 U.S. 833, 874 (1992).

in governmental operated programs,³⁰² the Supreme Court reviewed these governmental decisions by determining whether such action was arbitrary or capricious.³⁰³

Second, some of these cases involved rights that may well be fundamental but resolution of the case did not require that determination.³⁰⁴ Accordingly, at the very least, substantive liberty includes not only protection of fundamental rights through particularly rigorous judicial scrutiny of government conduct, but also a freedom from all substantial arbitrary impositions and purposeless restraints.³⁰⁵ Notwithstanding the Supreme Court's professed desire to limit the

302. The individuals in *Board of Curators of University of Missouri v. Horowitz* and *Regents of University of Michigan v. Ewing* sought continued inclusion in government operated academic programs that impacted upon the plaintiffs' careers. See *Ewing*, 474 U.S. at 214; *Horowitz*, 435 U.S. at 78. The plaintiff in *Kelley v. Johnson* challenged government rules regulating the appearance of the local police department and not citizens as a whole. See *Kelley*, 425 U.S. at 238. Moreover, these cases involved attempts by individuals to pursue career opportunities in particular government programs for which a limited number of positions were available. Certainly, a government decision that limits one particular career path differs from attempts to limit in full the opportunity to pursue career goals in general. See, e.g., *In re Ruffalo*, 390 U.S. 544, 550 (1968) (recognizing implicitly protected liberty interest in a license to practice law for procedural due process protection).

303. See *Ewing*, 474 U.S. at 225 (federal courts may only examine whether academic decisions constituted a substantial departure from accepted academic norms); *Horowitz*, 435 U.S. at 91-92; *Kelley*, 425 U.S. at 247 (requiring policeman to demonstrate no rational connection between regulation governing length of policeman's hair and promotion of public safety).

304. For example, in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the Court found that the State cannot involuntarily hospitalize a mentally ill person who is not dangerous to others and who can live safely in the community. *Id.* at 575-76. It may very well be that the right to liberty that is abridged in the civil commitment process is fundamental. See *Cooper v. Oklahoma*, 116 S. Ct. 1373, 1384 (1996) (citing *Addington v. Texas*, 441 U.S. 418 (1979) (setting forth the constitutionally required standard of proof in commitment hearings and addressing "proper protection of *fundamental rights* in circumstances in which the State proposes to take drastic action against an individual") (emphasis added)); *Foucha v. Louisiana*, 504 U.S. 71, 86 (1992) (stating freedom from physical restraint is a fundamental right). It is doubtful the Court would have reached a different result if it expressly held that physical liberty is a fundamental right. See, e.g., *Doremus v. Farrell*, 407 F. Supp. 509, 514 (D. Neb. 1975) (commenting that because of the fundamental rights involved in civil commitment, only the compelling interest of protecting against dangerousness will justify deprivation of liberty); *In re Harry M.*, 468 N.Y.S.2d 359, 363-65 (N.Y. App. Div. 1983) (commenting that the deprivation inherent in civil commitment requires overriding State interest; such overriding interest is protection of harm to self or others). Likewise, as the State in *Harper* could only medicate the prisoner when he posed a danger to himself or others or was gravely disabled, see *Washington v. Harper*, 494 U.S. 210, 221 (1990), the Court would have likely reached the same result if it determined that the right to refuse medication is a fundamental right. See *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (use of medication to protect against harm to self or others constitutes overriding justification for forced drugging).

305. See *Planned Parenthood*, 505 U.S. at 848-49 (quoting *Poe v. Ullman*, 367 U.S. 497, 543

scope of substantive due process, its willingness to find protected liberty interests in the absence of a determination that such interests are fundamental indicates that the Court may be moving to a more inclusive concept of protectable liberty in which the Court will utilize a continuum approach and balance the liberty interests protected by substantive due process against relevant state interests.³⁰⁶

This continuum approach also raises the question of whether the Court will move away from even assessing whether the state has infringed upon a fundamental right and simply determine whether a liberty interest exists and balance such interest against relevant state interests.³⁰⁷ This question has arisen as a result of the Supreme Court's decision in *Webster v. Reproductive Health Services*,³⁰⁸ in which Chief Justice Rehnquist noted that a woman's decision to have an abortion was "a liberty interest protected by the Due Process Clause."³⁰⁹ One year later in *Cruzan v. Director, Missouri Department of Health*,³¹⁰ Chief Justice Rehnquist characterized the right to refuse life sustaining support in the form of artificial hydration and nutrition as "more properly analyzed in terms of a Fourteenth Amendment *liberty interest*" than under the constitutional right of privacy.³¹¹

A significant difference may well exist between a fundamental constitutional right and a liberty interest protected by the substantive component of the Due Process Clause.³¹² A liberty interest approach could conceivably make it substantially more difficult for a patient to reject medication under federal law, as "a fundamental rights approach would normally involve strict compelling scrutiny, an exceedingly difficult standard for the government to meet, whereas

(1961) (Harlan, J. dissenting)). One can argue that in *Ewing, Horowitz, and Kelley v. Johnson*, the Court was willing to assume the existence of liberty interests because they were not necessary to the resolution of the cases and the Court has never determined that a desire to pursue a particular career choice is protected liberty. See *Collins v. City of Harker Heights*, 503 U.S. 115, 129-30 (1992) (assuming existence of state-created liberty interest and finding that deprivation was not arbitrary). However, the Court's reference in *Planned Parenthood* to limitations on arbitrary governmental conduct strongly suggests that limitations exist on the government's authority to limit a person's choices about how a person wishes to live his life. *Planned Parenthood*, 505 U.S. at 847-49; see also *Washington v. Glucksberg*, 117 S. Ct. 2258, 2271 (1997) (holding that the Constitution requires a prohibition against physician assisted suicide to be rationally related to legitimate government interests even when no fundamental right is involved); *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986) (finding no fundamental right to engage in homosexual behavior, but further declaring that rational basis exists for sodomy criminal statutes).

306. See T. Alexander Aleinkoff, *Constitutional Law in the Age of Balancing*, 96 YALE L.J. 943, 970-71 (1987).

307. See MARTIN A. SCHWARTZ & JOHN E. KIRKLIN, 1A SECTION 1983 LITIGATION: CLAIMS AND DEFENSES, § 3.7, at 141-42 (3d ed. 1997).

308. 492 U.S. 490 (1989).

309. *Id.* at 520.

310. 497 U.S. 261 (1990).

311. *Id.* at 279 n.7 (emphasis added).

312. SCHWARTZ & KIRKLIN, *supra* note 307, § 3.7 at 141-42.

a liberty interest approach would normally invoke deferential rational basis review, an exceedingly difficult standard for the plaintiff to overcome.”³¹³ However, upon analysis, it appears that the Supreme Court has not yet rejected a fundamental rights approach and Chief Justice Rehnquist’s opinions in *Webster* and *Cruzan* should not be read as final authority for such a rejection.³¹⁴ Rather, the opinions may simply be a recognition that those fundamental rights that fall within a private sphere³¹⁵ arise not out of a penumbral right of privacy as suggested in *Griswold v. Connecticut*,³¹⁶ but out of the Fourteenth Amendment’s protection of substantive liberty that necessarily requires an evaluation of the competing interests of the individual and the state.³¹⁷

Three years after *Webster*, in *Planned Parenthood v. Casey*,³¹⁸ the Supreme Court, in an opinion conspicuously devoid of reference to a right of privacy, nevertheless reaffirmed the fundamental right of a woman to choose an abortion: “The controlling word in the cases before us is ‘liberty.’ . . . [A]ll *fundamental rights* comprised within the term liberty are protected by the Federal Constitution.”³¹⁹ The Court in *Planned Parenthood* made frequent use of the terms “fundamental right,” “right,” “fundamental interest,” “liberty,” and “liberty interest.”³²⁰ This suggests that, notwithstanding the use of various terms, some

313. *Id.* at 142.

314. Indeed, in *Webster*, when rejecting the trimester approach for delineating relevant state interests, the Court’s analysis rested upon an assumption that abortion is a fundamental right: “The dissenters in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)], writing in the context of the *Roe* trimester analysis, would have . . . posit[ed] against the ‘fundamental right’ recognized in *Roe* the State’s ‘compelling interest’ in protecting potential human life throughout pregnancy. ‘[T]he State’s interest, if compelling after viability, is equally compelling before viability.’” *Webster v. Reproductive Health Serv.*, 492 U.S. 490, 519 (1989) (quoting *Thornburgh*, 476 U.S. at 795 (White, J. dissenting)).

315. *Paul v. Davis*, 424 U.S. 693, 713 (1976).

316. 381 U.S. 479, 483-86 (1965).

317. In rejecting the right of privacy as a source of a constitutionally protected interest in refusing life-sustaining treatment, the Court in *Cruzan* recognized that “‘whether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.’” *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 279 (1990) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). Hence, when referring to substantive liberty as a “liberty interest” in *Webster*, the Court evaluated “the claims of the State to protect the fetus as a form of human life against the claims of a woman to decide for herself whether or not to abort a fetus she was carrying.” *Webster*, 492 U.S. at 520. More significantly, Justices O’Connor and Kennedy were two of the five members of the Court who joined Chief Justice Rehnquist’s opinion in *Cruzan*, 497 U.S. at 263. These two justices comprised part of the plurality opinion in *Planned Parenthood* that made frequent reference to fundamental rights and interests. *Planned Parenthood v. Casey*, 505 U.S. 833, 833 (1992); see *infra* notes 319-20 and accompanying text.

318. 505 U.S. 833 (1992).

319. *Id.* at 846 (emphasis added) (internal citations omitted).

320. The plurality opinion in *Planned Parenthood* made a number of other references to the

rights or interests are fundamental.³²¹ The scope of the fundamental right is determined by balancing it against relevant state interests.³²²

More recently, the Supreme Court reaffirmed the concept of fundamental rights in *Cooper v. Oklahoma*,³²³ in which the Court concluded that a “defendant’s fundamental right to be tried only while competent outweighs the State’s interest in the efficient operation of its criminal justice system.”³²⁴ Significantly, when the Court compared the deprivation of rights from an incompetent defendant with that from a mentally ill person facing civil commitment, the Court noted that “[b]oth cases concern the proper protection of *fundamental rights* in circumstances in which the State proposes to take drastic action against an individual. The requirement that the grounds for civil commitment be shown by clear and convincing evidence protects the individual’s *fundamental interest* in liberty.”³²⁵ In *Washington v. Glucksberg*³²⁶ all nine

right to an abortion. *E.g.*, *Planned Parenthood*, 505 U.S. at 871 (stating, “The woman’s right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*.”). However, the interchangeable use of all of these terms supports Chief Justice Rehnquist’s view that “there is wisdom in not unnecessarily attempting to elaborate the abstract differences between a ‘fundamental right’ . . . , a ‘limited fundamental constitutional right’ . . . or a liberty interest.” *Webster*, 492 U.S. at 520 (citations omitted). The interchangeable use of the terms “fundamental right” and “fundamental interest” can be seen in other instances. *See, e.g.*, *Washington v. Harper*, 494 U.S. 210, 241 (1990) (Stevens, J., dissenting) (characterizing the right to refuse drugs as a “fundamental liberty interest deserving the highest order of protection”); *Moore v. City of East Cleveland*, 431 U.S. 494, 551 (1977) (White, J., dissenting) (strict scrutiny is employed when fundamental interest is involved).

321. *See Glucksberg*, 117 S. Ct. at 2283 n.10 (Souter J. concurring) (stating, “Our cases have used various terms to refer to fundamental liberty interests.”).

322. *See id.* (citations omitted) (commenting that although the Supreme Court has used various terms to refer to fundamental liberty interests, “[p]recision in terminology . . . favors reserving the label ‘right’ for instances in which the individual’s liberty interest actually trumps the government’s countervailing interests; only then does the individual have anything legally enforceable as against the state’s attempt at regulation.”); *see also* *Rogers III*, 457 U.S. 291, 299 (1982) (citing, *inter alia*, *Roe v. Wade*, 410 U.S. 113 (1973)) (commenting that substantive due process involves identification of constitutional interest and identification of state interests that might outweigh it). Accordingly, the Court’s opinion in *Planned Parenthood* should be read to indicate that after the balancing of individual and government interests, there is a right of a woman to choose an abortion that is a part of liberty and not a right of privacy. *See, e.g.*, *Planned Parenthood*, 505 U.S. at 869 (stating, “[I]t is a constitutional liberty of the woman to have some freedom to terminate her pregnancy.”); *id.* at 873 (stating, “Jurisprudence relating to all liberties save perhaps abortion has recognized [that] not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right”); *id.* at 876 (stating, “The undue burden standard is the appropriate means of reconciling the State’s interest with the woman’s constitutionally protected liberty.”).

323. 116 S. Ct. 1373 (1996).

324. *Id.* at 1383.

325. *Id.* at 1384 (emphasis added). The Supreme Court’s reference to the right of a person

members of the Court concluded that the Due Process Clause “provides heightened protection against government interference with certain fundamental rights and liberty interests.”³²⁷

As a result of the Supreme Court’s continued reference to fundamental rights and interests, Chief Justice Rehnquist’s opinions in *Webster* and *Cruzan* can be seen not as a repudiation of the concept of fundamental rights, but as a clarification that substantive liberty within the Fourteenth Amendment gives rise to fundamental personal rights, and such rights do not arise from a right of privacy. Indeed, while rejecting the concept of a right of privacy, Chief Justice Rehnquist has recognized the existence of fundamental rights in the areas of personal or family privacy and autonomy.³²⁸

Accordingly, these opinions appear to forestall rejection of the fundamental rights approach in constitutional analysis. Rather, substantive due process analysis establishes that there is a hierarchy of constitutional protection depending upon the interest asserted and the context in which it is asserted. First, the continued reference to the concept of fundamental interests and rights, particularly in *Planned Parenthood* and *Glucksberg*, indicates that the Court is willing to determine whether a given interest fits within the category of rights traditionally deemed fundamental under either the “ordered liberty” or “history and tradition” standards. These rights include decisions about family and

to remain free from civil commitment as a fundamental right and fundamental interest in succeeding sentences gives credence to Chief Justice Rehnquist’s caveat that one should not attempt to distinguish between fundamental rights and interests. See *supra* note 320. Admittedly, *Cooper v Oklahoma* was as much a procedural due process case as it was a substantive due process case, as it addressed the issue of whether a state could presume a defendant competent and require him to prove that he was competent to stand trial by clear and convincing evidence. *Cooper*, 116 S. Ct. at 1377. However, in addressing this question, the Court applied the same test that it would have in a substantive due process case: whether the state evidentiary rules offend a principle of justice “so rooted in the traditions and conscience of our people as to be ranked as fundamental.” *Id.* (internal quotations omitted). The Supreme Court’s examination of historical practices in *Cooper v Oklahoma* to determine whether a procedural right is fundamental and hence subject to detailed scrutiny illustrates the Court’s willingness to recognize the interrelationship between substantive and procedural due process analysis. See *id.*; see also *M.L.B. v. S.L.J.*, 117 S. Ct. 555, 563 n.6 (1996) (relying on substantive due process cases relating to family matters to find need for heightened procedural protection in a parental rights termination proceeding).

326. 117 S. Ct. 2258 (1997).

327. *Id.* at 2267.

328. *Id.*; *Planned Parenthood*, 505 U.S. at 951 (Rehnquist, C.J., concurring and dissenting).

In the same vein, when the Court in *Cruzan* stated that a right to refuse treatment is more properly analyzed in terms of a Fourteenth Amendment liberty interest than the right of privacy, the Court cited only *Bowers v. Hardwick* a case whose decision rested on whether the protected activity was fundamental. *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 279 n.7 (1990); see *Bowers v. Hardwick*, 478 U.S. 186, 191-94 (1986). This further indicates that Chief Justice Rehnquist does not believe that a court should forego analysis of whether an interest asserted is fundamental.

parenthood, as well as bodily integrity.³²⁹ Second, Supreme Court decisions in such cases as *O'Connor v. Donaldson*³³⁰ and *Washington v. Harper*,³³¹ together with such decisions as *Kelley v. Johnson*³³² and *Board of Curators of University of Missouri v. Horowitz*,³³³ reflect the willingness of the Supreme Court to protect liberty that does not necessarily satisfy the "ordered liberty" or "history and tradition" standards as long as the liberty in question is part of a person's orderly pursuit of happiness.³³⁴ An abridgement of these rights requires either a balancing of competing individual and state interests or a utilization of an arbitrary and capricious standard. Use of either standard depends upon the magnitude of the liberty interest asserted and the context in which it is infringed.³³⁵

The last class of substantive rights belongs to individuals whom the state has deprived of liberty through incarceration, institutionalization, or other similar restraint.³³⁶ The substantive component of the Due Process Clause protects this class of individuals because "when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."³³⁷

On one level, the distinction between fundamental rights and liberty interests may not be particularly significant. Either approach requires a balancing of rights that places the scope of an individual's right to refuse medication at the mercy of the subjective values of judges who are evaluating the right. One judge's overriding justification, or compelling interest, that will support an

329. See *Planned Parenthood*, 505 U.S. at 849.

330. 422 U.S. 563 (1975).

331. 494 U.S. 210 (1990).

332. 425 U.S. 238 (1976).

333. 435 U.S. 78 (1978).

334. See *supra* note 275 and accompanying text.

335. See *supra* notes 302-04 and accompanying text.

336. *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 200 (1989). In both *Board of Curators of University of Missouri v. Horowitz*, 435 U.S. 78, 91-92 (1978) and *Regents of the University of Michigan v. Ewing*, 474 U.S. 214, 223 (1985), the Court assumed that substantive due process protected individuals from arbitrary state action in the university setting. Even if the Court were to eventually so hold, and there is substantial question as to whether it would, see *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992), any such protection would be no greater than that afforded to those individuals whose substantive due process rights arise out of their confinement. See *Ewing*, 474 U.S. at 225 (subjecting any academic decisions to the professional judgment standard of *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982)).

337. *DeShaney*, 489 U.S. at 199-200. Since the Supreme Court in *Youngberg* first recognized this substantive due process protection, little question exists that government action that abridges these liberty interests of incarcerated individuals will be subject to far less scrutiny than those rights traditionally deemed fundamental. Compare *Youngberg*, 457 U.S. at 317, 323 (finding the state retains considerable discretion in determining scope of responsibilities to provide protection from harm and treatment), with *Roe v. Wade*, 410 U.S. 113, 155 (1973) (compelling state interest necessary when government seeks to override a fundamental right).

infringement on a fundamental right is another judge's significant interest that justifies overriding an important liberty interest.³³⁸ In either case, one can expect that since the well-entrenched right to bodily autonomy serves as a basis for the liberty interest out of which the right to refuse medication arises, the government will have a heavy burden when attempting to justify any infringement on the right to refuse.

However, on a different level, whether or not the right to refuse medication is fundamental has one significant implication. Not only must the state set forth a compelling state interest in order to justify the infringement of a fundamental right, but any limitation must be narrowly tailored to further only those compelling government interests.³³⁹ Such requirement serves as the basis for the "least restrictive alternative" doctrine, a rule of law that serves as a further limitation upon the government's authority to administer medication over objection.³⁴⁰

Little question exists that patients retain a liberty interest in refusing medication that requires some substantive due process protection.³⁴¹ Part V.B will establish that the right to refuse fits within the category of fundamental rights which affords individuals who wish to refuse medication the broadest constitutional protection.

B. The Fundamental Nature of the Right to Refuse

A determination of whether the right to refuse is fundamental requires analysis of whether the right to refuse satisfies either the "history and tradition"

338. Indeed, the Court has not been exacting in terms of the magnitude of state interests needed to justify an abridgement of a fundamental right. *Compare Roe*, 410 U.S. at 155 (compelling state interest needed), *with Zablocki v. Redhail*, 434 U.S. 374, 388 (1978) (only sufficiently important state interest can support interference with fundamental right); *see also Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977) (intrusions on family living arrangements requires careful examination of governmental interests); *Loving v. Virginia*, 388 U.S. 1, 11 (1967) (overriding purpose needed to justify racial classification). The Supreme Court has taken pains to indicate that application of the requirement of a compelling government interest does not forbode a particular result but instead requires a court to engage in careful balancing. *See Adarand Constructors, Inc. v. Pena*, 115 S. Ct. 2097, 2117 (1995) ("we wish to dispel the notion that strict scrutiny is strict in theory, but fatal in fact") (internal quotations omitted). In the refusal of treatment context, the significance of the state interest needed to override a patient's decision to refuse is further lessened because the Supreme Court has strongly suggested that state law should guide the balancing process of individual and state interests. *See Rogers III*, 457 U.S. 291, 304 (1982). For a further discussion in the balancing of interests in the refusal of treatment context, *see infra* notes 418-70 and accompanying text.

339. *See, e.g., Zablocki*, 434 U.S. at 388; *Washington v. Glucksberg*, 117 S. Ct. 2258, 2268 (1997); *Reno v. Flores*, 507 U.S. 292, 302 (1993).

340. *See infra* notes 471-80 and accompanying text.

341. *See Rogers III*, 457 U.S. at 299 & n.16; *Washington v. Harper*, 494 U.S. 210, 221 (1992).

or “ordered liberty” tests.³⁴² Such an evaluation requires a definition of the right. The Supreme Court has framed the issue of whether, and to what extent, an “involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs.”³⁴³ Supreme Court case law establishes that it is not important that the class seeking to exercise this right is comprised of institutionalized mentally ill people.

First, in an analogous context, the Supreme Court has never concluded that a right is less fundamental than it would ordinarily be merely because a prisoner, as opposed to an ordinary citizen, sought to exercise it.³⁴⁴ Rather, the Court simply subjects an abridgement of a prisoner’s fundamental right to a different standard of review than it would apply if an ordinary citizen were to suffer such an abridgement.³⁴⁵

Furthermore, even if one subscribes to the methodology of Justice Scalia in determining the characterization of the right in question, which the majority of the Court apparently does not,³⁴⁶ the result is the same. There is simply no historical tradition either protecting or denying the right of psychiatrically hospitalized patients to refuse drugs.³⁴⁷ Moving to what might constitute the next

342. See *supra* notes 277-79 and accompanying text.

343. *Rogers III*, 457 U.S. at 298-99; see also *Harper*, 494 U.S. at 221 (characterizing the interest as a prisoner’s interest in refusing unwanted administration of antipsychotic drugs).

344. See, e.g., *Turner v. Safley*, 482 U.S. 78, 95 (1987) (recognizing prisoner’s fundamental right to marry).

345. See *Harper*, 494 U.S. at 223 (stating that the Supreme Court will apply a “reasonably related to penological interests” standard “even when the constitutional right claimed to have been infringed is fundamental, and the State under other circumstances would have been required to satisfy a more rigorous standard of review.”). Indeed, it is telling that when, in *Planned Parenthood*, the Court set forth the proposition that marriage is a fundamental right even though it is not mentioned in the Constitution, the Court cited with approval *Turner*, 482 U.S. at 94-99. *Planned Parenthood v. Casey*, 505 U.S. 833, 848 (1992). Part IV.C will address the proper standard of review to govern a psychiatric patient’s decision to refuse drugs.

346. See *supra* notes 290-92 and accompanying text.

347. Courts first addressed the right to refuse drugs in the early 1970’s. See *Brooks, supra* note 47, at 341 & n.3 (citing *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971); *In re B.*, 383 A.2d 760 (N.J. Super. Ct. Law Div. 1977)). This is not surprising since antipsychotic medication was not produced until the 1950’s. See *PERLIN, supra* note 29, § 5.02, at 218. Indeed, research details that the provision of antipsychotic medication was first challenged in *Cox v. Hecker*, 218 F. Supp. 749 (E.D. Pa. 1963). In *Cox*, the court granted judgment to state hospital officials in a malpractice claim on the ground that the plaintiff failed to establish through expert testimony that the administration of Thorazine was improper. *Id.* at 753.

Similarly, state statutes addressing the treatment rights of patients are of relatively recent origin. See, e.g., ALA. CODE § 22-8-1 (1984) (delineating the right to refuse treatment, first passed in 1971); ARK. CODE ANN. § 20-47-218(B)(4) (Michie 1997) (treatment statute passed in 1989); CONN. GEN. STAT. ANN. § 17a-543(b) (Michie 1997) (right to refuse treatment statute evolved from 1958 statute); IOWA CODE § 229.23(2) (1997) (treatment statute first passed in 1962). Both the absence of case and statutory law can be contrasted with the prevalence of laws prohibiting abortion

level of tradition, there is also no tradition protecting or denying the right of psychiatric patients to refuse any sort of treatment or to make informed treatment decisions.³⁴⁸ Hence, one must move to the next level of generality which appears to be the rights of individuals in general to refuse unwanted treatment modalities.³⁴⁹ Accordingly one must determine whether the aspect of liberty that a psychiatric patient wishes to exercise, namely, a desire to refuse drugs and medical treatment, fits within an aspect of liberty that the Supreme Court has deemed fundamental.³⁵⁰

The Supreme Court is willing to equate one's interest in refusing antipsychotic medication with the right to bodily integrity, which carries with it a limitation on the government's authority to compel medical treatment. In *Planned Parenthood v. Casey*,³⁵¹ the Court recognized that *Roe v. Wade*³⁵² could be viewed not only as upholding the concept of liberty in a general sense, which the Court referred to as "*Griswold* liberty,"³⁵³ but also as "a rule (whether or not

and sodomy that existed in the 19th century. See *Planned Parenthood v. Casey*, 505 U.S. 833, 952 (1992) (Rehnquist, C.J., dissenting); *Bowers v. Hardwick*, 478 U.S. 186, 192-93 (1986).

348. An examination of West's American Digest, which chronicles cases from 1658 until 1896, and the First Decennial through the Seventh Decennial, reveals that until the 1970's *Cox v. Hecker* was the only case to challenge the provision of treatment. See *Cox*, 218 F. Supp. at 749. In the 1970's, courts began to address the right to refuse unwanted treatment modalities on a sporadic basis. See *Stowers v. Wolodzko*, 191 N.W.2d 355, 362, 365 (Mich. 1971) (finding that forced treatment not authorized by law constituted an assault and battery); *New York City Health & Hosps. Corp. v. Stein*, 70 Misc. 2d 944, 947 (N.Y. Sup. Ct. 1972) (recognizing right of competent patient to refuse electroshock treatment); *Kaimowitz v. Michigan Dep't of Mental Health*, unpublished (reprinted in ALEXANDER D. BROOKS, *LAW PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 902 (1974) (prohibiting psychosurgery, i.e., lobotomy); *Price v. Sheppard*, 239 N.W.2d 905, 910-912 (Minn. 1976) (setting forth limits on the state's efforts to administer electroshock therapy); *Aden v. Younger*, 129 Cal. Rptr. 535, 548-549 (Cal. App. 1976) (recognizing right of competent patients to refuse electroconvulsive therapy). These limited cases cannot be said to constitute an historical tradition protecting the right of psychiatric patients to bodily autonomy.

349. One can assert that this is not the correct level and one should focus on how society traditionally addressed the issue of compulsory treatment in the form of civil commitment. However, framing the level of generality in this manner fails to take into account the significant difference between commitment and the provision of unwanted treatment, namely, the physical invasion on one's body that society has historically protected. See *infra* notes 359-63 and 373-76 accompanying text. If nothing else, the difficulty in determining what constitutes the appropriate levels of generality illustrates the difficulty in applying the methodology of Justice Scalia. See *TRIBE & DORF*, *supra* note 287, at 1090-91.

350. See *Albright v. Oliver*, 510 U.S. 266, 272 (1994); *Washington v. Glucksberg*, 117 S. Ct. 2258, 2267 (1997).

351. 505 U.S. 833 (1992).

352. 410 U.S. 113 (1973).

353. In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the Court recognized that a right to use contraceptives fell within a zone of privacy that the Constitution protected. *Id.* at 484-86.

mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection.³⁵⁴ In support of this interpretation of *Roe*, the Court cited, *inter alia*, its most recent refusal of medication cases, *Riggins v. Nevada*,³⁵⁵ and *Washington v. Harper*.³⁵⁶ Significantly, the Court concluded that whether one views the right to abortion as emanating from *Griswold* liberty or the right to bodily integrity, which permits a person to refuse unwanted medical treatment, the result is the same.³⁵⁷

Furthermore, the right to make significant decisions about one's body is rooted in the history and traditions of the American people.³⁵⁸ As far back as 1891, the Supreme Court recognized the significant nature of this right in *Union Pacific Railway Co. v. Botsford*³⁵⁹: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person."³⁶⁰ The Supreme Court has recognized that the concept of bodily integrity in *Botsford* served as a framework for the informed consent doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."³⁶¹ Significantly in *Cruzan v. Director, Missouri Department of Health*,³⁶² the Court recognized that the doctrine of informed consent embodies the right to refuse medication: "The logical corollary of the doctrine of informed consent is that the patient

354. *Planned Parenthood*, 505 U.S. at 857.

355. 504 U.S. 127 (1992).

356. *Id.* (citing *Riggins*, 504 U.S. at 135; *Washington v. Harper*, 494 U.S. 210 (1990)).

357. *Id.*; see also *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring) (stating the "Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause").

358. See *Michael H. v. Gerald D.*, 491 U.S. 100, 122 (1989); *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986).

359. 141 U.S. 250 (1891).

360. *Id.* at 251. *Botsford* involved an attempt by a defendant in a civil action to require the plaintiff to submit to a surgical examination to determine the scope of her injury. The Supreme Court interpreted a federal statute governing trials in federal courts. *Id.* at 256. However, this does not weaken *Botsford* as indicia of the historical protection of the common law protection of bodily autonomy. Its pertinence to constitutional analysis lies in its recognition of the historical protection of a person's right to control her body.

361. *Cruzan*, 497 U.S. at 269 (quoting *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30 (1914)); see also *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905) (stating, "under a free government at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent . . . to violate without permission the bodily integrity of his patient by major or capital operation"). For further discussion of the common law as a source of protection for patients who wish to refuse drugs, see generally *Common Law Remedy*, *supra* note 11.

362. 497 U.S. 261 (1990).

generally possesses the right not to consent, that is, to refuse treatment.”³⁶³ The Supreme Court’s opinion in *Riggins v. Nevada*,³⁶⁴ further suggests that the Court considers the right to refuse medication as fundamental. First, the Court equated the right of a pretrial detainee to refuse drugs with other “infringements of fundamental constitutional rights.”³⁶⁵ Second, the Court concluded that the trial court erred when it authorized the forced drugging of a criminal defendant because it failed to consider whether or not the medication, in light of less intrusive alternatives, was essential for the safety of the defendant or to others.³⁶⁶ Finally, the Court interpreted *Washington v. Harper*³⁶⁷ as requiring findings of an “overriding justification” and medical appropriateness as the accepted rationale for administering medication over objection to a prisoner.³⁶⁸ The Court recognized that the state court failed to find that safety considerations or “other compelling concerns” outweighed Riggins’ interest in freedom from unwanted antipsychotic drugs.³⁶⁹ Requiring both an overriding justification for governmental conduct and an assessment of whether less intrusive alternatives existed, the Court’s analysis is consistent with its own approach for examining actions that unduly burden a fundamental right.³⁷⁰

Because of their adoption of the highly deferential professional judgment standard, it is not surprising that courts that have addressed the right of a civil patient to refuse medication under the Federal Constitution after the Supreme Court’s remand of *Rennie IV* have failed to examine whether the right to refuse medication is fundamental.³⁷¹ However, prior to the Supreme Court’s remand of

363. *Id.* at 270.

364. 504 U.S. 127 (1992).

365. *Id.* at 135 (quoting *O’Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987)).

366. *Id.*

367. 494 U.S. 210 (1992).

368. *Riggins*, 504 U.S. at 135.

369. *Id.* at 136.

370. *See, e.g., Zablocki v. Redhail*, 434 U.S. 374, 388 (1977); *Roe v. Wade*, 410 U.S. 113, 155 (1973). Admittedly, while the dissent in *Riggins* noted that the majority’s analysis amounted to an application of the strict scrutiny standard, *Riggins*, 504 U.S. at 156 (Thomas, J., dissenting), the majority opinion left resolution of this question for another day as it proclaimed that the majority did not “adopt a standard of strict scrutiny.” *Id.* at 136. Rather, the majority concluded the state court violated the defendant’s rights because there had been no findings about either the necessity of the medication or the existence of available alternatives. *Id.*

371. *See, e.g., Dautremont v. Broadlands Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release v. Provost*, 722 F.2d 960, 977-81 (2d Cir. 1983); *Rennie V*, 720 F.2d 266, 268-77 (3d Cir. 1983); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1321-1323 (N.D. Texas 1984). None of the five opinions issued by the *en banc* panel of the Third Circuit in *Rennie V* re-examined the issue of the nature of the right to refuse. However, one can argue that since the plurality opinion and two of the three concurring opinions addressed the issue of less restrictive alternatives, which is required when examining an infringement of a fundamental right, the judges were, at least implicitly, attempting to determine whether the right to refuse is fundamental in nature. It is worth noting that the Third Circuit recognized that *Rennie V* rested on

Rennie IV, when courts examined the source of the right to refuse, they either explicitly recognized that the right to refuse is fundamental or implicitly did so by concluding that the right of privacy encompasses the right to refuse.³⁷²

Besides the Supreme Court's opinion in *Riggins*, it is difficult to imagine intrusions on the body that are more significant than the administration of antipsychotic and other psychotropic medication. Antipsychotic medication is, by definition, mind-altering in nature, and presents a risk of debilitating side effects that may be permanent.³⁷³ However, more important than the risks of side effects is the Supreme Court's recognition that "[a]t the heart of liberty is the right to define one's own concept of existence,"³⁷⁴ which means that liberty certainly includes deciding whether or not to submit to a regimen of psychotropic medication.³⁷⁵ No one can seriously dispute that forcing a person diagnosed as mentally ill to accept medication shapes a substantial aspect of the person's life, which abridges a patient's right to bodily autonomy.³⁷⁶ In addition,

the proposition that the right of an involuntarily hospitalized person to refuse medication "is derived from each person's fundamental right to be free from unjustified intrusions on personal security." *White v. Napoleon*, 897 F.2d 103, 112 (3d Cir. 1990).

Two courts that addressed the right of a pretrial detainee to refuse medication have concluded that the right is fundamental. *See Bee v. Greaves*, 744 F.2d 1387, 1392-93 (10th Cir. 1984); *Woodland v. Angus*, 820 F. Supp. 1497, 1509 (D. Utah 1993).

372. *See Rennie III*, 653 F.2d 836, 844 (3d Cir. 1981) (forcible administration of medication implicates right to remain free from unjustified intrusions on personal security); *Rogers II*, 634 F.2d 650, 653 (1st Cir. 1980) (constitutional interest in deciding for oneself to submit to or refuse antipsychotic drugs most likely derives from the penumbral right to privacy, bodily integrity, or personal security); *Davis v. Hubbard*, 506 F. Supp. 915, 929-30 (N.D. Ohio 1980); *Rogers I*, 478 F. Supp. 1342, 1366 (D. Mass. 1979) (right to dispose of one's property fundamental to any ordered liberty; such right pales in comparison to decision as to whether to accept or refuse psychotropic medication which is basic to any right of privacy); *Rennie I*, 462 F. Supp. 1131, 1144 (D. N.J. 1988) (right to refuse treatment best founded on right of privacy which is broad enough to include right to protect one's mental processes from government interference); *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980).

373. *See supra* notes 78-128 and accompanying text; *Gelman, supra* note 44, at 1265 (stating that severe harms caused by antipsychotic drugs occur on "far broader scale than lobotomy ever did").

374. *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

375. *See, e.g., Gelman, supra* note 44, at 1208 (commenting that when government forcibly administers medication, it "does not merely invade a body but reconstitutes a person's physical constitution to suit its purposes").

376. *See Rubinfeld, supra* note 283, at 784. It is the state's systemic attempts to shape a person's existence that separates in part the administration of medication issue from a trilogy of Supreme Court cases involving intrusions on the body in which the Court's decisions substantially focused on the risk of harm to the person.

In *Rochin v. California*, 342 U.S. 165 (1952), police involuntarily transported a suspect to a hospital and forced an emetic solution through a tube into his stomach that induced vomiting. *Id.* at 166. The police found two morphine capsules in the vomited matter. *Id.* The Court found that

the state has decided for the patient that the risks associated with psychotropic medication are acceptable. In so doing, the state implicitly decides for the patient that any harm suffered is justified regardless of the ultimate efficacy of the treatment. The patient loses the right to make medical decisions that may substantially define his or her existence and may significantly debilitate him or her.³⁷⁷ Since *Riggins* and *Harper* served as authority for the proposition that the constitutional interests in personal security and bodily integrity are fundamental, and since *Planned Parenthood* served as authority for the conclusion that the

the police conduct “shock[ed] the conscience,” *id.* at 172, and reversed the defendant’s conviction. *Id.* at 174.

Twelve years later in *Schmerber v. California*, 384 U.S. 757 (1966) the Court examined the issue of whether the Fourth Amendment’s protection of personal privacy and dignity protected a defendant who was charged with driving under the influence of alcohol from an unwanted blood test. In holding that it did not, the Court noted that “[s]uch tests are a commonplace in these days of periodic physical examination and experience with them teaches that the quantity of blood extracted is minimal, and that for most people, the procedure involves no risk, trauma, or pain.” *Id.* at 771. The Court warned that while the Constitution permitted the minor intrusion of a blood test, such a holding does not indicate that more substantial intrusions are permitted. *Id.* at 772.

It was such a more substantial intrusion, namely, surgery to remove a bullet in order to use the bullet as evidence, that the Court prohibited in *Winston v. Lee*, 470 U.S. 753 (1985). A critical factor in determining whether an intrusion was justified, which distinguished this case from *Schmerber*, was the extent to which the proposed procedure would threaten the health or safety of the individual. *Id.* at 761-62 n.5. While the parties disagreed as to the magnitude of the risk involved, it was exactly this disagreement that established a risk. *See id.* at 764.

It is not particularly pertinent that *Winston* was a Fourth Amendment case, as the Supreme Court relied on it to support its substantive due process analysis in *Planned Parenthood*, 505 U.S. at 849. While *Winston* and its antecedents support the concept of bodily integrity essential to the Supreme Court’s analysis in *Planned Parenthood*, they, like the situation in *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250 (1891), involved one-time attempts by the state to invade a person’s body. As such, because substantive due process involves a balancing of the individual’s rights and the demands of organized society, *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982), the magnitude of harm to the individual is a greater consideration when evaluating the scope of a person’s right to refuse drugs.

More significantly, the magnitude of side effects plays a limited role in constitutional analysis because the historic sanctity of the right to refuse has evolved from the common law right to control one’s own person that found constitutional protection under *Botsford*, 141 U.S. at 256. Under common law analysis, the magnitude of intrusions have no bearing on the right to control one’s course of treatment. *See supra* notes 353-63 and accompanying text; *see also infra* note 379 and accompanying text. It is important to recognize the limited role in constitutional analysis played by drugs’ harmful side effects. At least one court limited its analysis of the right to refuse medication to the right to refuse antipsychotic drugs because the court concluded that antipsychotic drugs have a far higher potential for harmful side effects than do psychotropic medication in general, which may include anti-depressants and lithium. *See Rogers II*, 634 F.2d 650, 653 n.1 (1st Cir. 1980).

377. *See supra* notes 55-128 and accompanying text.

right to an abortion is fundamental,³⁷⁸ it is inconceivable that the right to refuse medication can be characterized in a manner other than fundamental.³⁷⁹

C. *The Standard of Review*

A recognition that the right to refuse medication is fundamental in nature only begins the inquiry as to the scope of this right.³⁸⁰ A court must then examine the competing state interests to determine under what circumstances state interests will override the patient's interest in refusing treatment.³⁸¹ In evaluating these competing considerations, a court must adopt a standard of review to scrutinize governmental conduct which will impact the scope of deference that the court will give to the state's decision to administer medication over objection.³⁸² Put another way, the particular standard of review adopted by a court is particularly important because it "determines when the Due Process Clause of the Fourteenth Amendment will override a State's substantive policy choices, as reflected in its laws."³⁸³

The Supreme Court has held that, at least in the institutional setting of a prison, "when a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests."³⁸⁴ Accordingly, actions of prison officials "are judged under a 'reasonableness' test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights."³⁸⁵ The Supreme Court has promulgated the reasonableness standard (or the *Turner* standard) in order to facilitate the resolution of difficult judgments concerning institutional operations by prison administrators other than the courts.³⁸⁶

378. *Planned Parenthood*, 505 U.S. at 847-51, 857.

379. *See Harper*, 494 U.S. at 238, 241 (Stevens, J., dissenting) (stating that "liberty of citizens to resist the administration of mind altering drugs arises from our Nation's most basic values" and that the right of competent individual to refuse drugs "is a fundamental liberty interest deserving the highest order of protection").

380. *See Planned Parenthood*, 505 U.S. at 919 n.5 (Stevens, J., concurring in part and dissenting in part); *Rogers III*, 457 U.S. 291, 299 (1982).

381. *Harper*, 494 U.S. at 220; *Rogers III*, 457 U.S. at 299; *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990).

382. *See, e.g., Webster v. Reproductive Health Servs.*, 492 U.S. 490, 548 (1989) (Blackmun, J., dissenting) (commenting that the rational basis, intermediate and strict scrutiny tests measure strength and scope of constitutional rights to be balanced against competing interests of the government); *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 356-358 (1987) (Brennan, J., dissenting) (stating "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.").

383. *Foucha v. Louisiana*, 504 U.S. 71, 116 (1992) (Thomas, J., dissenting).

384. *Turner v. Safley*, 482 U.S. 78, 89 (1987).

385. *O'Lone*, 482 U.S. at 349.

386. *Turner*, 482 U.S. at 89. In recognizing the desirability of deferring to prison administrators, the Court concluded that

Upon initial analysis, one may conclude that a state's interest in maintaining hospital operations parallels that of its interests in prison administration, which similarly warrants the adoption of an identical or similar standard of review.³⁸⁷ However, upon scrutiny, there are marked differences between the confinement of mentally ill individuals and the confinement of prisoners which make adoption of the *Turner* standard, or criteria similar to the *Turner* standard, inappropriate. Prisons and psychiatric hospitals involve two entirely different settings, housing two entirely different populations who have been confined for entirely different sets of reasons, and whose confinement has engendered entirely different legal consequences.

In formulating the standard of review applicable to the prison context, the Supreme Court has taken account of "the unique circumstances of penal confinement."³⁸⁸ A person convicted of a crime has acted with a specific *mens rea* and engaged in behavior that has violated social norms by engaging in behavior that is not "within a range of conduct that is generally acceptable."³⁸⁹

These individuals have demonstrated an "inability, or refusal, to conform their conduct to the norms demanded by a civilized society."³⁹⁰

On the other hand, civil hospitals contain both voluntary and involuntary patients. These individuals do not pose the potential management problem that prisoners present.³⁹¹ Unlike prisoners who have acted with a particular state of

[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 rule would also distort the decisionmaking process, for every administrative judgment would be subject to the possibility that some court somewhere would conclude that it had a less restrictive way of solving the problem at hand. Courts inevitably would become the primary arbiters of what constitutes the best solution to every administrative problem, thereby "unnecessarily perpetuat[ing] the involvement of the federal courts in affairs of prison administration."

Id. (quoting *Procunier v. Martinez*, 416 U.S. 396, 407 (1974)).

387. See *White v. Napoleon*, 897 F.2d 103, 113 (1990) (stating "Given the similarity of the State's interests in the administration of mental hospitals and prisons, the limitation on a prisoner's right of refusal should be similar to the limitation on the right of an involuntarily committed mental patient.").

388. *Riggins v. Nevada*, 504 U.S. 127, 134 (1992).

389. *Jones v. United States*, 463 U.S. 354, 367 (1983) (quoting *Addington v. Texas*, 441 U.S. 418, 426-427 (1979)).

390. *Jones v. North Carolina Prisoners' Union*, 433 U.S. 119, 137 (1977) (Burger, C.J., concurring).

391. The Supreme Court has recognized that prison life contains the "ever-present potential for violent confrontation and conflagration." *Jones*, 433 U.S. at 132. There is ample case law arising out of prison riots. See, e.g., *Hillard v. Coughlin*, 187 A.D.2d 136 (1993); *Jones v. Coughlin*, 177 A.D.2d 1061 (1991); *Whitely v. Albers*, 475 U.S. 312 (1986). On the other hand, LEXIS and WESTLAW searches have not been able to uncover any sort of documentation of even one riot in a psychiatric hospital.

mind to engage in conduct that is deemed dangerous to society,³⁹² not all civil patients have engaged in dangerous conduct. Rather, they have been confined simply because they pose a *risk* of harm to themselves or others.³⁹³ The commission of a criminal act is so significant from a constitutional perspective that it provides justification for a state to treat an insanity acquittee, someone who has been found not guilty by reason of mental disease or defect, differently than civilly committed patients by imposing more stringent release and discharge procedures.³⁹⁴ Moreover, while it is well settled that the Constitution permits a state to involuntarily confine individuals who have been deemed to pose a danger to themselves or others,³⁹⁵ many patients are confined for another reason. Rather, these patients require hospitalization because their illness is so debilitating that they are unable to meet the basic necessities of life.³⁹⁶ Accordingly, particularly with the supervision that a hospital setting provides,³⁹⁷ psychiatric patients do not comprise the threatening population that prisoners frequently do.³⁹⁸ Hence, psychiatric patients pose a substantially smaller risk of harm than do prisoners.³⁹⁹

392. See *Jones*, 463 U.S. at 364-65.

393. See John Monahan & David B. Wexler, *A Definite Maybe: Proof and Probability in Civil Commitment*, 2 L. & HUMAN BEHAV. 37, 38 (1978) (stating that civil commitment may be premised on characteristics of an individual which is associated with dangerous behavior); see also *Jones*, 463 U.S. at 367 (recognizing that individuals can be civilly committed without engaging in a violation of any criminal laws); *Project Release v. Prevost*, 722 F.2d 960, 973-74 (1983) (finding that an overt act evincing dangerousness is not a constitutional prerequisite for commitment); *In re Harry M.*, 468 N.Y.S.2d 259, 365 (N.Y. App. Div. 1983) (defining dangerous as a *risk* of harm to self or others).

394. *Jones*, 463 U.S. at 370; *Glatz v. Kort*, 807 F.2d 1514, 1522 (10th Cir. 1986); *Warren v. Harvey*, 632 F.2d 925, 931 (2d Cir. 1980); *United States v. Ecker*, 543 F.2d 178, 195-96 (D.C. Cir. 1976).

395. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (“[A] state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”); *Project Release*, 722 F.2d at 973.

396. See, e.g., *O'Connor*, 422 U.S. at 574 n.9 (stating that “even if there is no foreseeable risk of self-injury or suicide, a person is literally ‘dangerous to himself’ if for physical or other reasons he is helpless to avoid the hazards of freedom”); *Lynch v. Baxley*, 386 F. Supp. 378, 391 (M.D. Ala. 1974) (finding that harm that justifies commitment can manifest itself in neglect or refusal to care for oneself); *In re Harry M.*, 468 N.Y.S.2d at 365 (stating danger to self includes inability to meet essential needs of food, clothing or shelter).

397. Hospital staff are trained in dealing with potential violence and can lessen the threat of harm by utilizing such techniques as segregation, physical restraints, psychotherapy and behavior therapy. *Morris*, *supra* note 227, at 358 n.71.

398. See, e.g., *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) (recognizing that commitment eliminates threat of harm and except in emergency situations, hospital personnel are not in danger); *Rogers I*, 478 F. Supp. 1342, 1369 (D. Mass. 1979); *Opinion of the Justices*, 465 A.2d 484, 489-90 (N.H. 1983).

399. *Morris*, *supra* note 227, at 358.

Second, in no way can a civil commitment proceeding be equated with a criminal prosecution.⁴⁰⁰ Incarceration in a prison is society's response to a criminal offense that reflects, *inter alia*, retribution.⁴⁰¹ Because of its punitive nature, prison confinement is supposed to be more onerous than confinement in a psychiatric hospital.⁴⁰² The conviction of a crime results in a forfeiture of many basic liberties that ordinary citizens possess.⁴⁰³ That a large number of states require prisoners to forfeit basic liberties is relevant when formulating constitutional standards pertaining to fundamental rights, such as the reasonableness test in *Turner v. Safley*.⁴⁰⁴ In sum, "[l]awful incarceration brings about the necessary withdrawal or limitation of many privileges and rights, a retraction justified by the considerations underlying our penal system."⁴⁰⁵ As such, constitutional standards pertaining to individual rights in prisons are based upon, *inter alia*, an individual's status as a prisoner.⁴⁰⁶ The reasonableness standard of *Turner* reflects society's determination that by committing crimes, the rights of prisoners are narrower than ordinary citizens.⁴⁰⁷

400. *Addington v. Texas*, 441 U.S. 418, 428 (1979).

401. *Jones v. United States*, 463 U.S. 354, 368-69 (1983).

402. *See Heller v. Doe*, 509 U.S. 312, 325 (1993).

403. *See, e.g.*, ALASKA STAT. § 33.30.241 (Michie 1996) (felony involving moral turpitude disqualified from voting); ARIZ. REV. STAT. ANN. § 13-904 (West Supp. 1997) (felony conviction suspends such civil rights as the right to vote, hold a public office, serve as a juror and any civil right reasonably necessary for prison security); CAL. PENAL CODE §2600 (West 1982) (prisoner forfeits rights necessary for reasonable security); FLA. STAT. ANN. § 944.292 (conviction suspends civil rights) (West 1996); HAW. REV. STAT. ANN. § 831-25 (Michie 1994) (loss of right to vote and hold office); ILL. COMP. STAT. ANN. § 5-5-5 (West 1997) (loss of right to vote or hold office); MISS. CODE ANN. § 99-19-35 (1972) (convict prohibited from holding office); NEB. REV. STAT. § 29-112 (1993) (civil rights and privileges); N.Y. CIV. RIGHTS LAW § 79 (McKinney 1992) (imprisonment results in forfeiture of civil rights); OHIO REV. CODE ANN. § 2961.01 (Banks-Baldwin 1997) (denial of right to hold office); OKLA. STAT. ANN. § 65 (West 1983) (imprisonment suspends civil rights); R.I. GEN. LAWS § 13-6-1 (1956) (person subject to life imprisonment shall be deemed dead with respect to all civil rights).

404. 482 U.S. 78 (1987). *Cf. Schall v. Martin*, 467 U.S. 253, 268 (1984) (commenting that a practice followed by a large number of states is plainly worth considering to determine whether the practice offends some principle of justice "so rooted in the traditions and conscience of our people as to be ranked as fundamental"); *Board of Curators of Univ. of Mo. v. Horowitz*, 435 U.S. 78, 88 (1978) (quoting *Leland v. Oregon*, 343 U.S. 790, 798 (1952) (quoting *Snyder v. Massachusetts*, 291 U.S. 97 (1934))).

405. *Jones v. North Carolina Prisoners' Union*, 433 U.S. 119, 125 (1977) (quoting *Price v. Johnston*, 334 U.S. 266, 285 (1948)).

406. *See Pell v. Procunier*, 417 U.S. 817, 822 (1974) (prison inmate retains only those First Amendment rights consistent with his prisoner status).

407. *See supra* note 404 and accompanying text; *Cooper v. Oklahoma*, 517 U.S. 348, 360, 368 (1996) (finding the fact that only four states place the burden of proving incompetence by clear and convincing evidence evinces the "deep roots and fundamental character" of a defendants' right not to stand trial unless it is more likely than not that he has capacity to stand trial).

On the other hand, civilly committed individuals “are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”⁴⁰⁸ Significantly, civilly committed patients, unlike prisoners, retain their civil rights in virtually every state.⁴⁰⁹ Additionally, case law arising out of jurisdictions that have addressed the right to refuse medication in both the psychiatric hospital and prison contexts support the appropriateness of according less deference to hospital clinicians than to prison officials. These jurisdictions have limited the forcible administration of medication to civilly committed patients to instances when an emergency was imminent or when such individuals were found incompetent to make treatment decisions.⁴¹⁰ However, these same courts permitted institutional considerations, such as the maintenance of prison discipline, to override a prisoner’s interest in refusing medication.⁴¹¹

408. *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982).

409. ALA. CODE §§ 22-52-1 to 22-52-72 (1984); ALASKA STAT. § 47.30.835 (Michie 1984); ARIZ. REV. STAT. ANN. § 36-506 (West 1993); ARK. CODE ANN. § 20-47-220 (Michie Supp. 1989); CAL. WELF. & INST. CODE §§ 5325.1, 5327 (West 1984); COLO. REV. STAT. § 27-10-104 (1990); CONN. GEN. STAT. ANN. § 17a-541 (West 1992); D.C. CODE ANN. § 21-564 (1981); FLA. STAT. ANN. § 394.459(1) (West 1993); GA. CODE ANN. § 37-3-140 (1985); HAW. REV. STAT. § 334-61 (1985); IDAHO CODE § 66-346(a)(6) (1989); 405 ILL. COMP. STAT. ANN. 5/2-100 (West 1997); IND. CODE ANN. § 12-26-2-8 (Michie 1997); IOWA CODE ANN. § 229.27(1) (West 1994); HAW. STAT. ANN. 59-2948(a) (West 1978 and Supp. 1997); KAN. STAT. ANN. 59-2948 (West 1978 & Supp. 1997); LA. REV. STAT. ANN. § 28-1-171 (West 1989); ME. REV. STAT. ANN. tit. 34-B, § 3803(1) (West 1988); MD. CODE ANN. HEALTH GEN. I § 10-704 (Supp. 1989); MASS. ANN. LAWS ch. 123, § 23 (West Supp. 1998); MICH. COMP. LAWS ANN. § 330.1489(1) (West 1992); MINN. STAT. ANN. § 253B.23(2) (West 1994); MISS. CODE ANN. § 41-21-101 (1993); MO. ANN. STAT. § 630.120 (West 1988); MONT. CODE ANN. § 53-21-141 (1997); NEB. REV. STAT. § 83-1066(1) (1994); NEV. REV. STAT. ANN. § 433A.460 (Michie 1996); N.H. REV. STAT. ANN. § 135-C:56 (1996); N.J. STATE ANN. § 30:4-24.2(a), 30:4-24.1 (West 1997); N.M. STAT. ANN. § 43-1-5 (Michie 1989); N.Y. MENTAL HYG. LAW § 33.01 (McKinney 1996); N.C. GEN. STAT. § 122C-58 (1996); N.D. CENT. CODE § 25-03.1-33 (1995); OHIO REV. CODE ANN. § 5122.301 (Banks-Baldwin 1996); OKLA. STATE ANN. tit. 43A, § 1-105 (West 1990); OR. REV. STAT. § 426.385(n) (Supp. 1996); 50 PA. CONS. STAT. ANN. § 7113 (West Supp. 1997); R.I. GEN. LAWS § 40.1-5-5(6) (1984); S.C. CODE ANN. § 44-22-80 (Law. Co-op. 1985); S.D. CODIFIED LAWS § 27A-12-33 (Michie 1984); TENN. CODE ANN. §33-3-104(5) (Supp. 1997); TEX. HEALTH & SAFETY CODE ANN. 576.002 (West 1992); UTAH CODE ANN. § 62(A)-12-245 (1986); VT. STAT. ANN. tit. 18, § 7705(a) (Michie 1987); VA. CODE ANN. § 37.1-87 (Michie 1996); WASH. REV. CODE ANN. § 71.05.450 (West 1992); W. VA. CODE § 27-5-9(a) (1992); WIS. STAT. ANN. § 51.80 (West 1996); WYO. STAT. ANN. § 25-10-121 (Michie 1997). Kentucky has no express provisions.

410. *Rogers v. Commissioner of Dep’t of Mental Health*, 458 N.E.2d 308, 314, 321-22 (Mass. 1983); *Opinion of the Justices*, 465 A.2d 484, 489 (N.H. 1983).

411. *Commissioner of Correction v. Myers*, 399 N.E.2d 452, 458 (Mass. 1979); *In re Caulk*, 480 A.2d 93, 96 (N.H. 1984). In contrast to the provision of treatment in the prison context, the Supreme Judicial Court of Massachusetts explicitly held that the right to control one’s own course of treatment is “superior to the institutional considerations.” *Rogers*, 458 N.E.2d at 317.

Although hospital clinicians are entitled to less deference than prison doctors, this does not necessarily mean that a court should apply the same standard of review that it would apply for an infringement of a fundamental right belonging to a non-confined citizen. An intermediate level of scrutiny may serve to accommodate the competing institutional state concerns and individual desires to avoid intrusive medication. Drawing from the equal protection context, a court might hold that the forced administration of medication is permissible if it serves important government objectives and is substantially related to the achievement of those objectives.⁴¹²

However, upon analysis, a court should apply the same standard of review that it would apply when evaluating an infringement of any other fundamental right belonging to non-hospitalized individuals. Society civilly commits mentally ill individuals for the purpose of providing a benefit in the form of compulsory treatment and such confinement does not have a punitive purpose.⁴¹³ More importantly, the near unanimity of the provisions that guarantee a retention of civil rights upon commitment evinces a societal recognition that civilly committed patients should be provided with the same rights as ordinary citizens.⁴¹⁴ This militates toward a standard of review that does not defer to institutional considerations but rather one that requires the government to justify its conduct in the same manner that it would have to justify an infringement of fundamental rights of an ordinary citizen.⁴¹⁵ Indeed, while society labels prisoners less than full citizens and the standard of review reflects this status,⁴¹⁶

412. See *Metro Broad., Inc. v. FCC*, 497 U.S. 547, 565 (1990) (involving a challenge to policies of the FCC that gave preferences to minorities); *United States v. Virginia*, 518 U.S. 515 (1996) (challenging males only admission policy of the Virginia Military Institute).

Under this test, it is possible, but not certain, that the forced administration of medication would pass constitutional scrutiny. Providing treatment to mentally ill individuals is an important objective. See, e.g., *Washington v. Harper*, 494 U.S. 210, 225-26 (1990). However, a state's interest in providing medication over objection to all patients is not as great as the state's interest in *Harper* in which the state had an interest in forcibly medicating prisoners who were creating a danger within the prison setting or were gravely disabled. *Id.* at 221-22; see, e.g., *Jones v. United States*, 463 U.S. 354, 370 (1983) (government interest in providing treatment to insanity acquittees insufficient to justify confinement in absence of dangerousness).

413. See *Goetz v. Crosson*, 967 F.2d 29, 34-35 (2d Cir. 1992).

414. See *Cooper v. Oklahoma*, 517 U.S. 348 (1996).

415. Cf. *Martin v. Schall*, 467 U.S. 253, 268 (1984); *O'Lone v. Shabazz*, 482 U.S. 342, 356-58 (1987). Indeed, a comparison of the Supreme Court's decisions in *Harper* and *Rogers III* supports this conclusion. In *Harper*, 494 U.S. at 223-27, the Court built its Due Process Clause analysis around the *Turner* reasonableness standard. On the other hand, while at the time the Court decided *Rogers III* there was ample case law recognizing the need to defer to institutional considerations in a prison setting. See, e.g., *Procunier v. Martinez*, 416 U.S. 396, 405 (1974); *Pell v. Procunier*, 417 U.S. 817, 827 (1974); *Jones v. North Carolina Prisoners' Union*, 433 U.S. 119, 128-129 (1977). The Supreme Court eschewed reliance upon any of these institutional concerns when it decided *Rogers III*, 457 U.S. at 300-04.

416. See *supra* notes 401-04 and accompanying text.

society views civilly committed patients as equal citizens.⁴¹⁷ The standard of review should reflect this societal determination.

D. The State Interests that Override, and Accordingly, Limit the Fundamental Right to Refuse Medication

When assessing the scope of the right to refuse medication, a court must balance the competing individual and state interests.⁴¹⁸ Generally, only a compelling state interest will override a fundamental right and only when the means are tailored to further these interests.⁴¹⁹ Perhaps because the Supreme Court was concerned about a court excessively imposing its own values on the balancing process,⁴²⁰ the Supreme Court in *Rogers III* concluded that when evaluating government attempts to override an interest in refusing medication, a court “may look to state law” to identify the scope of the competing individual and state interests.⁴²¹ Reliance on state law to guide the balancing process when evaluating the scope of the right to refuse is appropriate because history and tradition protect the common law right to determine one’s own course of treatment. That common law right serves as the underpinning for the determination that the right to refuse medication is fundamental.⁴²² In this sense, reliance on state law provides for a consistent and non-arbitrary application of history and tradition when delineating the scope of the right to refuse.⁴²³

The Supreme Court’s decision in *Ingraham v. Wright*⁴²⁴ further suggests that liberty within the Fourteenth Amendment includes the common law right to bodily autonomy and that the common law will define the scope of a patient’s substantive right to refuse. Reference to *Ingraham* is particularly apt because when, in *Rogers III*, the Supreme Court cited *Ingraham* it suggested that a court may look to state law to guide the balancing process.⁴²⁵

In *Ingraham*, the Court examined the contours of a child’s right to remain free from corporal punishment and recognized that liberty within the Fourteenth Amendment “included the right ‘generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free

417. See *supra* note 408-09 and accompanying text.

418. See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2283-84 (1997) (Souter, J., concurring); *Rogers III*, 457 U.S. at 299; see also *Youngberg*, 457 U.S. at 320 (substantive that due process requires balancing of “the liberty of the individual” and “the demands of an organized society”) (quoting *Poe v. Ullman*, 367 U.S. 497, 452 (1961) (Harlin, J. dissenting)).

419. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 388 (1978); *Roe v. Wade*, 410 U.S. 113, 155 (1973).

420. See *Youngberg*, 457 U.S. at 321.

421. *Rogers III*, 457 U.S. at 304.

422. See *supra* notes 358-61 and accompanying text.

423. See *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

424. 430 U.S. 651 (1977).

425. *Rogers III*, 457 U.S. at 304.

men."⁴²⁶ This common law liberty included the right to remain free from unjustified intrusions on personal security.⁴²⁷ However, because a child's liberty interest in avoiding corporal punishment was rooted in history, it was subject to historic limitations that defined the scope of the protected right⁴²⁸: "Under that longstanding accommodation of interests, there can be no deprivation of substantive rights as long as disciplinary corporal punishment is within the limits of the common-law privilege."⁴²⁹ While *Ingraham* addressed the procedural protections required when a school imposed corporal punishment, the Court's discussion of the interrelationship between common law rights and Fourteenth Amendment liberty is certainly instructive.

When the Supreme Court in *Rogers III* relied upon *Ingraham* as authority for its pronouncement that a court should resort to common law to identify the weight to accord the competing individual and state interests, the Court closed the constitutional circle begun in *Union Pacific Railway Co. v. Botsford*.⁴³⁰ In *Botsford*, the Court recognized that the Constitution protects the common law right of citizens to control the sanctity of their bodies.⁴³¹ In *Meyer v. Nebraska*,⁴³² the Court recognized that liberty included at least those common law rights necessary to an orderly pursuit of happiness.⁴³³ *Meyer* served as authority for *Ingraham* which served as authority for *Rogers III*. Hence, *Rogers III* and *Ingraham* stand for the position that, at the very least, because the right to personal security, which includes the right to control one own's course of treatment, is fundamental, the Constitution's substantive protection is at least as broad as common law.

State court decisions addressing the right to refuse medication and the right to decline life-sustaining treatment provide guidance when evaluating the weight to accord competing individual and state interests. A number of state courts, most of which were the highest courts in the state, have addressed the right to refuse medication.⁴³⁴ Many of these courts have addressed the question of when,

426. *Ingraham*, 430 U.S. at 673 (quoting *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923)).

427. *Id.* In support of its conclusion that common law liberty included the right to personal security, the Supreme Court cited, *inter alia*, *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250, 251-252 (1891), which recognized the right to make decisions about one's body, and *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905), which addressed an individual's right to remain free from an unwanted medical vaccination. *Id.* at n.42.

428. *Ingraham*, 430 U.S. at 675.

429. *Id.*

430. 141 U.S. 250 (1891).

431. *Id.* at 251.

432. 262 U.S. 390 (1923).

433. *Id.* at 399.

434. See, e.g., *Anderson v. State*, 663 P.2d 570 (Ariz. Ct. App. 1982); *Riese v. Saint Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Cal App. 1987); *People v. Medina*, 705 P.2d 961 (Colo. 1985); *Goedecke v. State Dep't of Insts.*, 603 P.2d 123 (Colo. 1979); *In re Mental Commitment of M.P.*, 510 N.E.2d 645 (Ind. 1987); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308 (Mass. 1983); *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988); *Opinion of the Justices*,

under state law, state interests will override an individual's interest in refusing medication. Generally, these courts have interpreted state statutory law, the state constitution or common law. These courts have concluded that the only state interests that are sufficiently compelling to justify the forcible administration of medication are the state interests in alleviating dangerous situations within a hospital setting, i.e., emergencies, and providing help to patients who lack the capacity to make treatment decisions.⁴³⁵

In the absence of a state court decision addressing the right to refuse drugs, case law governing the right to decline life-sustaining treatment can be instructive. Little question exists that, like the right to refuse medication, the decision to decline life-sustaining treatment falls within one's right to bodily autonomy a right protected by common law and state constitutions.⁴³⁶ Generally, four state interests have been offered to override an individual's right under state law to refuse life-sustaining treatment: (1) the preservation of life; (2) the protection of innocent third parties; (3) the prevention of suicide; and (4) maintenance of ethical standards of the medical profession.⁴³⁷ Any assessment

465 A.2d 484 (N.H. 1983); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986); *In re K.K.B.*, 609 P.2d 747 (Okla. 1980); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883 (Wis. 1987).

435. See *Riese*, 271 Cal. Rptr. at 210 (under state statute, state may not forcibly administer medication in non-emergency situation absent a judicial determination of incompetence); *Goedecke*, 603 P.2d at 125 (common law right to refuse medication in non-emergency situations absent determination that patient is incapable in participating in treatment decisions); *In re Mental Commitment of M.P.*, 510 N.E.2d at 647 (in order to override statutory right to refuse treatment, state must demonstrate, *inter alia*, that probable benefits from treatment outweigh risk of harm to, and personal concerns of, patient); *Rogers*, 458 N.E.2d at 314-21 (under state law, absent a judicial determination of incompetence, state may forcibly medicate only if patient poses an imminent threat of harm and there are no less intrusive alternatives); *Jarvis*, 418 N.W.2d at 148 & n. 7 (finding of incompetence prerequisite to involuntary medication under state law); *Opinion of the Justices*, 465 A.2d at 488-89 (only protection of patient and others from harm and treatment of incompetent patient justify forced treatment under state constitution); *Rivers*, 495 N.E.2d at 343 (only present danger within a hospital and the provision of treatment to an incompetent patient are sufficiently compelling to override patient's interest in refusing treatment under state constitution). In *In re K.K.B.*, 609 P.2d at 751, the court held that absent an emergency, patients could refuse medication. However, the court apparently based this decision not on state law but on the right to privacy under the Federal Constitution. *Id.* *State ex rel. Jones*, 416 N.W. at 894 (under state law, only when medication is necessary to prevent harm or when probable cause exists to believe patient is incompetent, may state override right to refuse medication).

436. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301-02 (Cal. App. 1986); *Foody v. Manchester Mem'l Hosp.*, 482 A.2d 713, 717 (Conn. Super. 1984); *In re L.H.R.*, 321 S.E.2d 716, 722 (Ga. 1984); *In re Gardner*, 534 A.2d 947, 951 (Me. 1987); *Brophy v. New England Sinai Hosp, Inc.*, 497 N.E.2d 626, 633 (Mass. 1986); *In re Caulk*, 480 A.2d 93, 95 (N.H. 1984); *In re Conroy*, 486 A.2d 1209, 1221-22 (N.J. 1985); *In re Storar*, 52 N.Y.2d 363, 377 (1981); *Eichner v. Dillon*, 426 N.Y.S.2d 517, 536 (N.Y. App. Div. 1980); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051-52 (Ohio Ct. App. 1984).

437. See, e.g., *Thor v. Superior Court*, 855 P.2d 375, 383 (Cal. 1993); *Bouvia*, 225 Cal. Rptr.

of the weight to accord interests in preserving life and preventing suicide are irrelevant when extrapolating right to die case law to the refusal of treatment context. Denying patients the right to refuse medication when they pose a danger to others within the hospital setting is essentially equivalent to the interest in protecting innocent third parties. Accordingly, if one relies upon right to die case law to examine what state interests will override a patient's right to refuse medication, only the interest in maintaining the ethical integrity of the medical profession can serve to further limit a patient's right to refuse.

Yet, the state interest in maintaining the ethical integrity of the medical profession does not constitute a particularly strong interest.⁴³⁸ Indeed, to the extent that the doctrine of informed consent requires physicians to provide enough information about proposed treatment measures so that patients can make knowing and intelligent decisions about the treatment recommended, such law subordinates the ethical integrity of the medical profession to the individual's right to control his or her own course of treatment.

While the Supreme Court's decisions in *Rogers III*, *Youngberg* and *Ingraham* render inappropriate any attempts to reject state law, including common law, as the framework to balance competing interests,⁴³⁹ if one looks to Federal Constitutional law, the results remain the same. This is so because an absence of state law requires a court to find an overriding justification for, or compelling state interest that justifies, the forcible administration of medication.⁴⁴⁰

The state interest in forcibly medicating patients in order to provide treatment to legally competent patients who could benefit from treatment is not sufficiently compelling. It is well-settled that the government may not confine for compulsory treatment individuals who are mentally ill, but are not dangerous.⁴⁴¹ Hence, the state interest in providing treatment deemed beneficial

at 307; *Foody*, 482 A.2d at 718; *Satz v. Permuter*, 379 So. 2d 359, 360 (Fla. 1980), *aff'g* 362 So. 2d 160, 162 (Fla. App. 1978); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984); *In re Conroy*, 486 A.2d at 1223; *Brophy*, 497 N.E.2d at 634; *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983).

438. See Clayton, *supra* note 25, at 24. As the author recognized, "there is 'no justification for physicians in general, or psychiatrists in particular, to have more power than such other experts to override the expressed wishes of people or to have greater responsibility for harm to self or the public caused by the intemperate behavior of clients.'" *Id.*; see also *Thor*, 855 P.2d at 386; *Bouvia*, 225 Cal. Rptr. at 305; *Satz*, 362 So. 2d at 163-64; *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426-27 (Mass. 1977); *In re Conroy* 486 A.2d at 1224-25; *Rivers*, 495 N.E.2d at 343. Furthermore, because physicians consider care and treatment to be their first priority, see Stefan, *supra* note 14, at 657, permitting medical ethics to override the right to refuse is tantamount to adopting the professional judgment standard as a test for the standard for refusing medication.

439. See *supra* notes 424-29 and accompanying text.

440. See *Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Roe v. Wade*, 410 U.S. 113, 155 (1973).

441. See, e.g., *Jones v. United States*, 463 U.S. 354, 370 (1983); *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *Project Release v. Prevost*, 722 F.2d 960, 973 (2d Cir. 1983); *Doremus v. Farrell*, 407 F. Supp. 509, 514 (D. Neb. 1975). In *Jones*, the Supreme Court equated insanity

is insufficient to override an individual's interest in physical liberty.⁴⁴² There is nothing to indicate that one's fundamental interest in bodily autonomy is appreciably less compelling than a person's interest in physical liberty as to enable the government to provide treatment to a legally competent person.⁴⁴³

The Supreme Court's decision in *Jacobson v. Massachusetts*⁴⁴⁴ is consistent with the proposition that only the state interest in preventing or eliminating physical harm can justify the intrusive nature of forced medication. In *Jacobson*,

acquittes to civil patients and concluded that a patient is entitled to release if he is not dangerous, regardless of whether he is still mentally ill and can still benefit from treatment. The Court concluded that the "purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness. The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous." *Jones*, 463 U.S. at 368 (emphasis added). In *Foucha v. Louisiana*, 504 U.S. 71, 77-78 (1990), the Supreme Court reaffirmed this holding.

442. See *supra* note 441. Two cases illustrate this rationale. In *Doremus*, the court recognized the following:

Considering the fundamental rights involved in civil commitment, the *parens patriae* power must require a compelling interest of the state to justify the deprivation of liberty. In the mental health field, where diagnosis and treatment are uncertain, the need for treatment without some degree of imminent harm to the person or dangerousness to society is not a compelling justification.

Doremus, 407 F. Supp. at 514 (emphasis added).

In holding that the state cannot confine a nondangerous individual, the court in *In re Harry M.*, 468 N.Y.S.2d 359, 364 (N.Y. App. Div. 1983), concluded that "[a]bsent an overriding State interest . . . a patient has the basic right to control his own course of treatment . . . Society abounds with persons who should be hospitalized, either for gallbladder surgery, back operations, corrective orthopedic surgery, or other reasons; yet, in these areas society would not contemplate involuntary hospitalization for treatment." (internal quotes omitted).

These civil commitment cases that address what overriding state interests justify forced treatment in the form of involuntary hospitalization involved legally competent individuals, as it is well settled that even after civil commitment, patients remain legally competent. See *supra* note 409 and accompanying text. However, courts have recognized, that when patients have been found legally incompetent, at least in connection with their ability to make treatment decisions, the state interest in providing treatment to individuals who lack the ability to make such decisions for themselves constitutes a sufficiently compelling state interest that justifies forced treatment. See *Rogers II*, 634 F.2d 650, 657 (1st Cir. 1980), *Winters v. Miller*, 446 F.2d 65, 71 (2d Cir. 1971); *In re K.K.B.*, 609 P.2d 747, 750 (Okla. 1980).

443. Indeed, while the Supreme Court has frequently recognized the fundamental nature of the right to make medical decisions that impact upon the physical condition of a person, see *supra* notes 353-55 and accompanying text, the Court has only recently indicated that physical liberty is a right that is fundamental in nature. See *Foucha*, 504 U.S. at 80, 86. Previous cases required a determination of dangerousness in order to justify the confinement of a mentally ill person without concluding that liberty is fundamental. See *O'Connor*, 422 U.S. at 576; *Jones*, 463 U.S. at 366-70; *Project Release*, 722 F.2d at 971-73.

444. 197 U.S. 11 (1905).

the Court examined a challenge to a Massachusetts law that permitted local governments to require individuals to submit to a vaccination.⁴⁴⁵ In scrutinizing this law, the Court recognized that the state legislature sought to “suppress the evils of a smallpox epidemic,”⁴⁴⁶ which created an “emergency.”⁴⁴⁷ The Court concluded that governmental attempts to prevent imminent harm overrode an individual’s right to self-determination: “[T]he power of the public to guard itself against imminent danger depends in every case involving the control of one’s body upon his willingness to submit to reasonable regulations . . . for the purpose of protecting the public collectively against such danger.”⁴⁴⁸ Hence, the state’s police power permitted the government to enact regulations that “will protect the public health and the public safety.”⁴⁴⁹ *Jacobson* clearly stands for the proposition that compulsory treatment is permissible when the physical well-being of people is at stake. The Court in *Jacobson* permitted the state to require vaccinations because smallpox threatened life, not because the state’s police power permitted forced treatment that would provide treatment that some would deem beneficial.⁴⁵⁰

445. *Id.* at 12.

446. *Id.* at 30-31.

447. *Id.* at 27.

448. *Id.* at 29-30.

449. *Id.* at 25.

450. Over 50 years prior to *Jacobson*, John Stuart Mill set forth a philosophical basis for the right to refuse medical care except in extremely limited circumstances, which serves as justification today for a right to refuse medication:

[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection . . . [T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right . . . The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

Wayne McCormick, *Property and Liberty—Institutional Competence and the Functions of Rights*, 51 WASH. & LEE L. REV. 1, 5 (1994) (quoting JOHN S. MILL, ON LIBERTY 9 (Rapaport ed. 1978) (1859)).

Former Chief Justice Warren Burger addressed this topic when he sat on the Court of Appeals for the District of Columbia. He noted that the right to remain free from governmental interference derives in part from Justice Brandeis’ dissent in *Olmstead v. United States*, 277 U.S. 438 (1928), in which Justice Brandeis recognized that “[t]he markers of our Constitution* * * sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.” Application of President & Directors of Georgetown College, Inc., 331 F.2d 1010, 1016-17 (D.C. Cir. 1964 (Burger, J., dissenting) (quoting *Olmstead*, 277 U.S. at

A psychiatric hospital has the means for protecting against individuals with dangerous tendencies, such as placing the patients on more restrictive wards. Consequently, a patient poses a sufficient danger as to warrant the forced administration of medication only when he creates an emergency within the hospital.⁴⁵¹ Significantly, in *Riggins v. Nevada*,⁴⁵² the Supreme Court, relying in part on the civil commitment case of *Addington v. Texas*,⁴⁵³ noted that the state would have satisfied due process if, *inter alia*, medication was necessary for the safety of the patient or others.⁴⁵⁴

Likewise, as the New York Court of Appeals recognized when interpreting the New York Constitution, state interests indigenous to a hospital setting, such as preserving time and resources of hospital staff, increasing the process of deinstitutionalization and maintaining the ethical integrity of the medical profession should not outweigh an individual's interest in refusing drugs.⁴⁵⁵ While the New York Court of Appeals summarily reached this conclusion in a footnote, the court made the right decision. Medical ethics is simply not a

478 (Brandeis, J., dissenting)). Justice Burger went on to add that "[n]othing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk." *Id.* at 1017 (emphasis added). If nothing else, the right to be left alone encompasses the right to forego treatment deemed medically necessary if one is willing to suffer the consequences. This may require some patients to choose between prolonged confinement without medication or discharge into the community under a treatment regimen that will produce debilitating physical consequences. See *supra* notes 78-128 and accompanying text.

451. See *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980); *Rogers I*, 478 F. Supp. 1342, 1369 (D. Mass 1979); Opinion of the Justices, 465 A.2d 484, 489-90 (N.H. 1983).

452. 504 U.S. 127 (1992).

453. 441 U.S. 418 (1979).

454. *Riggins*, 504 U.S. at 135.

455. See *Rivers v. Katz*, 495 N.E.2d 337, 334 n.6 (N.Y. 1986). One authority argues that the interests of other patients in control of another patient's crazy behavior justifies the forcible administration of medication. See Clayton, *supra* note 25, at 29 n.99 (citing STONE, LAW, PSYCHIATRY & MORALITY 153-154 (1984)). Courts would very likely reject such an assertion. First, when any non-refusers create an emergency situation and pose a danger to other patients, the state can override the refusers right to refuse. See *supra* note 410 and accompanying text. Second, the behavior of refusers within a hospital setting should not significantly interfere with the treatment provided to other patients. Staff can isolate disruptive, nondangerous refusers. This should not unduly utilize clinical resources and such patient care could be undertaken with direct care staff who are non-professionals. Indeed, as refusers will generally want less contact with professional staff, these individuals enable treating physicians to spend more time with other patients. Finally, all involuntarily hospitalized patients are so mentally ill that they require in-patient hospitalization because they pose a risk of danger to themselves or others. See *supra* note 395 and accompanying text. Is Dr. Stone suggesting that the very crazy have a constitutional interest in not being subject to the intrusive nature of the very, very crazy while receiving their milieu therapy that will help make them better and such interest outweighs the right to bodily autonomy?

particularly strong interest and is subordinate to a patient's desires.⁴⁵⁶ The process of deinstitutionalization is related to both the state's interest in conserving staff resources and lessening the financial burden since the government would theoretically have a smaller hospital population. However, when assessing constitutional rights, a state's financial interest is simply not sufficiently compelling to justify an infringement of the right to bodily autonomy.⁴⁵⁷ Similarly, while the state has an interest in conserving its limited mental health resources,⁴⁵⁸ for numerous reasons this interest does not outweigh an individual's interest in self-determination. There are few, if any, more firmly entrenched rights within our constitutional system of government than a person's right to control his or her own course of treatment regardless of the consequences.⁴⁵⁹ Furthermore, because many patients are treatment resistant,⁴⁶⁰ it is simply constitutionally indefensible to subject all individuals to the potentially disabling effects of medication. The Constitution incorporates higher values than governmental efficiency.⁴⁶¹

Moreover, it is unclear whether the forcible administration of medication furthers the government's interest in conserving its limited facilities. As one court found after the state instituted a right to refuse medication, "the recognition of the right has [not] had any adverse effects on the operation of the institution or on its treatment goals."⁴⁶² In another state hospital that instituted a right to refuse policy, treatment improved without hospital personnel suffering substantial additional burdens.⁴⁶³

Further, overriding a patient's right to refuse does not guarantee provision of successful treatment since the ability of state-operated psychiatric systems to provide adequate diagnosis and treatment is questionable.⁴⁶⁴ It is generally

456. See *supra* note 438 and accompanying text.

457. Cf. *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969) (limiting welfare costs is not a "constitutionally permissible state objective"); *Ake v. Oklahoma*, 470 U.S. 68, 78-79, (1985) (state economic interest insufficient to justify denial of psychiatric assistance).

458. See *Parham v. J.R.*, 442 U.S. 584, 604-05 (1979).

459. See *supra* notes 359-63 and accompanying text.

460. See *supra* note 65 and accompanying text.

461. See, e.g., *Goldberg v. Kelly*, 397 U.S. 254, 265-66 (1970); see also *Cooper v. Oklahoma*, 116 S. Ct. 1373, 1383 (1996). Admittedly, the fiscal and administrative burdens that a state faces are relevant to assessing what procedural protections the government must provide when it seeks to abridge a constitutionally protected liberty or property interest. See *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). However, a significant difference exists between incorporating the governmental interest in administrative efficiency when delineating procedural protections for *any* protected interest, such as a state job or a public entitlement, and permitting the governmental interest in administrative efficiency to justify subjecting patients to the potentially disabling and life-threatening effects of antipsychotic drugs.

462. *Davis*, 506 F. Supp. at 937 n.31.

463. Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medication*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 213 (1980).

464. See *supra* notes 74-75 and accompanying text. See also *Ake v. Oklahoma*, 470 U.S. 68,

recognized that an antagonistic relationship between a patient and his doctor lessens the likelihood of clinical progress. A right to refuse encourages cooperation between a patient and his doctor and provides a far greater opportunity to receive treatment in which both the patient and physician concur.⁴⁶⁵

Furthermore, a right to refuse should not significantly impact hospital resources since the overwhelming percentage of patients do not refuse medication.⁴⁶⁶ Additionally, to the extent that a limited number of treatment refusals resulted in patients remaining confined for periods of time longer than they would have if hospital staff forcibly administered medication, state statutes permit state hospitals to assess care and treatment charges.⁴⁶⁷

Finally, a patient's right to make decisions that some deem foolish does not leave the state powerless to act when the severity of the patient's psychosis precludes assessment of the risks and benefits of choosing medication. Hence, just as most states aim to treat civilly committed patients like its "normal" citizens by permitting involuntarily hospitalized patients to retain their civil rights,⁴⁶⁸ states can obtain determinations of incompetence that enable hospitals to obtain judicial authorization to provide treatment over objection. This is similar to what general hospitals can do for incompetent patients who are not

81 (1985); *Addington v. Texas*, 441 U.S. 418, 429 (1979) (recognizing the "lack of certainty and the fallibility of psychiatric diagnosis"); *Ennis & Litwack*, *supra* note 74, at 711-17; *Lipton & Simon*, *supra* note 74, at 370; John Petrila, *Redefining Mental Health Law*, 16 L. & HUMAN BEHAV. 89, 93 (1992) (recognizing diagnostic difficulties in state-operated psychiatric hospitals) (citations omitted).

465. See Paul S. Appelbaum & Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 345 (recognizing clinical value of negotiation between doctor and patient that results from a right to refuse); *Brooks*, *supra* note 47, at 369; *Morris*, *supra* note 227, at 354 n.54 (finding that the legal right to refuse model resulted in a clinical benefit to patients as it created an effective therapeutic alliance between doctor and patient).

466. See, e.g., J. Richard Ciccone et al., *Medication Refusal and Judicial Activism: A Reexamination of the Effects of the Rivers Decision*, 44 HOSP. & COMMUNITY PSYCHIATRY 555, 557 (1993); J. Richard Ciccone et al., *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 BULL. AM. ACAD. PSYCH. LAW 203, 208 (1990); Julie Zito et al., *One Year Under Rivers: Drug Refused in a New York State Psychiatric Facility*, 12 INT. J. LAW & PSYCH. 295, 302 (1989).

467. See, e.g., N.Y. MENTAL HYG. LAW § 43.01 (McKinney 1996). Courts have invariably recognized that states may impose care and treatment charges and have rejected any challenges to statutorily imposed care and treatment charges to civilly committed patients. See, e.g., *In re Nichols*, 388 N.W.2d 682 (Mich. Ct. App. 1986); *Chill v. Mississippi Hosp. Reimbursement Comm'n*, 429 So. 2d 574 (Miss. 1983); *Oklahoma ex rel. Western State Hosp. v. Stoner*, 614 P.2d 59 (Okla. 1980). Indeed, litigation throughout the country reveals that many states appropriate patients' Social Security benefits, sometimes illegally, to satisfy care and treatment charges. See, e.g., *Crawford v. Gould*, 56 F.3d 1162, 1165-68 (9th Cir. 1995); *King v. Schafer*, 940 F.2d 1182 (8th Cir. 1991).

468. See *supra* note 409 and accompanying text.

civily committed.⁴⁶⁹ Subjecting civily committed patients to a state's incompetency laws permits patients to make seemingly unwise decisions as long as such individuals can weigh the risks and benefits of any decision to reject medication.⁴⁷⁰

E. Medication as the Least Intrusive Means of Treatment

1. An Historical Overview.—Even when medication is necessary to satisfy the state's overriding interests, namely, controlling hospital emergencies and treating patients found incompetent to make treatment decisions, the need for such medication may not justify the forcible administration of antipsychotic medication. Rather, because forced drugging abridges a patient's fundamental right to bodily autonomy, due process requires that the drugs be the least restrictive means of satisfying the state interest in question.⁴⁷¹

The Supreme Court first formulated the least intrusive means test in *Shelton v. Tucker*,⁴⁷² when it declared that,

even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.⁴⁷³

After *Shelton v. Tucker*, numerous courts applied the least restrictive alternative test to the civil commitment setting or other contexts involving psychiatric

469. See *Woodland v. Angus*, 820 F. Supp. 1497, 1514 n.20 (D. Utah 1993); see also *Guardianship of Collier*, 653 A.2d 898 (Me. 1995).

470. As one authority noted:

At issue in deciding whether to respect a person's hospitalization and treatment refusal in his decisionmaking competence, that is, the person's ability, within reasonable, culturally determined limits, to attend to and weigh data relevant to the decision whether to accept or reject hospitalization and treatment. This type of determination focuses on the person's ability to perform the process of deciding rather than on the final decision. Focusing on this process avoids the logical fallacy of assuming that because a decision seems inexplicable, disturbing, or irrational in a given instance or series of instances, it must be true that the decisionmaker is incapable of rational decisionmaking.

Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 SO. CAL. L. REV. 527, 632-633 (1978) (footnotes omitted).

471. See *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

472. 364 U.S. 479 (1960).

473. *Shelton*, 364 U.S. at 488 (footnotes omitted). Subsequently, the Supreme Court was more explicit: "[E]ven when pursuing a legitimate interest, a State may not choose means that unnecessarily restrict constitutionally protected liberty,' and we have required that States adopt the least drastic means to achieve their ends." *Illinois State Bd. of Elections v. Socialist Workers Party*, 440 U.S. 173, 185 (1979) (quoting *Kusper v. Pontikes*, 414 U.S. 51, 58-59 (1973)).

hospitalization.⁴⁷⁴ A few courts, at least prior to *Youngberg v. Romeo*,⁴⁷⁵ applied the least restrictive alternative in the refusal of treatment context.⁴⁷⁶

However, after *Youngberg*, a number of courts, relying on that case, held there is no right to receive treatment in the least restrictive environment,⁴⁷⁷ thereby, at least implicitly, rejecting the applicability of the least restrictive alternative to any aspect of treatment in an institutional setting for people with mental disabilities. Similarly, after the Supreme Court's remand in *Rennie IV*, a majority of the Third Circuit failed to address whether the forced administration of medication abridges a fundamental right and concluded that the least restrictive alternative test does not survive *Youngberg*.⁴⁷⁸ However, both *Riggins v. Nevada*⁴⁷⁹ and a recognition that the right to refuse is fundamental strongly suggest that the least restrictive alternative governs the administration of psychotropic medication as the Supreme Court has applied the least restrictive alternative analysis in numerous other contexts in which fundamental liberties were at stake.⁴⁸⁰

474. See, e.g., *DeAngelas v. Plaut*, 503 F. Supp. 775, 780-81 (D. Conn. 1980) (holding state statute unconstitutional because of failure to require less restrictive alternatives); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974) (holding burden rests with state to demonstrate that proposed commitment is the least restrictive environment consistent with the person's needs); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096 (E.D. Wisc. 1972) (stating "person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable"), vacated on the grounds, 414 U.S. 473, reinstated and enforced, 379 F. Supp. 1376 (E.D. Wisc. 1974), vacated on the grounds, 421 U.S. 957 (1975) reinstated, 413 F. Supp. 1318 (E.D. Wisc. 1976); *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969) (noting the "principle of least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment"); *Lake v. Cameron*, 364 F.2d 657, 659-61 (D.C. Cir. 1966) (finding court has duty to explore alternatives to institutional confinement).

475. 457 U.S. 1119 (1982).

476. See *Rennie III*, 653 F.2d 836, 845-47 (3d Cir. 1981); *Rogers II*, 634 F.2d 650, 657 (1st Cir. 1980).

477. See, e.g., *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980, 992 (10th Cir. 1992); *Lelsz v. Kavanagh*, 807 F.2d 1243, 1251 (5th Cir. 1987); *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1249 (2d Cir. 1984).

478. See *Rennie V*, 720 F.2d 266, 269-70 (3d Cir. 1983). However, one court has rejected the applicability of *Youngberg* to the refusal of treatment context and has concluded that since the least restrictive alternative test applies whenever the state seeks to interfere with fundamental liberties, hospital staff must rule out less restrictive alternatives, such as segregation or use of less potent medication, prior to administering medication over objection to a pretrial detainee hospitalized because of an incapacity to stand trial. *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984).

479. 504 U.S. 127 (1992).

480. See, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972) (right to vote); *Shapiro v. Thompson* 394 U.S. 618, 637 (1969) (right to interstate travel).

Riggins is also consistent with decisions based upon state law that have held that least

2. *Evaluating the Least Restrictive Alternative in Practice.*—The least restrictive alternative has frequently been viewed with hostility in the context of the provision of treatment to mentally ill individuals, particularly by the medical profession.⁴⁸¹ Generally, such criticism focuses on the difficulty in determining what constitutes the least restrictive method of treatment.⁴⁸²

However, once one recognizes that a right to refuse treatment exists except in an emergency or when a patient has been found incompetent to make treatment decisions, application of the least restrictive method of treatment in some respects is particularly easy to apply. When administering medication to eliminate an emergency, twenty-five milligrams of a drug is less restrictive than fifty milligrams, fifty milligrams is less restrictive than one hundred, and so forth. Likewise, a drug that is not an antipsychotic, such as Ativan,⁴⁸³ which produces less debilitating side effects than antipsychotic drugs, constitutes a less restrictive form of treatment.⁴⁸⁴

Arguably, hospital staff may have difficulty assessing whether the administration of medication, either antipsychotic medication or a less potent type of psychotropic drug, is less restrictive than other treatment or behavioral

restrictive alternative considerations govern the forced drugging of patients. See *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 321 (Mass. 1983); *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986).

Utilization of the least restrictive alternative rule in the refusal of treatment context does not mean that case law rejecting the least restrictive alternative in the context of the right to treatment is now bad law. Rather, as the right to refuse treatment is a fundamental right and hence, qualitatively different than the right to treatment, see *supra* notes 236-38 and 344-79 and accompanying texts, application of the least restrictive alternative in the refusal of treatment context does not mean that the least restrictive alternative analysis governs right to treatment cases.

481. See, e.g., Thomas G. Gutheil et al., *The Inappropriateness of "Least Restrictive Alternative" Analysis for Involuntary Procedures with the Institutionalized Mentally Ill*, 22 J. PSYCHIATRY & LAW. 7 (1983); P. Browning Hoffman & Lawrence L. Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977). For a more benign view of this doctrine, see Ingo Keilitz et al., *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 ST. LOUIS U. L. REV. 691 (1985).

482. See *Romeo v. Youngberg*, 644 F.2d 147, 180 (Seitz, C.J., concurring); Gutheil et al., *supra* note 481, at 15; Hoffman & Foust, *supra* note 481, at 1150 n.142. Hoffman utilizes the following hypothetical situation to illustrate the difficulty in determining what constitutes the least restrictive treatment. A physician can treat a psychotic patient more quickly and efficiently with an intermuscular injection of medication that may produce severe side effects. On the other hand, the clinician can use oral medicine that might produce less side effects but require the patient to remain hospitalized for an appreciably longer period of time. *Id.*

483. Ativan is an antianxiety drug with sedative effects. PHYSICIANS DESK REFERENCE 3011, 3013 (52d ed. 1998).

484. Admittedly, in an emergency, a physician may well need to write an order that authorizes the administration of medication that comes in injectable form as it may not be possible, at least in some situations, to ask a patient whether he is willing to accept medication that can be given only orally. However, a drug such as Ativan can be administered by injection. *Id.* at 3011.

modalities such as seclusion or restraint.⁴⁸⁵ Hospital staff can lessen this difficulty by asking patients during the admission process what type of emergency intervention they would prefer if such action becomes necessary.⁴⁸⁶ Alternatively, patients can sign an advanced directive that specifies the type of forced intervention they would want hospital staff to administer if their clinical condition deteriorates to such a degree that they are creating an emergency on the ward.⁴⁸⁷

When administering treatment over objection to patients deemed incompetent to make their own treatment decisions, application of the least restrictive alternative should be no more difficult. Hospital physicians can attempt to determine the types of drugs that in the past produced any harmful side effects and not use such medications in any treatment regimen. Physicians can gather such information from the hospital record that should contain the patients' clinical histories.

Furthermore, use of the least restrictive alternative will not result in the involvement of the federal judiciary in the treatment plans of many patients, a concern that led to the adoption of the professional judgment standard in *Youngberg*.⁴⁸⁸ Procedural due process requires that an independent factfinder of some sort determine whether a patient is incompetent to make treatment decisions.⁴⁸⁹ At the same time, the independent factfinder could also determine what constitutes the least intrusive mode of treatment. Hence, whether a state court, an administrative official or administrative panel serves as the independent factfinder,⁴⁹⁰ the presence of an independent decision maker should eliminate individual challenges in federal court.⁴⁹¹

485. Restraint has been defined as "the use of any apparatus that interferes with the free movement of the patient and which the patient is unable to remove easily." N.Y. COMP. CODES R. & REGS. tit. 14, § 27.2(d) (1995). Seclusion is "the presence of a patient in a room alone with closed door which is not possible for the patient to open from the inside. *Id.* § 27.2(e). In one study involving patients at a county psychiatric hospital, 64% of the patients preferred medication and 36% preferred seclusion or restraint as a means of intervention when necessitated by a clinical emergency. Yvette Sheline & Teresa Nelson, *Patient Choice: Deciding Between Psychotropic Medication and Physical Restraints in an Emergency*, 21 BULL. AM. ACAD. PSYCHIATRY & LAW 321, 324 (1993).

486. See Sheline & Nelson, *supra* note 485, at 327.

487. In *In re Rosa M.*, 597 N.Y.S.2d 544 (Sup. Ct. N.Y. Cty. 1991), the court denied an application from a psychiatric hospital to administer electro-convulsive therapy to an incompetent patient. The court recognized that when competent, the patient withdrew her consent to the treatment. *Id.* at 545. Accordingly because the patient had a fundamental right to control her own treatment, the hospital was prohibited from administering electro-convulsive therapy, even when she became incompetent. *Id.*

488. See *supra* notes 242-43 and accompanying text.

489. See *Washington v. Harper*, 494 U.S. 210, 233 (1990).

490. Compare *Rivers v. Katz*, 495 N.E.2d 337, 343-44 (N.Y. 1986), with *R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Tex. 1984).

491. See *University of Tenn. v. Elliott*, 478 U.S. 788, 799 (1986); *Migra v. Warren City Sch.*

F. State Law as a Basis for a Federal Right to Refuse Medication

Perhaps the most significant aspect of *Washington v. Harper*⁴⁹² is the Supreme Court's explicit recognition that state law can serve as a source of a federal right to refuse medication independent of any right conferred by the Due Process Clause of the Fourteenth Amendment itself.⁴⁹³ The Supreme Court has never squarely addressed the issue of whether state-created liberty interests are protected by both the substantive and procedural components of the Due Process Clause or only require procedural protection.⁴⁹⁴ However, the Court's opinion in *Harper* strongly substantiates that state law can create a substantive liberty interest that defines the scope of one's essential right to refuse medication.

In *Harper*, the Court noted that state law creates a protected liberty interest and determines "what factual circumstances must exist before the State may administer antipsychotic drugs."⁴⁹⁵ This occurs when state law uses language of an unmistakably mandatory character prohibiting governmental conduct absent specified substantive predicates.⁴⁹⁶ When state law limits the forcible administration of medication to certain specified circumstances, state law creates a justifiable expectation that the government will not administer medication unless those circumstances exist.⁴⁹⁷

In concluding in *Harper* that the prisoner possessed a liberty interest in refusing medication except if he is mentally ill and either gravely disabled or dangerous,⁴⁹⁸ the Court cited *Hewitt v. Helms*,⁴⁹⁹ and *Vitek v. Jones*.⁵⁰⁰ This is noteworthy because these cases examined state created liberty interests by virtue of the mandatory nature of state law. The Court did not cite *Rogers III*, *Rennie IV*, or *Youngberg*, cases that one would expect to serve as authority for a

Dist. Bd. of Educ., 465 U.S. 75, 81 (1984).

492. 494 U.S. 210 (1990).

493. *See id.* at 221-22.

494. Former Justice Powell believes that "substantive due process rights are created only by the Constitution. *Regents of the Univ. of Mich. v. Ewing*, 474 U.S. 214, 229 (1985) (Powell J. concurring). Similarly, relying upon Justice Powell's concurrence in *Ewing*, the Fourth Circuit concluded that "substantive due process rights arise solely from the Constitution." *Huang v. Board of Governors of Univ. of N.C.*, 902 F.2d 1134, 1142 n.10 (4th Cir. 1990). The Eleventh Circuit also reached the same conclusion. *See McKinney v. Pate*, 20 F.3d 1550, 1556 (11th Cir. 1994) (en banc), *cert. denied*, 115 S. Ct. 898 (1995). On the other hand, the Seventh Circuit concluded that the Due Process Clause protects substantive liberty interests created by state law. *See Villanova v. Abrams*, 972 F.2d 792, 798 (7th Cir. 1992).

495. *Harper*, 494 U.S. at 220.

496. *Id.* at 220-21.

497. *Id.* at 221.

498. *Id.*

499. 459 U.S. 460, 471-72 (1983).

500. 445 U.S. 480, 488-91 (1980).

substantive right to refuse medication.⁵⁰¹ Hence, the opinion states that state law defined the scope of the prisoner's right to refuse.⁵⁰² This is evident in the Court's opinion addressing the prisoner's substantive right to refuse medication under the Due Process Clause in the absence of any state-created liberty interest. The Court also held that "the Due Process Clause confers upon the respondent no greater right than that recognized under state law."⁵⁰³

Because state law of a mandatory nature defines the scope of a patient's right to refuse medication, a broad constitutional right to refuse drugs exists in many jurisdictions. In most states, there is a common law right to determine one's

501. See *Harper*, 494 U.S. at 221. One can argue that *Harper* does not necessarily establish that state law can always create substantive liberty interests. Rather, the refusal of treatment context presents a situation in which substantive protections exist independent of state law as a result of the historic protections to the right to bodily autonomy. If, as the Court in *Rogers III* suggested, state law governs the weight to accord the competing interests of the individual and the state, 457 U.S. 291, 304 (1982), then state law does not create substantive interests but simply helps define the scope of the right that arises independently under the Federal Constitution. See *id.* However, such an interpretation of *Harper* is not necessarily consistent with dicta from *Rogers III* in which the Court noted that "substantive liberty interests [can be] created by state as well as federal law." *Id.* at 300.

502. In addressing the scope of Mr. Harper's right to refuse drugs, the Court recognized that its grant of *certiorari* included a review of both "the substance of the inmate's right, as well as the procedural guarantees." *Harper*, 494 U.S. at 220-21. The Court then stated that "[w]e address these questions beginning with the substantive one." *Id.* at 221. The Court then concluded that "state law recognizes a liberty interest . . . which permits refusal of antipsychotic drugs unless certain preconditions are met," *id.* at 228, and rejected the prisoner's contention that the State's "substantive standards are deficient under the Constitution." *Id.* at 227. At this point in its opinion, the Court stated that "we address next what procedural protections are necessary to ensure that the decision to medicate an inmate against his will is neither arbitrary nor erroneous under the standards we have discussed above." *Id.* at 228. Hence, the portion of the opinion that addressed the prisoner's rights as defined by state law addressed the substantive aspect of the right to refuse.

503. *Id.* at 222. This sentence must be interpreted as a comparison between rights under the Due Process Clause itself and state created liberty interests that are also protected by the Fourteenth Amendment. It cannot be interpreted as a comparison rights protected by the Fourteenth Amendment and rights protected only under state law. Because the Eleventh Amendment prohibits a federal court from enjoining state officials in order to protect rights under state law, *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 87, 117 (1984) it would have been fruitless for the Court to engage in any discussion about rights that were not subject to review by the Supreme Court under state law itself.

Ultimately, one can argue that because the Supreme Court ruled that the prisoner's right to refuse drugs was no greater than what was guaranteed to him under state law, the Court was willing to assume that state law created substantive rights. While this is true, one must ask why the Court explicitly stated that it was addressing the prisoner's substantive due process rights if it did not believe that state law could create substantive rights. Indeed, in *Collins v. City of Harker Heights*, when the Court wanted to assume the existence of a substantive interest created by state law, the Court explicitly stated so. 503 U.S. 115, 129 (1992).

course of treatment that permits individuals to refuse medical treatment in non-emergency situations.⁵⁰⁴ This common law right can serve as a basis for a state created liberty interest.⁵⁰⁵ This common law right does not necessarily serve as a source of protection for institutionalized mentally ill individuals. In virtually every state, citizens do not forfeit any civil right as a result of involuntary hospitalization or the receipt of services for mental health.⁵⁰⁶ Furthermore, in most states, notwithstanding any civil commitment, patients remain competent as a matter of law.⁵⁰⁷ Accordingly, the combination of the common law right to determine one's course of treatment and state statutory laws that provide that patients (1) do not forfeit any civil rights upon civil commitment or receipt of services of mental illness, and (2) remain competent notwithstanding civil commitment, creates in many jurisdictions a justifiable expectation that patients can choose whether or not to accept medication in non-emergency situations or when they have been found to be incompetent.⁵⁰⁸

504. See, e.g., *supra* note 361 accompanying text; *Common Law Remedy*, *supra* note 11, at 1736-37.

505. See *Regents of the Univ. of Mich. v. Ewing*, 474 U.S. 214, 224 n.9 (1985); *Rennie III*, 653 F.2d at 841-42.

506. See *supra* note 409 and accompanying text.

507. See ARK. CODE ANN. § 20-47-223 (Michie 1991); CAL. WELF. & INST. CODE § 5331 (West 1992 & Supp. 1998); COLO. REV. STAT. § 27-10-104 (1997); CONN. GEN. STAT. ANN. § 17a-541 (West 1988); D.C. CODE ANN. § 21-564 (1989); FLA. STAT. ANN. § 394.459(1) (West 1986); 405 ILL. COMP. STAT. ANN. 5/2-101 (West 1997); IND. CODE ANN. § 12-27-2-3 (1993); IOWA CODE ANN. § 229.27 (West 1994 & Supp. 1998); KAN. STAT. ANN. 59-2948(b) (West 1997); LA. REV. STAT. ANN. § 171B (West 1989 & Supp. 1998); ME. REV. STAT. ANN. tit. 34-B, § 3803(1) (West 1988); MASS. GEN. LAWS ANN. ch. 123, § 24 (West 1998); MICH. COMP. LAWS ANN. § 330.1489 (West 1992); MISS. CODE ANN. § 41-21-101 (Michie 1993); MO. ANN. STAT. § 630.120 (West 1988); MONT. CODE ANN. § 53-21-141 (1997); NEB. REV. STAT. §83-1066(1) (1994); NEV. REV. STAT. ANN. § 433A.460 (Michie 1996 & Supp. 1997); N.H. REV. STAT. ANN. § 135-C:56(II) (1996) N.J. STAT. ANN. § 30:4-24.2(c) (West 1997); N.M. STAT. ANN. § 43-1-5 (Michie 1997); N.Y. MENTAL HYG. LAW § 29:03 (McKinney 1996); N.C. GEN. STAT. § 122C-203 (1996); N.D. CENT. CODE § 25-03.1-33 (1995); OHIO REV. CODE ANN. § 5122.301 (Anderson 1996); OKLA. STAT. ANN. tit. 43A., § 1-105 (West 1990); OR. REV. STAT. § 426.295(1) (1995); S.C. CODE ANN. § 44-17-580(2) (Law Co-op 1985); TENN. CODE ANN. § 33-3-104(5) (1984 & Supp. 1997); VT. STAT. ANN. tit. 18, § 7706 (1987); VA. CODE ANN. § 37.1-87 (Michie 1996 & Supp. 1997); WASH. REV. CODE ANN. § 71.05.450 (West 1992 & Supp. 1998) W. VA. CODE § 27-5-9(a) (1992); WIS. STAT. ANN. § 51.59 (West 1987); WYO. STAT. ANN. § 25-10-121 (1997).

508. See, e.g., *Goedecke v. State Dep't of Insts.*, 603 P.2d 123, 125 (Colo. 1979); *Rivers*; 495 N.E.2d at 344. Because both the right to refuse treatment that arises out of state-created liberty interests and the right conferred by the Fourteenth Amendment, as detailed in *Rogers III*, rest on the common law to determine the scope of one rights, see *supra* notes 421-34 and accompanying text, regardless of the approach taken, the result is the same. However, reliance upon the state-created liberty interest approach has one potential significant impact. When addressing rights arising out of state-created liberty interests, the Supreme Court has never adopted an institutional based standard of review to govern decisions by governmental officials. See, e.g., *Harper*, 494 U.S.

However, many jurisdictions contain more specific statutory or administrative law governing the right to refuse medication; some limit the right to refuse, some do not.⁵⁰⁹ In those jurisdictions that contain statutory law addressing the right to refuse medication, such statutory law may re-define a patient's right to refuse medication, and concomitantly impact the scope of a patient's state created liberty interest. Unambiguous statutory law can limit one's common law rights.⁵¹⁰ Furthermore, when statutory law governing medication conflicts with provisions that prohibit the forfeiture of civil rights and/or declare that patients remain competent, the former provisions will supersede the latter as rules of statutory construction provide that when a specific statute conflicts with laws of a more general nature, the specific statute controls.⁵¹¹

at 221; *Hewitt v. Helms*, 459 U.S. 460, 466-72 (1983). Hence, if one rejects the author's contention that there should be no institutional standard of review when assessing rights under the Fourteenth Amendment itself, the use of a state-created liberty interest approach still affords patients a right to refuse that is defined by a patient's common law rights under state law.

509. See, e.g., ARIZ. REV. STAT. ANN. §§ 36-512, 36-513 (West 1993) (right to refuse except in true medical emergency); CONN. GEN. STAT. ANN. §17a-543(b) (West 1992 & Supp. 1998) (involuntary patients may be administered treatment over consent); FLA. STAT. ANN. §394.459(3) (West 1998) (right to refuse except in emergency or after judicial determination of incompetence); GA. CODE ANN. § 37-3-163(b) (1995) (no right to refuse in emergency or later concurrence of need for treatment by second physician); HAW. REV. STAT. ANN. § 334E-1 (Michie 1996) (informed consent required before all treatment); IDAHO CODE § 66-346(4) (1996) (right to refuse specific modes of treatment); 405 ILL. COMP. STAT. ANN. 5/2-107, 5/107.1 (West 1997) (right to refuse except in emergency or under court order that finds patient exhibits deterioration, lacks capacity to make a reasoned treatment decision, benefits from medication outweigh the harm and other factors are present); IOWA CODE § 229.23(2) (West 1994) (no right to refuse after court order of commitment); KY. REV. STAT. ANN. §§ 202A.191; 202A.196 (Michie 1995) (right to refuse except if court orders otherwise after considering necessity of medication to protect against harm, the capacity of patient to give informed consent, the existence of less restrictive alternatives and risks of permanent side effects); NEV. REV. STAT. ANN. § 433.484 (Michie 1996) (right of competent individual to refuse except in emergency situation); N.C. GEN. STAT. § 122C-57(e) (1996 & Supp. 1997) (hospital may administer medication over objection in emergency, when involuntarily committed patient is incapable of participating in treatment plan, or significant possibility that patient will harm himself or others without treatment); N.H. REV. STAT. ANN. § 135-C:57 (1996) (right to refuse except in emergency situation); N.M. STAT. ANN. § 43-1-15 (Michie 1993) (right of competent adult to refuse treatment); S.C. CODE ANN. § 44-22-140 (Law Co-op & Supp. 1997) (right to refuse only psychiatric treatment that is not standard); S.D. CODIFIED LAWS § 27A-12-3.23 (Michie Supp. 1997) (hospital may administer medication over objection in an emergency to prevent serious physical harm to self or others or significant deterioration of mental illness); WIS. STAT. ANN. § 51.61(1)(g) (West 1997) (no right to refuse after commitment hearing).

510. NORMAN J. SINGER, 3 SUTHERLAND STATUTORY CONSTRUCTION § 61.01, at 171-73 (5th ed. 1992 & Supp. 1998).

511. See, e.g., *Williams v. State Farm Mut. Auto. Ins. Co.*, 763 F. Supp. 121, 127 (E.D. Pa. 1991); *Gaynor v. Union Trust Co.*, 582 A.2d 190, 199 (Conn. 1990); *Wilson v. Unsatisfied Claim*

However, any state law that limits a patient's common law right to control his or her own course of treatment must clearly limit such right as it is also a well-settled rule of statutory interpretation that statutes in derogation of the common law will be strictly construed and any limitation of one's common law right must be clearly set forth.⁵¹² Similarly, in jurisdictions where there are administrative regulations governing the right to refuse, the administrative regulations will not limit one's state-created liberty interest since government agencies may only promulgate those regulations that are consistent with statutory law.⁵¹³ Accordingly, in jurisdictions that provide for a common law right to determine one's treatment and have statutory provisions regarding competency and the maintenance of civil rights, administrative regulations that limit a patient's common law right to determine his or her own course of treatment are invalid. Such administrative regulations impermissibly conflict with state statutory law because the regulations result in a patient forfeiting his or her common law right to determine his or her own course of treatment even though the patient remains competent as a matter of law.⁵¹⁴

CONCLUSION

An analysis of the Supreme Court's decisions in *Washington v. Harper*⁵¹⁵ and *Riggins v. Nevada*⁵¹⁶ establishes that it is an error to apply the professional judgment standard of *Youngberg v. Romeo*⁵¹⁷ to cases involving the forcible

and Judgment Fund, 536 A.2d 752, 756 (N.J. 1988); *State v. Stephens*, 807 P.2d 241, 245 (N.M. Ct. App. 1991); *People v. Lawrence*, 474 N.E.2d 593, 596, 204 (N.Y. 1984); *Hammond v. City of Dallas*, 712 S.W.2d 496, 498 (Tex. 1986); *Paternity of J.S.C. v. T.L.G.*, 400 N.W.2d 48, 55 (Wis. Ct. App. 1986).

512. See, e.g., *Pigford v. People*, 593 P.2d 354, 356 (Colo. 1979); *Blue Cross & Blue Shield of Conn., Inc. v. Mike*, 439 A.2d 1026, 1032 (Conn. 1981); *Heard v. Neighbor Newspapers, Inc.*, 383 S.E.2d 553, 554 (Ga. 1989); *Burns Int'l Sec. Servs. v. Department of Transp.*, 671 P.2d 446, 449 (Haw. 1983); *Macku By and Through Macku v. Drackett Prods.*, 343 N.W.2d 21, 58, 61 (Neb. 1984); *Gancalves v. Regent Hotels*, 447 N.E.2d 693, 697 (N.Y. 1983); *Reliance Ins. Co. v. Chevron U.S.A., Inc.*, 713 P.2d 766, 770 (Wyo. 1986).

513. See, e.g., *Manhattan Gen. Equip. Co. v. Commissioner of Internal Revenue*, 297 U.S. 129, 134 (1936); *McComb v. Wambaugh*, 934 F.2d 474, 481 (3d Cir. 1991); *Shelton v. Mutual Sav. & Loan Ass'n*, 738 F. Supp. 1050, 1057 (E.D. Mich. 1990); *Ex parte State Dep't of Human Resources*, 548 So. 2d 176, 178 (Ala. 1988); *Natural Resources & Env'tl. Protection Cabinet v. Pinnacle Coal Corp.*, 729 S.W.2d 438, 439 (Ky. 1987); *Parmley v. Missouri Dental Bd.*, 719 S.W.2d 745, 755 (Mo. 1986); *Smith v. North Dakota Workers Compensation Bureau*, 447 N.W.2d 250, 262 (N.D. 1989).

514. See *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986) (invalidating state administrative provision because it resulting in forced administration of medication in violation of common law right to determine one's own course of treatment and state constitution).

515. 494 U.S. 210 (1990).

516. 504 U.S. 127 (1992).

517. 457 U.S. 1119 (1982).

administration of medication to civilly committed patients. Courts that applied the *Youngberg* standard erred because of their failure to (1) reconcile the Supreme Court's dispositions of *Rogers III* and *Rennie IV*, and (2) scrutinize the constitutional differences between refusing medication and providing care and treatment to a profoundly retarded individual. State courts have generally recognized a broad right to refuse under federal law.⁵¹⁸ However, the scope of a patient's right to refuse under federal law is inextricably tied to state law because state law (1) serves to guide the balancing of individual and state interests, and (2) creates protectable substantive interests. Litigants should no longer be afraid of federal courts as a mechanism to protect against the unwanted administration of medication and should invoke this forum when they believe it serves their clients' interests to do so.⁵¹⁹

518. See *supra* notes 22, 435 and accompanying text.

519. For a discussion of the factors to consider when deciding whether to file a civil rights lawsuit in federal and state court, see SCHWARTZ & KIRKLIN, *supra* note 307, §§ 1.17-1.18, at 64-68.

