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CAN MENTAL HEALTH PROFESSIONALS PREDICT JUDICIAL DECISIONMAKING? CONSTITUTIONAL AND TORT LIABILITY ASPECTS OF THE RIGHT OF THE INSTITUTIONALIZED MENTALLY DISABLED TO REFUSE TREATMENT: ON THE CUTTING EDGE*

Michael L. Perlin**

INTRODUCTION

Few subjects are as paradoxical as that of making predictions in the area of law and mental health. Lawyers have written¹ and lectured² extensively on what a poor job mental health professionals usually do in predicting dangerousness,³ a conclusion which seems to reflect the bulk of expert opinion by a full range of behavioralists as

* Adapted from a speech given at the Touro Law School Symposium on Mental Health Law, Feb. 13, 1986.

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1. See Perlin, *The Supreme Court, The Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91 (1986) [hereinafter cited as *Barefoot's Ake*]; Rodriguez, LeWinn & Perlin, *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders* 14 RUTGERS L.J. 397 (1983) [hereinafter cited as *Defense Under Siege*]; Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Burger's Time-Consuming Procedural Minuets Theory in Parham v. J.R.*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 149 (1981); PLOTKIN, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977); FRIEDMAN, *The Mentally Handicapped Citizen and Institutional Labor*, 87 HARV. L. REV. 567 (1974); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974).

2. See M. Perlin, *Adequacy of Forensic Psychiatric Evaluations*, (Oct. 1977) (paper presented to the American Academy of Psychiatry and Law, annual national meeting); M. Perlin, *The Great Debate: Resolved — Psychiatrists Cannot Predict Dangerousness*, (Oct. 1979) (paper presented to the American Academy of Psychiatry and Law, annual national meeting); M. Perlin *The Use of Expert Witnesses in the Civil Commitment Process*, (Dec. 1983) (paper presented to the Minnesota Mental Health Law Project CLE Seminar).

3. The prototype legal analysis in Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Court Room*, 62 CALIF. L. REV. 693 (1974).

well.⁴ Ironically, it is a conclusion that has not, at least in a criminal case context, been enthusiastically embraced by the United States Supreme Court.⁵

On the other hand, we expect that mental health professionals will be able to do an excellent job at another sort of prediction: the prediction of how courts will rule on a variety of legal issues involving the continually-changing relationship between law and mental health. To some extent, it is this sort of prediction which may well be the centerpiece of attention for the indefinite future. While this is a topic that may cause mental health professionals some free-floating anxiety, it is also an issue which is in need of a measure of clarification.

There is no question that, in recent years, we have seen a massive proliferation of litigation involving all aspects of the law as it affects mentally disabled persons. Litigated issues have involved the civil rights of patients,⁶ the constitutional contours of the commitment process,⁷ the interplay between criminal law and mental disability,⁸ and the impact of mental disability on traditional civil law principles.⁹ This litigation, one of the most "volatile"¹⁰ areas of the law, has continued to grow "unabated".¹¹ A look at the Supreme Court's

4. See American Psychiatric Ass'n, *Clinical Aspects of the Violent Individual* 28 (1974); Cocozza & Steadman, *Some Refinements in the Measurement and Prediction of Dangerous Behavior*, 131 AM. J. PSYCHIATRY 1021 (1974); A. Stone, *Mental Health and Law: A System in Transition* 33 (1975). See generally *Defense Under Siege*, *supra* note 1, at 421-24.

5. See *Barefoot v. Estelle*, 463 U.S. 880 (1983), and *Jones v. United States*, 463 U.S. 354 (1983). But cf. *Barefoot*, 463 U.S. at 916 (Blackmun, J., dissenting) and *Jones*, 463 U.S. at 371 (Brennan, J., dissenting). See generally *Barefoot's Ake*, *supra* note 1, see also Margulies, *The "Pandemonium Between the Mad and the Bad:" Procedures for the Commitment and Release of Insanity Acquittes After Jones v. United States*, 36 RUTGERS L. REV. 793 (1984).

6. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), modified 653 F.2d 836 (3d Cir. 1981), vacated and remanded 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), suppl. 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

7. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Parham v. J.R.*, 442 U.S. 584 (1979).

8. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880 (1983); *Ake v. Oklahoma*, 470 U.S. 68 (1985).

9. See, e.g., *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

10. See Perlin, *Institutionalization and the Law*, in PSYCHIATRIC SERVICES IN INSTITUTIONAL SETTINGS 75 (1978) [hereinafter cited as *Institutionalization*].

11. See Perlin, *Recent Developments in Mental Health Law*, 6 PSYCH. CLINICS OF NORTH AMERICA 539 (1983) [hereinafter cited as *Recent Developments*].

1986 docket, showing more than half a dozen more cases,¹² underscores that "‘fluxiness’ is the only absolute."¹³

In few areas has there been as much controversy,¹⁴ confrontation and contentiousness¹⁵ as in the area of the right of institutionalized mentally disabled persons to refuse the imposition of antipsychotic drug treatment.¹⁶ Here, for a variety of reasons, including, but not limited to, the patients' desire to avoid the full-range of now-well-known side effects caused by many of the drugs in question,¹⁷ pa-

12. See, e.g., *Wainwright v. Greenfield*, 106 S. Ct. 634 (1986) (use of defendant's silence following arrest and *Miranda* warnings as evidence of his sanity violated due process clause); *Allen v. Illinois*, 106 S. Ct. 2988 (1986) (privilege against self-incrimination inapplicable to action brought under Illinois' Sexually Dangerous Persons Act; involuntary commitment alone does not trigger full range of criminal procedural protections); *Ford v. Wainwright*, 106 S. Ct. 2595 (1986) (eighth amendment prohibits execution of insane prisoner); *Smith v. Murray*, 106 S. Ct. 2678 (1986) (procedural default rule, see *Wainwright v. Sykes*, 433 U.S. 72 (1977), barred relief in case where court-appointed psychiatrist, who failed to inform defendant of such potential consequences, testified on state's behalf in sentencing phase of capital punishment case); *United States v. Galioto*, 106 S. Ct. 2683 (1986) (equal protection challenge to blanket statutory ban on purchase of firearms by ex-mental patients, see 18 U.S.C. § 922(d)(4), (g), (h), mooted by statutory amendments providing certain exceptions to policy, see *Firearms Owners' Protection Act*, Pub. L. No. 99-308, 100 Stat. 449 (1986)); *Colorado v. Connelly*, 107 S. Ct. 515 (1986) (admissibility, under *Miranda*, of inculpatory statement made by severely mentally disabled criminal defendant); see also *United States v. Paralyzed Veterans of America*, 106 S. Ct. 2705 (1986) (Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, prohibiting discrimination against handicapped persons in "any program or activity receiving Federal financial assistance," not applicable to commercial airlines); *Arlene v. School Bd. of Nassau County*, 772 F.2d 759 (11th Cir. 1985), *cert. granted*, 106 S. Ct. 1633 (1986) (applicability of section 504 to individual "afflicted with . . . tuberculosis").

13. *Institutionalization*, *supra* note 10, quoting Perlin, *The Rights of the Mentally Handicapped*, 98 N.J.L.J. 1057 (1975).

14. For a sampling of the relevant legal literature, see, e.g., Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977) [hereinafter cited as *Limiting the Orgy*]; Gelman, *Mental Hospital Drugs, Professionalism and the Constitution*, 72 GEO. L.J. 1725 (1984) [hereinafter cited as *Mental Hospital Drugs*]; Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363 (1980); Brooks, *The Constitutional Right to Refuse Antipsychotic Medication*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179 (1980) [hereinafter cited as *The Constitutional Right*].

15. The rhetoric has certainly been contentious. Compare, e.g., Appelbaum and Gutheil, *The Patient Always Pays: Reflections on the Boston State Case and the Right to Rot*, 5 MASS. MED. 3 (1980), and Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot,"* 137 AM. J. PSYCHIATRY 720 (1980), with *Limiting the Orgy*, *supra* note 14. But see, e.g., Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 INT'L J. L. & PSYCHIATRY 219, 234 (1981) (criticizing "extravagant rhetoric").

16. While this issue is often simply referred to in the shorthand phrase "the right to refuse treatment," the extended description more accurately focuses on some of the major questions to be considered in any attempt to fully understand and explore the scope of the problems at hand.

17. In addition, the toxic effects of the drugs in question became readily apparent:

Temporary muscular side effects (disappearing on drug termination); dystonic reactions, such as muscle spasm in the eyes and face; irregular grimacing or writhing move-

tients have sought judicial relief as a means of either terminating or altering unwanted medical treatment.¹⁸

While some of the subsequent lawsuits *may* have been "unusually contentious,"¹⁹ they have also established an agenda for the resolution of a "significant ethical conflict."²⁰ Here, it appears that "'patients' rights groups and their allies among the mental disability bar and bench stand alone pitted against the remainder of the mental health establishment,"²¹ a conflict which may be "perhaps the piv-

ments; tongue protrusion; akathisia (inability to stay still and agitation); and parkinsonisms (drooling, muscle stiffness, shuffling gait and tremors). Nonmuscular effects include drowsiness, weakness, dizziness, low blood pressure, dry mouth, blurred vision, loss of sexual desire, frigidity, apathy, depression, constipation and diarrhea. Other serious, though less frequent effects include skin rash and skin discoloration, cardiovascular disease and sudden death.

B. Furrow, *Malpractice in Psychiatry* 61 (1980) (footnotes omitted), citing, inter alia, Ayd, *A Survey of Drug-Induced Extrapyramidal Reactions*, 175 J.A.M.A. 1054 (1961). See for a recent survey of deaths resulting from the administration of such drugs, Levenson, *Neuroleptic Malignant Syndrome*, 142 AM. J. PSYCHIATRY 1137 (1985).

Of all of the side effects, however, the most feared, and the one which appears to be the most irreversible, was found to be tardive dyskinesia:

The tongue, mouth and chin are common signs of tardive dyskinesia: the tongue sweeps from side to side, the mouth opens and closes, and the jaw moves in all directions. Fingers, arms and legs may display comparable movements; swallowing, speech or breathing can be affected as well. The movements are uncontrollable, although their intensity varies from case to case. In severe cases, the involuntary movements impede walking and even digestion. Health can be endangered, and often the victim's appearance becomes grotesque. Tardive dyskinesia is common: estimates of the disorder's prevalence rates (the proportion of patients with tardive dyskinesia at any particular time) ranges as high as sixty-five percent; fifteen to twenty percent is a widely accepted estimate. It can develop after prolonged drug exposure, normally six months or longer, and usually persists throughout the patient's lifetime. There generally is no cure. *Mental Hospital Drugs*, *supra* note 14, at 1742-43 (footnotes omitted), and sources cited at *id.* nn.85-90.

18. See *Rennie v. Klein*, 462 F. Supp. 1144 (D.N.J. 1978) (plaintiff sought *different* medication regime); see generally Brotman, *Behind the Bench on Rennie v. Klein*, in *REFUSING TREATMENTS IN MENTAL HEALTH INSTITUTIONS* 31 (1979).

The social and ethical issue raised when patients express their desire to refuse medical treatment are, of course, not new. See, e.g., Reiser, *Refusing Treatment for Mental Illness: Historical and Ethical Dimensions*, 137 AM. J. PSYCHIATRY 329 (1980) (dating problem to fifth century B.C.); Blackwell, *Schizophrenic and Neuroleptic Drugs: A Biopsychosocial Perspective*, in *REFUSING TREATMENTS IN MENTAL HEALTH INSTITUTIONS* 31 (1979).

19. Gelman, *Mental Hospital Drugging — Atomistic and Structural Remedies*, 32 CLEVE. ST. L. REV. 221, 222 (1983-84).

20. Sadoff, *Patient Rights versus Patient Needs: Who Decides?* 44 J. CLINICAL PSYCHIATRY, 27, 28 (June 1983).

21. Brown, *The Right to Refuse Treatment and the Movement for Mental Health Reform*, 9 J. HEALTH POL. POL'Y & L. 291, 296 (1984).

otal issue in the determination of the future direction of the relationship between law and mental health."²²

There are two different, but overlapping, issues which are of serious concern and are the focal point of this Article: the scope and significance of recent developments in both the constitutional and tort law aspects of the right to refuse treatment. While there are many points in common between the two areas, there are also some significant differences, and it is helpful to point them out as well. In addition, some recent suggestions which have been made for dealing with the assessment of legal responsibility in cases where patients develop irreversible side effects such as tardive dyskinesia, especially in cases where they have not been afforded whatever constitutional rights they might possess with regard to their right to refuse such treatment, will be examined.

I. CONSTITUTIONAL LAW ISSUES²³

It has now been nearly five years since the United States Supreme Court issued its at-the-time baffling decision in *Mills v. Rogers*,²⁴ which appeared to sidestep the critical question of constitutional law which it had agreed to review in that case: "whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic drugs."²⁵

The Court's decision clearly left a spate of unanswered questions;²⁶ one commentator characterized it as "extinguish[ing]" the right to refuse,²⁷ while another observed that, in its aftermath, "the frustration and confusion among administrators and staff on state mental health facilities concerning the right to refuse remains un-

22. Perlin, *The Right to Refuse Treatment: A New Right Emerges*, 1 ADVOCACY NOW: J. OF PATIENT RTS. & MENTAL HEALTH ADVOC. 8 (1979).

23. Much of the material accompanying notes 24-193 is adapted from Perlin, *The Right to Refuse Treatment*, 6 *Directions in Psychiatry*, Lesson 14 (1986).

24. 457 U.S. 291 (1982). See generally *infra* text accompanying notes 41-51.

25. *Id.* at 293. At the same time, the Supreme Court granted *certiorari* in the other major right to refuse treatment case, *Rennie v. Klein*, 458 U.S. 1119 (1982), and remanded that case for reconsideration under the then-recently announced "right to training" decision in *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982).

For an update on post-*Youngberg* developments, see Perlin, *Ten Years After: Evolving Mental Health Advocacy and Judicial Trends*, 15 FORDHAM URB. L.J. (in Press).

26. Perlin, *Patients' Rights*, in PSYCHIATRY, ch. 35, at 1, 6 (Cavenar Ed. 1985) [hereinafter cited as *Patients' Rights*].

27. Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1727 (1982) [hereinafter cited as *Common Law Remedy*]. This interpretation has proven to be unduly negative. See *infra* notes 89-93, 105-93 and accompanying text.

changed.”²⁸ However, an examination of lower courts’ response to and interpretations of *Mills* reveals a near-unanimous body of law declaring that the right *does*, in fact, exist. A closer look at these developments should help clarify the extent of the right, the type of remedial processes needed to insure enforcement of the right, and some indication of how far the right has actually been extended.

A. *Before the Mills Decision*

The outlines of the right to refuse treatment²⁹ doctrine began to fill in with the litigation of the two cases³⁰ universally acknowledged to have set the stage for the legal debate on the extent and contours of the right.³¹ A brief recapitulation of these cases indicates the scope of the issue involved.³²

In the first case, *Rennie v. Klein*,³³ the Third Circuit substantially affirmed a District Court of New Jersey decision that held that involuntarily committed mental patients retained a qualified constitutional right to refuse the administration of antipsychotic drugs that might have “permanently disabling side effects.”³⁴ This decision was premised on the “liberty” section of the due process clause of the fourteenth amendment.³⁵ In the course of its decision, the circuit cited what it characterized as “dramatic” evidence in the record that “the risk of serious side effects stemming from the administration of antipsychotic drugs is a critical factor in our determination that a liberty interest is infringed by forced medication.”³⁶

28. Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. LEGAL MED. 107, 132 (1985) [hereinafter cited as *Current Status*].

29. Unless otherwise specified, this doctrine should be construed to deal solely with refusal of antipsychotic drugs. For analyses of cases involving the right to refuse other drugs (used punitively as “aversive therapy”) or to refuse such modalities of treatment as psychosurgery, see *Patients' Rights*, *supra* note 26, at 4-5; see generally *Limiting the Orgy*, *supra* note 14.

30. *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), *suppl.* 475 F. Supp. 1294 (D.N.J. 1979), *modified* 653 F.2d 836 (3d Cir. 1981), *vacated and remanded* 458 U.S. 1119 (1982); *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub. nom. Mills v. Rogers*, 457 U.S. 291 (1982).

31. See Weiner, *Supreme Court Decisions on Mental Health: A Review*, 33 HOSP. & COMMUNITY PSYCHIATRY 461 (1982).

32. The text accompanying notes 33-41, *infra*, and the sources cited in those notes, is from *Patients' Rights*, *supra* note 26, at 5, 16. See also Perlin, *Mental Health Law and the Supreme Court*, 3 *Directions in Psychiatry*, Lesson 5 (1983); *Recent Developments*, *supra* note 11; Perlin, *The United States Supreme Court and Mental Health Law: A Retrospective*, 4 MEDICINE & L. 49 (1985).

33. *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981).

34. *Rennie*, 653 F.2d at 843-45.

35. *Id.* at 844.

36. *Id.* at 843 n.8.

On the other hand, the court sharply limited the extent of due process protections available to patients who chose to exercise the right. The informal mandates of a state administrative policy, which called for treatment team consultations with outside psychiatrists, satisfied minimal constitutional law requirements.³⁷ The type of more stringent protections previously ordered by the district court (including formal hearings to be held before psychiatrists acting as factfinders)³⁸ were not required.

In *Rogers v. Okin*,³⁹ the First Circuit Court of Appeals held that patients had a constitutionally protected interest in being left free by the state to decide whether or not to submit to "serious and potentially harmful medical treatment represented by the administration of antipsychotic drugs."⁴⁰ The circuit court remanded the case to the District Court in Massachusetts . . . to develop procedures (presumably as the district court had done in *Rennie*) to insure that the patients' legal rights would be protected in a practical way.⁴¹

Both federal appeals courts found that the fact of commitment is *not* equivalent to a finding that an involuntary patient cannot retain some measure of autonomy in treatment decision-making, that such commitment is not an implicit finding of incompetency and that the "intrusivity" of "serious and potentially harmful medical treatment" is sufficient so that a risk/benefit calculus of some sort (taking side-effects into account) must be employed before the decision of a competent patient to refuse treatment can be overridden.

B. *The Mills Decision*

In a unanimous decision, the Supreme Court sidestepped the constitutional questions raised by *Mills*, by remanding the case to the First Circuit Court of Appeals for that court to consider the impact of an intervening Massachusetts state court decision.⁴²

37. *Id.* at 848-51.

38. *Id.* at 840.

39. 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub. nom.* *Mills v. Rogers*, 457 U.S. 291 (1982).

40. *Id.* at 653.

41. *Id.* at 660-61.

42. *Mills v. Rogers*, 457 U.S. 291, 306 (1982).

There, in *In re Roe*, 383 Mass. 415, 421 N.E.2d 40 (Mass. 1981), Massachusetts' highest court had held that a noninstitutionalized, mentally incompetent patient had a right to a judicial hearing at which he could assert his desire to refuse treatment with antipsychotic drugs. *Id.* at 51-52, a conclusion the state court had based "expressly . . . on the common law of Massachusetts as well as on the Federal Constitution." *Mills*, 457 U.S. at 301. Although *Roe* dealt only with the noninstitutionalized, the Supreme Court accepted *plaintiffs'* arguments

A closer reading of the text of *Mills*, however, reveals some substantive consideration by the Supreme Court of the underlying legal doctrines in question. First, the Court noted that all parties agreed that "the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs"⁴³ but observed that the core dispute focused on the definition of that interest and identification of the conditions under which it might be outweighed by competing state interests.⁴⁴ Second, the Court specifically "assume[d] . . . that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution⁴⁵ and that these interests are implicated by the involuntary administration of antipsychotic drugs."⁴⁶

However, even given these starting points of analysis, the Court restated a major principle of constitutional litigation: a state is always free, either under its own state constitution or under the common law, to create liberty or other due process interests broader than those minimally mandated by the federal Constitution;⁴⁷ interests which might be substantive⁴⁸ or procedural.⁴⁹

that "[*Roe*] may influence the correct disposition of the case at hand," *id.* at 302-03, and thus ordered the First Circuit to reconsider its *Rogers* opinion in light of *Roe*, *id.* at 306.

Although the plaintiff in *Roe* had been incompetent, he still was entitled to have "substituted judgment" exercised on his behalf. *Roe*, 421 N.E.2d at 51. This determination was "best made in courts of competent jurisdiction," *id.* at 52, and six factors were identified as guiding such decision-making: (1) the ward's expressed preferences regarding treatment; (2) the ward's religious beliefs; (3) the impact upon the ward's family; (4) the probability of adverse side effects; (5) the consequences if treatment is refused; and (6) the prognosis with treatment *id.* at 57. See *Mills*, 457 U.S. at 304 n.19.

43. *Mills*, 457 U.S. at 299. While defendants conceded that plaintiffs had a constitutional interest in freedom from bodily invasion, they denied that it was a "fundamental" interest and asserted that it, in employing an appropriate balancing test, was outweighed by "compelling state interests" in the administration of the drugs. *Id.* n.15.

44. *Id.* at 299.

45. Cf. *Vitek v. Jones*, 445 U.S. 480 (1980) (involuntary transfer of a mental patient to a mental hospital violates a liberty interest that is guaranteed by the due process clause of the fourteenth amendment).

46. *Mills*, 457 U.S. at 299 n.16.

47. *Id.* at 300.

48. *Id.*, citing, inter alia, *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 7 (1979).

49. Because state-created liberty interests are entitled to federal due process protection, see, e.g., *Vitek*, 445 U.S. at 488, "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." *Mills*, 457 U.S. at 300. "Moreover, a State may confer *procedural* protections of liberty interests that extend beyond those minimally required by the Constitution of the United States. If a State does so, the minimal requirements of the Federal Constitution would not be controlling, and would not need to be identified in order to determine the legal rights and duties of persons within the State." *Id.*

Thus, the Court projected, it was "distinctly possible" that Massachusetts recognizes substantive liberty interests of incompetents "that are broader" than those recognized by the federal Constitution,⁵⁰ as well as greater procedural protection of relevant liberty interests "than the minimum adequate to survive scrutiny under the Due Process Clause."⁵¹

The Court ultimately chose to remand *Mills* for reconsideration of the state law principles articulated in *Roe*,⁵² in part because of another well-established doctrine of constitutional adjudication that taught that federal constitutional decisions should be avoided whenever possible.⁵³

C. *The Rennie Remand*

To make matters even more perplexing, just one week after the Court issued its decision in *Rogers*, it granted *certiorari* in *Rennie v. Klein*,⁵⁴ and vacated and remanded to the Third Circuit for reconsideration, not in light of *Mills*, but in light of the Court's contemporaneous right to training decision in *Youngberg v. Romeo*.⁵⁵

D. *Unanswered Questions*

The Court's ruling in *Mills* left many unanswered questions:

1. What would be the practical impact of the Supreme Court's decision to sidestep the merits in *Rogers*?⁵⁶
2. Would the Court ever hear another right to refuse treatment case?⁵⁷

50. *Mills*, 457 U.S. at 303, comparing *Roe*, 421 N.E.2d at 51, to *Addington v. Texas*, 441 U.S. 418, 429-30 (1979).

51. *Mills*, 457 U.S. at 303-04, comparing *Roe*, 421 N.E.2d at 51, to *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982), and *Parham v. J.R.*, 442 U.S. 584, 608 n.16 (1979).

52. *In re Roe*, 383 Mass. 415, 421 N.E.2d 40 (Mass. 1981) (see note 42 for six factors to be followed in probate proceedings).

53. *Mills*, 457 U.S. at 305, citing, inter alia, *City of Mesquite v. Aladdin's Castle*, 455 U.S. 283, 294 (1982); *Ashwander v. Tennessee Valley Auth.*, 297 U.S. 288, 341, 347-48 (1936) (Brandeis, J., concurring).

54. *Rennie*, 458 U.S. 1119 (1982).

55. 457 U.S. 307 (1982).

56. See, e.g., *Current Status*, supra note 28, at 132; see also Brant, *The Hostility of the Burger Court to Mental Health Law Reform Litigation*, 11 BULL. AM. ACAD. PSYCHIATRY & L. 77, 83 (1983) (criticizing court's inaction as abdication of its responsibility to provide needed guidance to lower federal courts and to public officials) [hereinafter cited as *Hostility*].

57. Although it granted *certiorari* in *Ake v. Oklahoma*, 663 P.2d 1 (Okla. Crim. App. 1983), *rev'd*, 470 U.S. 68 (1985), on the question of whether a state can constitutionally force a criminal defendant to be heavily sedated with Thorazine while attending criminal proceedings against him in absence of any evidence that he failed to conduct himself properly in court,

3. If the Court *did* take such a case arising from a state without a well-developed body of state right to refuse treatment law (unlike, e.g., Massachusetts), how far would the Court go in defining the dimensions of a constitutional right? *Rogers* seemed to imply that the Court would be willing to make some such finding, via its allusion to the issue of the drugs' "significant side effects"⁵⁸; how much of a finding would it make?

4. However the Court ultimately defines the right (if it chooses to do so), how much procedural due process will be necessary to vindicate it?⁵⁹

5. How would the Court deal with a case that involved a patient's desire to refuse drugs beyond the range of antipsychotics that were at the heart of both *Rennie* and *Rogers*?⁶⁰

6. How would the Court deal with a right to refuse treatment case arising in a community setting?⁶¹

7. Finally, how would the Courts of Appeals "read" the Supreme Court's *Rogers* decision? Would they construe it expansively, narrowly, or would they confine it to its fact-specific setting?

Although few of these questions have been answered dispositively, consideration of the subsequent developments in both of the main

the Supreme Court ultimately decided *Ake* without reaching the question. See 53 U.S.L.W. 4179 (1984). See generally *Barefoot's Ake*, *supra* note 1.

58. *Mills*, 457 U.S. at 293-94 n.1. Note that the Court cited to both the literature which asserted that drug treatment was "essential not only to the treatment of individual disorders, but also to the preservation of institutional order generally needed for effective therapy," as well as that which emphasized that "antipsychotic drugs carry a significant risk of adverse side effects," *id.*, including, specifically, tardive dyskinesia, *id.* (citing *Rogers v. Okin*, 478 F. Supp. 1342, 1360 (D. Mass. 1979); and Byck, *Drugs and the Treatment of Psychiatric Disorders*, in L. GOODMAN AND A. GILMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 152 (5th ed. 1975)).

59. *Cf. Rennie*, 653 F.2d at 848-51 (weighing a New Jersey state regulation against the dictates of *Matthews v. Eldridge*, 424 U.S. 319, 335 (1976)), and see, e.g., *Parham v. J.R.*, 442 U.S. 584, 606-10 (1979).

60. See, e.g., *Rennie*, 653 F.2d at 839 n.2 ("only the antipsychotics are the subject of our opinion here").

61. *Cf. Youngberg v. Romeo*, 457 U.S. 307, 317 (1982) ("As a general matter, the State is under no constitutional duty to provide substantive services for those within its border.").

In one subsequent case, the Third Circuit *rejected* a *Rennie* argument made by a convicted criminal whose probationary term mandated participation in a group therapy program, noting that "the infringement of which [appellant] complains falls outside the range of facts to which [*Rennie*] . . . might be applied by reasonable analogy." *United States v. Stine*, 675 F.2d 69, 71 (3d Cir.), *cert. denied*, 458 U.S. 1110 (1982). On the other hand, the Court of Appeals added, "We need not and do not hold that a psychological counseling requirement can never be an infringement of a constitutional right of privacy. We hold only that when psychological counseling is reasonably related to the purposes of probation, its imposition is not unconstitutional." *Id.* at 72.

cases, as well as decisions in other jurisdictions, may help add perspective to some of these matters.

E. *Rogers on Remand*

Initially, the First Circuit certified⁶² the case directly to the Massachusetts Supreme Judicial Court for that court to respond to nine questions "which focus on the right of involuntarily committed mental patients to refuse treatment and the standards and procedures which must be followed to treat these patients with antipsychotic medication."⁶³

In a unanimous opinion premised *solely* on state statutory and common law,⁶⁴ the state court concluded⁶⁵ (1) that a committed mental patient was competent to make treatment decisions "until the patient is adjudicated incompetent by a judge,"⁶⁶ (2) that, where there is such an incompetency adjudication, the judge, "using a substituted judgment standard,"⁶⁷ shall decide whether the patient would

62. Approximately half of the states have enacted statutes which enable federal courts to certify unresolved questions of state law directly to the state courts for those courts to answer. See generally C. WRIGHT, *FEDERAL COURTS* § 52, at 313-15 (1983); see also, e.g., Lillich and Mundy, *Federal Court Certification of Doubtful State Law Questions*, 18 UCLA L. REV. 888 (1971).

63. *Rogers v. Comm'r of Dept. of Mental Health*, 390 Mass. 489, 458 N.E.2d 308, 310 (Mass. 1983). This aspect of the *Rogers* litigation is discussed extensively in Note, *Medical Law — The Right to Refuse Antipsychotic Drug Treatment: Substantive Rights and Procedural Guidelines in Massachusetts*, 7 W. NEW ENG. L. REV. 125 (1984) [hereinafter cited as Note, *Medical Law*].

64. Because the United States Supreme Court predicated its remand solely on the state court's earlier decision in *In re Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981), see *Mills*, 457 U.S. at 301-03, and because *Roe* did not construe the state constitution, the state court felt its answers to the certified questions were limited to state statutory and common law. See *Rogers*, 458 N.E.2d at 312 n.7. See also, e.g., *Keyhea v. Rushen*, 178 Cal. App. 3d 526, 223 Cal. Rptr. 746, 747 (Ct. App. 1986) (state prisoners have state statutory right to refuse long term treatment with antipsychotic drugs absent a judicial determination that they are incompetent to do so).

65. The court's specific answers to the certified questions are summarized in *Rogers*, 458 N.E.2d at 322-23.

66. *Id.* at 310. In coming to this decision, the court considered both state statutory law which specifies that a patient is not to be deemed incompetent to manage his affairs solely by reason of commitment to a mental hospital, see *id.* at 313, construing MASS. GEN. LAW ANN. ch. 123, § 25, (West 1986) and which fails to require incompetency as prerequisite for commitment, see *Rogers*, 458 N.E.2d at 313, construing MASS. GEN. LAWS ANN. ch. 123, §§ 7(a), 8(a) (West 1986), as well as state case law. See *Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981) and *In re Moe*, 385 Mass. 555, 432 N.E.2d 712 (1982) (in sterilization cases, guardian must obtain prior judicial approval before they may either consent to or refuse proposed "extraordinary" medical treatment), discussed in *Rogers*, 458 N.E.2d at 313.

67. The court specified that the six factors set out in *Roe*, see *supra* note 52, be considered in the substituted judgment assessment. *Rogers*, 458 N.E.2d at 323.

have consented to the administration of antipsychotic drugs"⁶⁸ and (3) that no state interest justified the use of such drugs "in a non-emergency situation without the patient's consent."⁶⁹ On the other hand, a patient could be treated against his will and without prior court approval to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness."⁷⁰

In addition, the court held that when such drugs were "used to prevent violence to third persons, to prevent suicide, or to preserve security," they were being used as "chemical restraints" and any such use must thus comply with state restraints/seclusion statutes, and accompanying regulations.⁷¹

Following the state certification decision, the case was again transferred to the First Circuit which ruled that the due process protections outlined by the Massachusetts Supreme Judicial Court were "substantive rights created by legitimate, objective expectations derived from state law [and] entitled to the procedural protections of the Fourteenth Amendment,"⁷² and that these rights "equal or exceed the rights provided in the federal Constitution."⁷³

The Court of Appeals thus remanded the case to the district court so that the court could "issue a declaration stating that the Massachusetts Supreme Judicial Court's recognition of substantive and procedural rights of involuntarily committed mentally ill patients in Massachusetts created for such patients a liberty interest under the Fourteenth Amendment of the federal Constitution."⁷⁴

F. *Rennie on Remand*

The *Rennie* case was somewhat more confusing. On remand, a sharply-fractured⁷⁵ Third Circuit reiterated the basic underlying substantive premise of its earlier decision, that involuntarily commit-

68. *Rogers*, 458 N.E.2d at 310. For a critical view of this aspect of *Rogers*, and one endorsing, instead, the suggestion of the trial court in *Rennie v. Klein*, 462 F. Supp. 1131, 1147-49 (D.N.J. 1978), that independent psychiatrists be used as decision-makers in such cases, see Note, *Medical Law*, *supra* note 63, at 144-45, and sources cited at *id.* nn.151-57.

69. *Rogers*, 458 N.E.2d at 311.

70. *Id.* In such cases, if the doctor expects to continue to treat the patient over the latter's objections, the doctor must seek an adjudication of incompetency; if the patient is adjudicated incompetent, the court must formulate a substituted judgment plan. *Id.*

71. *Id.* at 310-11. See MASS. GEN. LAWS ANN. ch. 123, § 21 (West 1986), and MASS. ADMIN. CODE, tit. 104, § 3.12 (1978).

72. *Rogers*, 738 F.2d at 6.

73. *Id.* at 9.

74. *Id.*

75. See *Rennie*, 720 F.2d 266 (3d Cir. 1963). There were five separate opinions released, with no more than three judges joining in any one opinion.

ted patients do have a constitutional right to refuse the administration of certain antipsychotic drugs.⁷⁶ It also reaffirmed that the procedures specified in the state administrative bulletin satisfied due process requirements,⁷⁷ and remanded to the district court for further proceedings.⁷⁸

On the other hand, it found that, after *Youngberg*, the concept of least intrusive means could no longer be employed.⁷⁹ Instead, the accepted professional judgment standard of *Youngberg*,⁸⁰ i.e., a decision to administer medication would be presumed to be valid unless it was shown to be a "substantial departure from accepted professional judgment, practice or standards,"⁸¹ was to be substituted.⁸²

A close analysis of the multiple opinions⁸³ reveals, further, that the circuit carefully considered the elements of accepted professional judgment, so that it could make the necessary assessment required by *Youngberg*. Thus, a majority of the judges felt that the determination required both an evaluation of side effects and an investigation of other treatment options. Also, a majority similarly rejected warehousing or administrative convenience as a justification for forcibly drugging patients.⁸⁴

The court unanimously determined that before a patient could be medicated against his will, it was necessary that a professional find him to be dangerous to himself or others. A majority felt that this standard must be met by a higher standard than the regular involuntary civil commitment criteria (i.e., simple dangerousness is not a sufficient basis upon which the state can predicate the forcible medication of a patient). Three judges would have reinstated the least intrusive means test as well.⁸⁵ Judge Gibbons, adhering to his dissent

76. *Id.* at 269 (Garth J., opinion).

77. *Id.* at 270 n.9.

78. *Id.* On remand, the district court would be free to consider, inter alia, the relevance of the Bill of Rights of the federal Mental Health Systems Act, see 42 U.S.C. § 9501, to "the remaining proceedings." *Rennie*, 720 F.2d at 270 n.10 (quoting *Rennie v. Klein*, 653 F.2d 836, 852 n.17 (3d Cir. 1981) (Weis, J., concurring)).

79. *Rennie*, 720 F.2d at 269 (Garth, J., opinion).

80. 457 U.S. 307, 323 (1982).

81. *Rennie*, 720 F.2d at 269 (Garth, J., opinion) (quoting *Youngberg*, 457 U.S. 307, 323).

82. The abandonment of the "least intrusive means" test was ordered over the pointed objections of four judges. See *Rennie*, 720 F.2d at 276-77 (Weis, J., concurring) and *id.* at 277 (Gibbons, J., dissenting).

83. See *supra* note 47.

84. The standard accepted by the court is to balance the "legitimate interest of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints." *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982).

85. *Rennie*, 720 F.2d at 276 (Weis, J., concurring) ("I fear that the latitude the majority allows in 'professional judgment' jeopardizes adequate protection of a patient's constitutional

in the Third Circuit's original *Rennie* opinion,⁸⁶ would have reinstated all of the district court's original injunction.⁸⁷ On remand, the district court merely entered a brief order, consented to by all parties, permanently enjoining defendants to comply with the most recent version of Administrative Bulletin 78-3, adding that the injunction "shall in no way affect the plaintiffs' rights or remedies under New Jersey state law."⁸⁸

G. Other Jurisdictions

How have *Rogers* and *Rennie* been dealt with in other jurisdictions? Responses have been mixed: other courts have interpreted the scope of the right to refuse treatment both broadly and narrowly. While many courts have continued to endorse the earlier *Rennie/Rogers* model, others have read those cases more restrictively in light of the Supreme Court's decisions. At least two cases, however, have resurrected the "least restrictive alternative" test that the Third Circuit abandoned in its *Rennie* remand opinion.

1. Broad readings of the right to refuse treatment

Where an incarcerated plaintiff alleged that she had been injected with a psychotropic drug against her will, the District of Columbia District Court ruled that a trial would be necessary to resolve factual disputes which remained in the case on such questions as whether a less intrusive alternative might have been satisfactorily employed by defendants.⁸⁹ The district court also concluded that "the reasoning in [the courts of appeals' opinions in] *Rogers* and *Rennie*, . . . remains persuasive,"⁹⁰ and states the appropriate legal standards.

rights"). Judge Weis specifically found that "[t]he consequences of error [involving the permanent side effects of antipsychotic drugs] are far more serious . . . than those of Romeo's physical restraints and therefore, a standard commensurate with the potential harm to the patient is required." *Id.* See *Youngberg*, 457 U.S. at 310 n.4 ("soft" restraints . . . were generally used").

86. See *Rennie v. Klein*, 653 F.2d at 865.

87. *Rennie*, 720 F.2d at 277 (Gibbons, J., dissenting).

88. *Rennie v. Klein*, No. 77-2624 (D.N.J., Aug. 16, 1984) (consent order).

89. *Osgood v. District of Columbia*, 567 F. Supp. 1026, 1036 (D.D.C. 1983) (Plaintiff refused treatment on the grounds of her beliefs as a Christian Scientist, which forbade her to receive injections. The District of Columbia District Court ruled that summary judgment was improper to decide issues such as the plaintiff's competency to decide to refuse treatment, the immediacy of the alleged emergency, the scope of the danger posed to plaintiff and others, as well as the availability of less restrictive alternatives.).

90. *Id.*, at 1031-32 n.1.

In weighing a challenge to New York's involuntary medication practices in *Project Release v. Prevost*, the Second Circuit stated that while "*Mills* did not definitively resolve the question of whether a liberty interest in refusing antipsychotic medication exists as a federal constitutional matter, the case appears to indicate that there is such an interest."⁹¹ *Mills* countenanced the creation of such an interest under state law,⁹² and the Court of Appeals found that such a right did exist under New York State law.⁹³

Subsequent to the *Project Release* decision, a New York state court found the rationale of *Rogers* and *Rennie* persuasive notwithstanding the Supreme Court remand (which it characterized as merely seeking to answer the question of whether "State law provided a broader protected right than was afforded by the [federal] Constitution").⁹⁴

91. *Project Release v. Prevost*, 722 F.2d 960, 979 (2d Cir. 1980) (emphasis added). In an action challenging the constitutionality of the voluntary, involuntary, and emergency commitment procedures of the New York Mental Hygiene Law, the Second Circuit discussed the question of the right to refuse antipsychotic medication on federal constitutional grounds, citing *Mills v. Rogers*, 457 U.S. 291 (1982). The court indicated that this question is still unresolved. However, the Supreme Court in *Mills* assumed for purposes of discussion that involuntarily committed mental patients do retain liberty interests protected by the Constitution, and these interests are implicated by the involuntary administration of antipsychotic drugs. See *supra* note 43 and accompanying text. Cf. *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986), discussed *infra* notes 123-43 and accompanying text.

92. *Id.*, (citing *Mills*, 457 U.S. at 299.)

93. *Id.* However, although the Court of Appeals did find that a right to refuse treatment did exist, the court also determined that minimum Due Process Standards were met by N.Y. ADMIN. CODE tit. 14, § 27.8-9 (1975). Citing *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), which dealt with the question of whether the Due Process Clause of the Fifth Amendment requires an evidentiary hearing before the termination of Social Security disability benefits, the Court of Appeals examined the three factors set forth by the Supreme Court to be considered in assessing the adequacy of State Agency proceedings under the Due Process Clause. These factors are (1) the private interests implicated, (2) the risk of an erroneous decision, and (3) the governmental interest. Applying these factors to N.Y. ADMIN. CODE tit. 14, § 27.8-9, the Court of Appeals found that the requirements of Due Process were satisfied.

94. *Savastano v. Saribeyoglu*, 126 Misc. 2d 52, 53, 480 N.Y.S.2d 977, 978 (N.Y. Sup. Ct. 1984). An application was brought on behalf of a patient at a mental health facility to vacate a determination by staff physicians to treat the patient with psychotropic drugs. The court ruled that since the patient was institutionalized pursuant to a court order of retention as an involuntary patient. A predicate for such an order is that the patient does not understand the need for treatment. This situation provides a sufficient basis for the professional determination to administer treatment without the consent of the patient. However, the court did recognize that, in furtherance of the patient's liberty interest, he may refuse treatment absent an emergency situation or a finding that he is incapable of understanding the need for treatment.

See also *Rivers*, *supra* note 91.

Similar decisions were reached by the Arizona⁹⁵ and New Hampshire⁹⁶ Supreme Courts, as well as an intermediate appellate court in Colorado.⁹⁷ Also, a series of consent orders have been entered elsewhere, in jurisdictions including California and Vermont, that basically track the approaches and procedures approved by the First and Third Circuits prior to the Supreme Court's 1982 remands.⁹⁸

2. Narrow readings of the right to refuse treatment

On the other hand, several cases have interpreted the right to refuse treatment relatively restrictively following the Supreme Court's remand in *Mills*.

A federal court in Texas rejected plaintiffs' argument that the First Circuit's original opinion in *Rogers* had "binding application" on the question of the extent of patients' right to refuse treatment.⁹⁹ The court pointed out that (1) the Circuit's decision had been vacated and remanded by the Supreme Court, and (2) it had "relied

95. *Anderson v. Arizona*, 663 P.2d 570 (Ariz. Ct. App. 1982). The Court of Appeals of Arizona reversed the trial court's order to administer psychotropic drugs to an involuntary patient at the Arizona state hospital. The court ruled that until the State could produce copies of (1) an individualized written treatment plan, (2) official department regulations governing the use of seclusion and restraint in non-emergency cases against the will of the patient, and (3) written agency procedures regarding the use of seclusion and restraint in non-emergency cases against the will of the patient, due process protects the patient's liberty interest to refuse treatment.

96. *Opinion of the Justice*, 465 A.2d 484 (N.H. Supp. Ct. 1983). The Supreme Court of New Hampshire gave its opinion on proposed legislation regarding administration of compulsory medication to involuntary mental patients under certain conditions, and stated that the state Constitution did provide mentally ill persons, like all other persons, with certain fundamental liberty interests.

97. *People in the Interest of Medina*, 662 P.2d 184 (Colo. Ct. App. 1983). The Colorado Court of Appeals held that an order to administer psychotropic drugs to an involuntarily committed mental patient was improper where no emergency existed, evidence was insufficient to enable the court to make findings regarding relevant factors, no attempt was made to communicate with the patient to determine his wishes and concerns, and the authorization was coextensive with the patient's certification with no provision for review.

98. See, e.g., *Jamison v. Farabee*, No. C 780445 WHO (N.D. Cal., April 26, 1983), reported in 7 MENT. DIS. L. RPTR. 436 (1983); *J.L. v. Miller*, No. S-418084-WnC (Vt. Sup. Ct., Washington Cty., May 20, 1985), reported in 9 MENT. & PHYS. DIS. L. REP. 261 (1985). For an early analysis of *Jamison*, see Bishop, *The Expanding Rights of Mental Patients*, CALIF. LAW. (Sept. 1984), at 69.

99. *R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Tex. 1984). The United States District Court reviewed a proposed commissioner's rule governing the manner in which a patient's consent must be sought prior to the administration of psychotropic drugs, holding that the proposed rule adequately protected the rights of involuntarily committed patients, in light of the standards enunciated in *Youngberg*.

heavily on the rather extensive body of statutory and common law of Massachusetts."¹⁰⁰

In a district court case from Wisconsin involving a patient found not guilty by reason of insanity, the court rejected the plaintiffs' argument that the state statutory scheme violated his constitutionally protected liberty interests in that it permitted nonconsensual drug treatment in other than emergency situations.¹⁰¹ Since, under state law, the plaintiffs' commitment was specifically for "custody, care and treatment,"¹⁰² the court construed the involuntary commitment to be "a finding of incompetency with regard to treatment decisions,"¹⁰³ and reasoned that "[n]onconsensual treatment is what involuntary commitment is all about."¹⁰⁴

3. Resurrection of the least restrictive alternative?

At least three post-*Mills* cases, however, have employed the concept of the least restrictive alternative in refusal of treatment matters.¹⁰⁵ In *Bee v. Greaves*,¹⁰⁶ the Tenth Circuit, in an expansive reading of a case emanating from a Utah county jail concerning a pretrial detainee's right to refuse treatment, ruled that "less restrictive alternatives, such as segregation or the use of less controversial drugs like tranquilizers or sedatives, should be ruled out before resorting to antipsychotic drugs."¹⁰⁷

The court of appeals began its analysis by noting that pretrial detainees retain certain constitutional rights. In holding that these rights include a liberty interest in "avoiding unwanted medication

100. *Id.*

101. *Stensvad v. Reivitz*, 601 F. Supp. 128 (W.D. Wis. 1985). Wisconsin state law stipulates that, generally, one could not be deemed incompetent by reason of admission to a mental health facility. See WIS. STAT. ANN. § 51.59(1) (West 1985). "No person is deemed incompetent . . . solely by reason of his or her admission to a facility in accordance with this chapter of detention or commitment under this chapter." However, the statute specifically does not authorize the refusal of treatment. § 51.59 (2). "This section does not authorize an individual who has been involuntarily committed or detained under this chapter to refuse treatment during such commitment or detention." *Id.* See § 51.61 (1)(g), "[F]ollowing a final commitment order, the subject individual does not have the right to refuse medication and treatment except as provided by this section." See also *id.* § 51.61(1)(h). Patients retain the right to be free from "unnecessary or excessive medication."

102. WIS. STAT. ANN. § 971.17(1) (West 1985).

103. *Stensvad*, 601 F. Supp. at 131.

104. *Id.*

105. In addition to the cases discussed *infra* in text accompanying notes 101-115, see also *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

106. *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 105 S. Ct. 1187 (1985).

107. *Id.* at 1396.

with [antipsychotic] drugs,"¹⁰⁸ the court reasoned that such an individual generally has a "constitutionally protected interest in making his own decision whether to accept or reject the administration of potentially dangerous drugs,"¹⁰⁹ as well as a first amendment right protecting the "communication of ideas."¹¹⁰

The court found that any decision to forcibly administer antipsychotic drugs "must be the product of professional judgment by appropriate medical authorities, applying accepted medical standards."¹¹¹ Such a decision requires an evaluation in each case "of all relevant circumstances, including the nature and gravity of the safety threat, the characteristics of the individual involved, and the likely effects of particular drugs."¹¹²

In addition, the court held that "the availability of alternative, less restrictive courses of action should also be considered."¹¹³ Because of the severe side effects of the drugs, "forcible medication cannot be viewed as a reasonable response to a safety or security threat if there exist 'less drastic means for achieving the same basic purpose.'"¹¹⁴

On this point, the court of appeals noted that, while the Supreme Court declined to apply a less intrusive means analysis in *Youngberg v. Romeo*,¹¹⁵ that case was distinguishable because it involved "temporary physical restraints rather than mental restraints with potentially long-term effects,"¹¹⁶ and because the plaintiff there was severely retarded and unable to care for himself.¹¹⁷ Because the

108. *Id.* at 1394.

109. *Id.* at 1392-93 (citing *Davis v. Hubbard*, 506 F. Supp. 915, 931-32 (N.D. Ohio 1980), tracing the history of right to refuse treatment and indicating that a person's interest in making decisions regarding his body is recognized in tort law, and *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977), recognizing a privacy interest in making certain kinds of important decisions).

110. *Id.* at 1393-94 (quoting *Davis v. Hubbard*, 506 F. Supp. at 927-29, and citing to the trial court opinion in *Rogers v. Okin*, 478 F. Supp. 1342, 1366-67 (D. Mass. 1979)).

111. *Id.* at 1393. (citing *Youngberg v. Romeo*, 457 U.S. 307, 321-23 (1982), and *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983)).

112. *Id.*

113. *Id.*

114. *Id.* quoting *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) *Shelton* was an action brought by teachers and others challenging the constitutionality of a state statute which required public school teachers to file affidavits regarding organizations to which they belonged, or contributed to, as a prerequisite of employment.

115. 457 U.S. at 322-23.

116. *Bee*, 744 F.2d at 1396 n.7 (citing *Rennie*, 720 F.2d at 274-77 (Weis, J., concurring)).

117. *Id.* (citing *Youngberg*, 457 U.S. at 310). For an analysis concluding that *Bee* distinguished *Youngberg* for the wrong reasons see Note, *Bee v. Greaves: Pretrial Detention and the Constitutional Right to Refuse Antipsychotic Drugs — A Missed Opportunity to Protect Fundamental Rights*, 22 AM. CRIM. L. REV. 836, 852-53 (1985) (*Bee*, unlike *Youngberg*, involved a pretrial detainee; Supreme Court policy of institutional deference limited to mental institutions).

plaintiff in *Bee* was not mentally incompetent and because of the proposed use of a "potentially dangerous drug,"¹¹⁸ "we believe the state is required to consider less restrictive alternatives."¹¹⁹

Bee thus stands for the proposition that one circuit has shown a willingness to use the least restrictive alternative test to weigh refusal of treatment claims in the context of a population generally seen as less in need of court protection than those institutionalized in facilities for the mentally disabled.¹²⁰

The least restrictive alternative approach of the *Bee* case has subsequently been implicitly adopted by the Colorado Supreme Court in a case involving an incompetent patient.¹²¹ In establishing that the mental health professional who wishes to medicate an objecting incompetent patient must satisfy this standard, the court specified:

Here the focus encompasses not only the gravity of any harmful effects from the proposed treatment but also the existence, feasibility and efficacy of alternative methods of treating the patient's condition or of alleviating the danger created by that condition. If less intrusive methods are available to effectively redress these concerns, then clearly the court should deny the motion for nonconsensual treatment.¹²²

4. Significance of *Rivers v. Katz*?

Most recently, the New York Court of Appeals issued what appears to be the broadest right to refuse treatment opinion yet de-

118. 744 F.2d at 1396 n.7. The drug in question in *Bee* was Thorazine, 744 F.2d at 1389-91.

119. 744 F.2d at 1396 n.7. For other conflicting readings of *Rennie* on this point, see *Stensvad v. Reivitz*, 601 F. Supp. 128, 131 (W.D. Wis 1985), and *R.A.J. v. Miller*, 590 F. Supp. 1310, 1319 (N.D. Tex. 1980) (Plaintiffs representing patients at eight state mental hospitals in Texas, brought an action against representatives of the Department of Mental Health and Mental Retardation for failing to comply with several provisions of a settlement agreement. The court, in discussing the broad range of equitable powers available to effectuate its orders, directed defendants to comply with the agreement. *Id.* at 1319).

120. See also Bunn, *More Meaningful Protection for the Right to Refuse Antipsychotic Drugs: Bee v. Greaves*, 62 CHI. KENT. L. REV. 323, 340 (1985) (*Bee*'s "refinement of the professional judgment standard clearly provides more meaningful protection for the right to refuse antipsychotic drugs"; impact of case's protection of plaintiffs at trial still "unclear"); Note, "*Bee v. Greaves: A Pre-trial Detainee's Constitutional Right to Refuse Antipsychotic Drugs Under the First and Fourteenth Amendments*", 63 DEN. U.L. REV. 273, 289-90 (1986). *Bee* sidestepped the Supreme Court's tacit ruling, see, *Rennie v. Klein*, 458 U.S. 1119 (1982), that medication decision making should be evaluated by the professional judgment standard set forth in *Youngberg*.

121. *People v. Medina*, 705 P.2d 961, 963 (Colo. 1985). *Medina* cited *Bee* on this point. *Id.* at 967 n.2.

122. *Id.* at 974.

cided by an appellate court, and the broadest opinion decided by *any* court since the remand opinion in *Rennie*.¹²³ In *Rivers v. Katz*,¹²⁴ the court ordered that in most cases,¹²⁵ a judicial determination "of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the state's *parens patriae* power."¹²⁶ The decision was based solely upon state constitutional and common law grounds,¹²⁷ involving (1) a broader class of drugs than any prior opinion,¹²⁸ and (2) a regulatory scheme already *approved* in large part on federal constitutional grounds by the Second Circuit.¹²⁹

Rivers was a consolidated action brought on behalf of three¹³⁰ involuntary¹³¹ patients at Harlem Valley Psychiatric Center,¹³² who attempted¹³³ to refuse the administration of certain antipsychotic medications.¹³⁴ In all instances, after the patients' objections were

123. *Rennie v. Klein*, 720 F.2d at 269.

124. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74, *reh'g denied*, 68 N.Y.2d 808 (1986).

125. *Id.* at 495, 495 N.E.2d at 343, 504 N.Y.S.2d at 80. Where a patient presents a danger to self or others or engages in dangerous or potentially destructive conduct within the institution, the state may be warranted, under police power grounds, in administering antipsychotic medication over the patient's objections. "The most obvious example of this is an emergency situation, such as when there is imminent danger to a patient or others in the immediate vicinity." *Id.* at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80 (citation omitted).

126. *Id.* at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

127. *Id.* at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78.

128. *Rivers* appears to be the first case involving a patient complaining about the administration of lithium. *Id.* at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77. *Cf. Rennie v. Klein*, 653 F.2d at 839 n.2 ("[D]rugs such as lithium . . . are not considered here"); *Rogers v. Okin*, 634 F.2d 650, 653 n.1 (1st Cir. 1980) (case exclusively concerned with antipsychotic drugs such as Thorazine, Mellaril, Prolixin, and Haldol; drugs such as lithium not covered); *Mills v. Rogers*, 457 U.S. at 292 n.1 (adopting classification used by First Circuit in *Rogers*).

129. *See Project Release v. Prevost*, 722 F.2d at 979-81, discussed *supra* note 91, and at text accompanying notes 91-93.

130. The trial court's denial of class certification was affirmed "since application of the principles of *stare decisis* will adequately protect subsequent litigants." *Rivers*, 67 N.Y.2d at 499, 495 N.E.2d at 345, 504 N.Y.S.2d at 82.

131. *See* N.Y. MENTAL HYG. LAW § 9.27 (McKinney 1978); *see generally id.*, §§ 9.01-9.59.

132. *Rivers*, 67 N.Y.2d at 490, 495 N.E.2d at 339, 504 N.Y.S.2d at 76. This was a New York State mental hospital.

133. *Id.* at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77. Each patient unsuccessfully invoked the state administrative procedures governing refusal of medication by state hospital patients. Under those regulations, *see* N.Y. ADMIN. CODE tit. 14, § 27.8 (1983), before such treatment is ordered over a patient's objection, the decision to medicate must be reviewed by "the head of the service." *Id.* § 27.8(c). Aggrieved patients then have a right to a counseled, *id.* § 27.8(d), appeal before the facility director, *id.* § 27.8(e)(1). That decision may then be appealed to the regional director of the state department of mental hygiene. *Id.* § 27.8(e)(3).

134. Plaintiff *Rivers* was medicated with Prolixin Hydrochloride, Prolixin Decanoate, and Mellaril. *Rivers*, 67 N.Y.2d at 490-91, 495 N.E.2d at 339-40, 504 N.Y.S.2d at 76-7. Plaintiff

overridden, and the medications involuntarily administered, the patients filed declaratory judgment actions¹³⁶ against the state commissioner of mental hygiene and hospital officials "to enjoin the nonconsensual administration of antipsychotic drugs and to obtain a declaration of their common-law and constitutional right to refuse medication."¹³⁸

The trial court dismissed plaintiffs' complaints on the theory that "the involuntary retention orders necessarily determined that these patients were so impaired by their mental illnesses that they were unable to competently make a choice in respect to their treatment."¹³⁷ The appellate division affirmed the lower court decision.¹³⁸

The court of appeals reversed, holding that the due process clause of the *state* constitution¹³⁹ "affords involuntarily committed mental patients a fundamental right to refuse antipsychotic medication."¹⁴⁰ The court also held that "neither mental illness nor institutionalization *per se* can stand as a justification for overriding an individual's fundamental right to refuse antipsychotic medication on either police power or *parens patriae* grounds."¹⁴¹

Katz was medicated with Navane and Lithium, *id.* at 491, 495 N.E.2d at 340, 504 N.Y.2d at 77, and plaintiff Grassi was medicated with Prolixin Hydrochloride, *id.* at 492, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

See id. at 490 n.1, 495 N.E.2d at 339 n.1, 504 N.Y.S.2d at 76 n.1. (discussing both usefulness and side effects of "antipsychotic drugs," citing to, *inter alia*, *Limiting the Orgy supra* note 14; *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981), *Rogers v. Okin*, 634 F.2d 650, 653 n.1 (1st Cir. 1980), *Davis v. Hubbard*, 506 F. Supp. 915, 928-29 (N.D. Ohio 1980)). The administration of Lithium (a drug first administered in 1949, *see Cade, Lithium Salts in the Treatment of Psychotic Excitement*, 36 MED. J. AUST. 349 (1949), and given to ameliorate manic episodes in patients with manic-depressive illness, *see generally Fieve, Lithium (Antimanic) Therapy*, in 2 FREEDMAN, KAPLAN & SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY II 1982 (2d ed. 1975); *see also* MODERN DRUG ENCYCLOPEDIA AND THERAPEUTIC INDEX 523 (Lewis ed. 1981)) was not specifically challenged in any of the cited cases.

135. Plaintiffs Rivers and Zatz filed one action, *Rivers*, 67 N.Y.2d at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77, while plaintiff Grassi filed a separate action, *id.* at 492, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

136. *Id.* at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

137. *Id.* at 491-92, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

138. *Rivers v. Katz*, 112 App. Div. 2d 926, 491 N.Y.S.2d 1011. (App. Div. 1985).

139. N.Y. Const. art. I, § 6. *Cf. Shad Alliance v. Smith Haven Mall*, 66 N.Y.2d 496, 498 N.Y.S. 2d 99, 488 N.E.2d 1211 (N.Y. 1985) (free speech provision of state constitution, *see*, art. I, § 8, did not preclude mall owner from enforcing, in the absence of state action, blanket no-handbilling policy, where the same court was *not* willing to construe the state constitution more expansively than the United States Supreme Court had interpreted the parallel provision of the federal constitution, *see Lloyd Corp. v. Tanner*, 407 U.S. 551 (1972); *cf. Pruneyard Shopping Center v. Robins*, 447 U.S. 74 (1980). All relevant cases are discussed in Ragosta, *Free Speech Access to Shipping Malls Under State Constitutions: Analysis and Rejection*, 37 SYRACUSE L. REV. 1 (1986)).

140. *Rivers*, 67 N.Y.S.2d at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78.

141. *Id.* at 498, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

First, the court restated the established common law principles¹⁴² that "every individual of 'adult years and sound mind has a right to determine what shall be done with his body' "¹⁴³ and to control the course of his medical treatment.¹⁴⁴ In the case of competent patients, this fundamental right, co-extensive with the patient's liberty interest protected by the state constitution's due process clause,¹⁴⁵ must be honored "even though the recommended treatment may be beneficial or even necessary to preserve the patient's life."¹⁴⁶ The court added:

In our system of free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires. . . . This right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness. . . .¹⁴⁷

142. *Id.* at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78. The court added that these principles were also recognized by the state legislature, *id.* at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78, citing to, N.Y. PUB. HEALTH LAW §§ 2504, 2805-d (1985) N.Y. CIV. PRAC. LAW § 4401-a (1987), and N.Y. ADMIN. CODE tit. 10 § 405.25(a)(7)(1986).

The cited sections provided for informed consent of adult individuals in situations involving "medical, dental, health and hospital services," N.Y. PUB. HEALTH LAW § 2504(1) (1985), set out the elements of and defenses to a medical malpractice claim based on an alleged lack of informed consent, *id.* § 2805-d(1) to (4), set the standard upon which to assess a motion for judgment at the end of plaintiff's case in such an action. N.Y. CIV. PRAC. LAW § 4401-a (1987), and mandate that hospitals establish written policies affording patients the right to "refuse treatment to the extent permitted by law and to be informed of the medical consequences of [their] action," N.Y. ADMIN. CODE tit. 10, § 405.25(a)(7)(1986).

143. *Rivers*, 67 N.Y.2d at 492, 495 N.E.2d at 341, 504 N.Y.S.2d 78, *quoting*, in part, *Schloendorff v. New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (Ct. App. 1914) (Cardozo, J.).

144. *Rivers*, 67 N.Y.2d at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78, citing *inter alla*, *Schloendorff*, 211 N.Y. 125, 105 N.E. 92 (Ct. App. 1914) and *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (Ct. App. 1981), *cert. denied*, 454 U.S. 858 (1981) (*Storar* was a so-called "right to die" case holding that, where, prior to becoming incompetent, an elderly patient had consistently expressed his views to not have his life prolonged by medical means if there were no hope for recovery, it was proper for the court to approve discontinuance of a respirator on which he was being maintained in a permanent vegetative state).

145. *Rivers*, 67 N.Y.2d at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78. *See Cooper v. Morin*, 49 N.Y.2d 69, 399 N.E.2d 1188, 424 N.Y.S.2d 168, 175 (Ct. App. 1979), *cert. denied sub. nom. Lombard v. Cooper*, 446 U.S. 984 (1980) (applying due process clause of state constitution to question of adequacy of jail conditions); *cf. Bell v. Wolfish*, 441 U.S. 520 (1979).

146. *Rivers*, 67 N.Y.2d 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78, citing *Storar*, 52 N.Y.2d at 377.

147. *Rivers*, 67 N.Y.2d at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78 (citations omitted).

The court specifically rejected defendant's argument that involuntarily committed mental patients were "presumptively incompetent" to exercise this right because involuntary commitment included an implicit determination "that the patient's illness has so impaired his judgment as to render him incapable of making decisions regarding treatment and care."¹⁴⁸ Without more, neither the fact of mental illness nor the fact of commitment "constitutes a sufficient basis to conclude that [such patients] lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being."¹⁴⁹

In fact, the court stressed, the "nearly unanimous modern trend in the courts,¹⁵⁰ and among both medical and legal commentators,¹⁵¹ is to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions."¹⁵² It concluded on this point by quoting Professor Brooks:

[T]here is ample evidence that many patients, despite their mental illness, are capable of making rational and knowledgeable decisions about medications. The fact that a mental patient may disagree with the psychiatrist's judgment about the benefit of medication outweighing the cost does not make the patient's decision incompetent.¹⁵³

On the other hand, the court recognized that the right to reject antipsychotic medication was not absolute, and that, under certain circumstances, it might have to yield to compelling state interests¹⁵⁴: an emergency situation where the patient was in "imminent danger

148. *Id.*

149. *Id.* at 494, 495 N.E.2d at 342, 504 N.Y.S.2d at 79. *See also Rennie*, 653 F.2d at 846 n.12 ("It is simply not true that all persons involuntarily committed are always incapable of making a rational decision on treatment . . . Psychiatric literature indicates that many forms of mental illness have a highly specific impact on the victims, leaving decision-making capacity and reasoning ability largely unimpaired"); *Rogers*, 634 F.2d at 658-59.

Rivers added that it was "well-accepted that mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, [and, as a result,] many mentally ill persons retain the capacity to function in a competent manner," *Rivers*, at 494, 495 N.E.2d 342, 504 N.Y.S.2d at 79, *see The Constitutional Right*, *supra* note 14, at 191; *Rogers*, 478 F. Supp. 1342, 1361 (D. Mass. 1979).

150. *See, e.g., Scott v. Plante*, 532 F.2d 939 (3d Cir. 1976); *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980).

151. *See, e.g., Limiting the Orgy*, *supra* note 14, at 488; *The Constitutional Right*, *supra* note 14, at 194-95.

152. *Rivers*, 67 N.Y.2d at 494-95, 495 N.E.2d at 342, 504 N.Y.S.2d at 79.

153. *Id.* at 495, 495 N.E.2d at 342, 504 N.Y.S.2d at 79, quoting *The Constitutional Right*, *supra* note 14, at 191.

154. *Rivers*, 67 N.Y.2d at 495, 495 N.E.2d at 343, 504 N.Y.S.2d at 80, citing, *inter alia*, *Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 438 N.Y.S.2d 266.

to [another] patient or others in the immediate vicinity,"¹⁵⁵ or, under the state's *parens patriae* power, where an individual is "incapable of making a competent decision concerning treatment on his own . . . [or] lacks the capacity to determine for himself whether he should take the drugs."¹⁵⁶

This determination, the court underscored, "is uniquely a judicial, not a medical function,"¹⁵⁷ and due process thus requires that "a court balances the individual's liberty interest against the State's asserted compelling need on the facts of each case to determine whether such medication may be forcibly administered."¹⁵⁸

The prior judicial determination in the later group of cases should be in the nature of a *de novo* hearing,¹⁵⁹ following exhaustion of the state's administrative review processes.¹⁶⁰ At this counseled¹⁶¹ hearing, the state must bear the burden of demonstrating, by clear and convincing evidence¹⁶², the patient's incapacity to make a treatment

155. *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80, citing, *inter alia*, N.Y. ADMIN. CODE tit. 14, § 27.8(b) (1962). Under this provision, facilities may treat objecting patients "where the treatment appears necessary to avoid serious harm to life or limb of the patients themselves or others." *Id.* § 27.8(b)(1); see also *id.* § 27.8(b)(3). This exception, the court explained, was premised on the state's police power. *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80. It noted, however, that no such claim was advanced by defendants in the case before it. In a footnote, the court explained what this exception does *not* include:

Any implication that state interests unrelated to the patient's well-being or those around him can outweigh his fundamental autonomy interest is rejected. Thus, the State's interest in providing a therapeutic environment, in preserving the time and resources of the hospital staff, in increasing the process of deinstitutionalization and in maintaining the ethical integrity of the medical profession, while important, cannot outweigh the fundamental individual rights here asserted. It is the needs and desires of the individual, not the requirements of the institution, that are paramount.

Id. at 495 n.6, 495 N.E.2d at 343 n.6, 504 N.Y.S.2d at 80 n.6.

Cf. Youngberg, 457 U.S. at 324 ("In deciding this case, we have weighed those postcommitment interests cognizable as liberty interests under the Due Process Clause of the Fourteenth Amendment against legitimate state interests *and in light of the constraints under which most state institutions necessarily operate.*" (emphasis added)).

156. *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80, quoting *Rogers*, 634 F.2d at 657.

157. *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

158. *Id.* at 498, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

159. *Id.* at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

160. *Id.* citing N.Y. ADMIN. CODE tit. 14 § 27.8 (1962).

161. *Id.* citing N.Y. JUD. LAW § 35(1)(a) (McKinney 1983) (counsel may be assigned, *inter alia*, in civil commitment proceedings if the court is satisfied the individual is financially unable to obtain counsel).

162. See *Addington v. Texas*, 441 U.S. 418, 424 (1979) (intermediate burden of proof, constitutionally mandated at civil commitment hearings, is used where "interests at stake . . . are deemed to be more substantial than mere loss of money").

decision.¹⁶³ If the court determines that the patient has the capability of making his own treatment decision, the state is precluded from administering such drugs.¹⁶⁴ On the other hand, if the court determines that the patient lacks such capacity:

The court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interest, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets this criteria.¹⁶⁵

The court thus concluded that the state's administrative review procedures failed to meet state constitutional muster.¹⁶⁶ The regulations were deficient in that they did not articulate "the standards to be followed or criteria to be considered at each stage of the administrative process" with respect to the patient's need for a particular drug, whether the drug is the "least intrusive," whether it is capable of producing the "least serious side effects, and the proper length of its use."¹⁶⁷

"[P]articularly disturbing" was the absence of any standard for determining the "permissible duration of forced medication".¹⁶⁸

Manifestly, when the medication is necessitated by the patient's dangerousness, a circumstance that would implicate the State's police power interest, it may well be that the need would continue only for so long as the dangerous condition exists. The determination would not necessarily imply incapacity and thus would not provide a justifiable

163. *Rivers*, 67 N.Y.2d at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

164. *Id.* The court listed eight factors that might be considered in evaluating an individual's capability to consent to or to refuse treatment:

(1) the person's knowledge that he had a choice to make; (2) the patient's ability to understand the available options, their advantages and disadvantages; (3) the patient's cognitive capacity to consider the relevant factors; (4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; (5) the absence of any interfering emotional state, such as severe panic depression, euphoria or emotional disability; (6) the absence of any interfering pathologic motivational pressure; (7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; (8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from the attitude if he does.

Id. citing R. Michels, *Competence to Refuse Treatment*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS — VALUES IN CONFLICT 115, 117-18 (1982).

165. *Rivers*, 67 N.Y.2d at 497-98, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

166. *Id.* at 498, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

167. *Id.*

168. *Id.*

basis for the exercise of the State's *parens patriae* authority to override the patient's objection or to continue the medication for a protracted period. When the medication is determined to be necessary in order to care for a patient who is unable to care for himself because of mental illness, the State's *parens patriae* power would be implicated, which, as we have said, may only be employed when it has been determined that the patient is unable to make a treatment decision.¹⁶⁹

Finally, the court ruled that state law mandating that hospital professional staff act "within the scope of professional license"¹⁷⁰ applied to the administrative process, and held that such "medical determinations as to the need to administer antipsychotic drugs must honor the patient's due process rights and be made in accordance with accepted professional judgment, practice and standards."¹⁷¹

Rivers is an important case for many reasons. First, there is virtually nothing in the opinion acknowledging the split¹⁷² in the way courts have construed the right to refuse treatment following the Supreme Court's decision in *Mills*¹⁷³ and the Third Circuit's *Rennie* remand decision.¹⁷⁴ While there is a *but see* citation to *Stensvad v. Reivitz*¹⁷⁵ on the question of the relationship between institutionalization and treatment decision making capacity,¹⁷⁶ a reading of *Rivers* alone would give little indication of the range of right to refuse treatment developments since 1982.¹⁷⁷

Second, there is no mention whatsoever of the *Project Release*¹⁷⁸ opinion in the course of *Rivers*. Since, in the former case, the Second Circuit upheld the constitutionality (on federal constitutional grounds)¹⁷⁹ of the very regulation struck down on state constitutional grounds by the *Rivers* court, the absence of any mention of *Project Release* is particularly stark. Third, the expansion of the class of drugs covered by the opinion to include Lithium¹⁸⁰ is a significant quantitative and qualitative increase in the universe of drugging de-

169. *Id.* at 498, 495 N.E.2d at 344-45, 504 N.Y.S.2d at 81-82.

170. N.Y. MENTAL HYG. LAW § 33.03(b)(3) (McKinney 1978). For the purpose of protecting patients in their care and treatment a facility director shall require the order of a staff member operating within the scope of a professional license for any treatment or therapy based on appropriate examination.

171. *Rivers*, 67 N.Y.2d at 498-99, 495 N.E.2d at 345, 504 N.Y.S.2d at 82.

172. *See supra* notes 89-119 and accompanying text.

173. 457 U.S. 291 (1982); *see supra* notes 42-54 and accompanying text.

174. 720 F.2d 266 (3d Cir. 1983); *see supra* notes 75-86 and accompanying text.

175. 601 F. Supp. 128 (W.D. Wis. 1985); *see supra* notes 101-05 and accompanying text.

176. *Rivers*, 67 N.Y.2d at 494, n.4, 495 N.E.2d at 342, n.4, 504 N.Y.S.2d at 79 n.4.

177. 457 U.S. 291 (1982), and *Rennie*, 458 U.S. 1119 (1982), were both remanded in 1982.

178. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

179. *Id.* at 980-81.

180. *Rivers*, 67 N.Y.2d at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

cisions in which constitutional due process decisions are now implicated.¹⁸¹

Fourth, the use in *Rivers* of a pre-administration judicial hearing, similar to that ordered by the Massachusetts Supreme Judicial Court in the *Rogers* remand¹⁸² is a ringing endorsement of the judicial model in an area where it appears likely that the United States Supreme Court would accept a more informal, medically-focused model so as to adequately satisfy the demands of the due process clause of the federal constitution.¹⁸³

Fifth, *Rivers*' paraphrase of the "professional judgment" language used by the United States Supreme Court in *Romeo* to support its holding that, in the administrative process, "medical determinations as to the need to administer antipsychotic drugs must honor the patient's due process rights,"¹⁸⁴ is more than mildly ironic. The *Romeo* language is now generally used to countenance more informal proce-

181. While there are important clinical side effect issues raised by the use of Lithium, see, e.g., Mann, Greenstein & Eilers, *Early Onset of Severe Dyskinesia Following Lithium-Haloperidol Treatment*, 140 AM. J. PSYCHIATRY 1385 (1983) (letter to the editor); Kane, *Extrapyramidal Side Effects with Lithium Treatment*, 135 AM. J. PSYCHIATRY 851 (1978); Cohen & Cohen, *Lithium Carbonate, Haloperidol and Irreversible Brain Damage*, 230 J. A. M. A. 1283 (1974); Spring & Frankel, *New Data on Lithium and Haloperidol Incompatibility*, 138 AM. J. PSYCHIATRY 818 (1981); Zorumski & Bakris, *Choreoathetosis Associated with Lithium: Case Report and Literature Review*, 140 AM. J. PSYCHIATRY 1621 (1983); Reisberg & Gordon, *Side Effects Associated with Lithium Therapy*, 36 ARCHIVES GENERAL PSYCHIATRY 879 (1979); Crews & Carpenter, *Lithium-Induced Aggravation of Tardive Dyskinesia*, 134 AM. J. PSYCHIATRY 933 (1977); Shukla & Muhherjee, *Lichen Simplex Chronicus During Lithium Treatment*, 141 AM. J. PSYCHIATRY 909 (1984); Shukla, *Lithium-Carbamazepine Neurotoxicity and Risk Factors*, 141 AM. J. PSYCHIATRY 1604 (1984); Bar Nathan, Brenner & Horowitz, *Nonspecific Stomatitis Due to Lithium Therapy*, 142 AM. J. PSYCHIATRY 1126 (1985) (letter to the editor), none of these is mentioned in the course of *Rivers*. The decision's "side effects footnote," see *Rivers*, 67 N.Y.2d at 490, n.1., 495 N.E.2d at 339, n.1., 504 N.Y.S.2d at 76, n.1., cf. *Mills*, 457 U.S. at 293, n.1 cites solely to articles and cases discussing the narrower class of drugs before the court in *Rennie* and *Rogers*.

182. *Rogers*, 458 N.E.2d at 313-315.

183. See, e.g., *Youngberg*, 457 U.S. at 322-23 ("[T]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions [about internal operations of state mental institutions]", Roth, *The Right to Refuse Psychiatric Treatment: Law and Medicine at the Interface*, 35 EMORY L.J. 139, 157 (1986) ("while the 'right to refuse' is a fascinating issue for law and psychiatry, the problem remains clinical").

Dr. Roth has written significantly and extensively about both the ethical and empirical issues raised by the implementation of the right to refuse treatment. See, e.g., Roth & Appelbaum, *What We Do and Do Not Know About Treatment Refusals in Mental Institutions*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS — VALUES IN CONFLICT 179 (1982); Roth, *Competency to Decide About Treatment or Research* 5 INT'L J. L. & PSYCHIATRY 29 (1982); Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977); Meisel, Roth & Lidz, *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285 (1977).

184. *Rivers*, 67 N.Y.2d at 498-99, 495 N.E.2d at 345, 504 N.Y.S.2d at 82.

dures¹⁸⁵ and as a standard under which "the judgment of medical authorities should determine the most efficacious treatment modality that will satisfy the treatment needs of the patient,"¹⁸⁶ not as justification for a due process model in some ways stricter than the trial court's original remedy in *Rennie*.¹⁸⁷

Sixth, the decision's sole reliance on state constitutional law¹⁸⁸ may be its most important legacy. While the trend toward the expanded use of state constitutions in a variety of due process and equal protection contexts has been well documented,¹⁸⁹ the use of such documents in deciding cases involving the rights of mental pa-

185. See *Rennie*, 720 F.2d at 269-70 (Garth, J., opinion).

186. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment* 39 VAND. L. REV. 83, 105 (1986). Project Release v. Prevost, 722 F.2d 960, 981 (2d Cir. 1983) relied specifically on the "professional judgment" language in *Youngberg*, 457 U.S. at 323, in its determination that the state regulations under attack met federal constitutional muster. 722 F.2d at 981.

187. See *Rennie*, 476 F. Supp. at 1314 (independent psychiatrists may hold informal hearing).

In addition, while *Rennie* discarded the "least intrusive means" analysis on remand in light of *Youngberg v. Romeo*, 720 F.2d at 269-70 (Garth, J., opinion), (see *supra* notes 79-82 and accompanying text) *Rivers* resurrects it, without any mention of the *Youngberg* decision. Cf. *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984), *cert. denied*, 105 S. Ct. 1187 (1985) (citing, in a "cf." reference, to the "professional judgment" language of *Youngberg*, 457 U.S. at 321-23).

188. While the opinion cites to common law authorities as well, it notes that these protections are "co-extensive with the patient's liberty interest protected by the due process clause of our state constitution." *Rivers*, 67 N.Y.2d at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78.

189. See generally Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?* 20 LOY. L.A.L. REV. 20 (1987) [hereinafter cited as *State Constitutions*].

For influential judicial writings, see, e.g. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977) (recognized as the Magna Carta of state Constitutional Law); Pollock, *State Constitutions as Separate Sources of Fundamental Rights*, 35 RUTGERS L. REV. 707 (1983); Pollock, *Adequate and Independent State Grounds as a Means of Balancing the Relationship Between State and Federal Courts*, 63 TEX. L. REV. 977 (1985); Utter, *Swimming in the Jaws of the Crocodile: State Court Comment on Federal Constitutional Issues When Disposing of Cases on State Constitutional Grounds*, 63 TEX. L. REV. 1025 (1985); Wright, *In Praise of State Courts: Confessions of a Federal Judge*, 11 HASTINGS CONST. L. Q. 165 (1984); Linde, *First Things First: Rediscovering the States' Bills of Rights*, 9 U. BALT. L. REV. 379 (1980); Mosk, *State Constitutionalism: Both Liberal and Conservative*, 63 TEX. L. REV. 1081 (1985); Mosk, *Whither Thou Goest — The State Constitution and Election Returns*, 7 WHITTIER L. REV. 753 (1985).

For important academic writings, see, e.g., Galie, *The Other Supreme Courts: Judicial Activism Among State Supreme Courts*, 33 SYRACUSE L. REV. 731 (1982); Howard, *State Courts and Constitutional Rights in the Day of the Burger Court*, 62 VA. L. REV. 873 (1976); Collins, *Reliance on State Constitutions — Away From a Reactionary Approach*, 9 HASTINGS CONST. L.Q. 1 (1981); Williams, *Equality Guarantees in State Constitutions*, 63 TEX. L. REV. 1195 (1985); Welsh, *Whose Federalism? — The Burger Court's Treatment of State Civil Liberties Judgments*, 10 HASTINGS CONST. L.Q. 819 (1983).

tients has been far more limited.¹⁹⁰ Although several important such cases have used state constitutions as the source of finding such rights,¹⁹¹ none appears to have the potential scope and impact of *Rivers*.¹⁹²

While it is far too early to speculate as to *Rivers*' ultimate impact, it should be self-evident that it is available as a model to high courts of other states, if they wish to "sidestep"¹⁹³ the Supreme Court's decisions in *Mills* and *Romeo* and the Third Circuit's cutbacks in its *Rennie* remand decision.

II. TORT LAW ISSUES

Having looked extensively at the constitutional law issues, it is necessary to consider tort law principles in order to determine what relationship, if any, there is between the two sets of doctrines.

In *Clites v. Iowa*,¹⁹⁴ the one major case that has considered the impact of a constitutional right to refuse treatment on tort liability, the Iowa Court of Appeals affirmed a jury's negligence verdict of over \$750,000 which had been awarded to a long-term resident of a state facility for the mentally retarded.¹⁹⁵ The plaintiff had been in-

Not all commentators have been so favorable. See, e.g., Maltz, *The Dark Side of State Court Activism*, 63 TEX. L. REV. 995 (1985).

190. See Meisel, *The Rights of the Mentally Ill Under the State Constitutions*, 45 LAW & CONTEMP. PROBS. 7 (1982); *State Constitutions*, *supra* note 189.

191. A right to refuse treatment has been found under the state constitution in *Opinion of the Justices*, 123 N.H. 554, 465 A.2d 484 (N.H. 1983); see also *Large v. Superior Court*, 148 Ariz. 229, 714 P.2d 399 (Ariz. 1986) (right to refuse treatment for mentally ill convicts); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984) (right to refuse treatment for incurably ill non-psychiatric patients who seek the discontinuation of artificial life support systems).

For other rights of mentally disabled persons found under state constitutions, see *State ex rel. Hawks v. Lazaro*, 157 W. Va. 417, 202 S.E.2d 109 (W. Va. 1974); *Fasulo v. Arafah*, 173 Conn. 473, 378 A.2d 553 (Conn. 1977); *Denton v. Commonwealth*, 383 S.W.2d 681 (Ky. 1964); *Proctor v. Butler*, 117 N.H. 927, 380 A.2d 673 (N.H. 1977); *In re Grady*, 85 N.J. 235, 426 A.2d 467 (N.J. 1981); *Conservatorship of Valerie N.*, 40 Cal. 3d 143, 707 P.2d 760, 219 Cal. Rptr. 387 (1985); see generally *State Constitutions*, *supra* note 189.

192. It is further ironic that, while *Rivers* declared a broad right to refuse treatment on state constitutional law grounds (ignoring the contrary federal constitutional decision of *Project Release*), the *Rennie* trial court originally rejected defendants' abstention argument, in part, because a New Jersey state trial court had previously approved — on state law grounds — of the involuntary administration of psychotropic drugs to resisting patients. See *Rennie*, 462 F. Supp. at 1142 and *In re Hospitalization of B.*, 156 N.J. Super. 231, 383 A.2d 760 (Super Ct. Law Div. 1977).

193. See Wexler, *Seclusion and Restraint: Lessons for Law, Psychiatry, and Psychology*, 5 INT'L J. L. & PSYCHIATRY 285, 290 (1982); *Current Status*, *supra* note 28, at 132; *Hostility*, *supra* note 56, at 83.

194. 322 N.W.2d 917 (Iowa Ct. App. 1982).

195. *Id.* at 919.

stitutionalized since age eleven; seven years later, hospital doctors began to prescribe antipsychotic drugs to "curb [his] aggressive behavior."¹⁹⁶ After receiving such drugs for five years, the plaintiff was diagnosed as suffering from tardive dyskinesia.¹⁹⁷

The plaintiff sued in state court, arguing that the defendants had failed to provide him with "reasonable medical treatment," and that his condition was proximately caused by their negligence.¹⁹⁸ The jury awarded him \$385,000 for future medical expenses, and \$375,000 for past and future pain and suffering. The defendants appealed this verdict.¹⁹⁹

In affirming, the court of appeals found that defendants' actions were to be assessed by the standard of "such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances,"²⁰⁰ the traditional test for negligence.²⁰¹ It found, on the record before it, that there was "substantial support" for a series of fact-findings that the trial court had made regarding the appropriate "industry standards of care."²⁰²

Thus, while it was "standard" for patients receiving major tranquilizers to be "closely monitored" via tests, physical exams and regular examinations by physicians, the plaintiff had not been visited by a physician for a three year period.²⁰³ The hospital staff's failure to react to the plaintiff's symptoms and alter his treatment program similarly fell short of industry standards, as did the hospital's failure to provide interim consultations with specialists, especially in light of the plaintiff's attending doctor's conceded unfamiliarity with tardive dyskinesia.²⁰⁴

Given the plaintiff's status and the type of drugs involved, the practice of polypharmacy was not warranted by industry standards, the court noted,²⁰⁵ citing the Third Circuit's original opinion in *Rennie* on the use of the least restrictive alternative standard.²⁰⁶ Further,

196. *Id.* at 918.

197. *Id.*

198. *Id.* at 919.

199. *Id.*

200. *Id.* (quoting *Speed v. State*, 240 N.W.2d 901, 908 (Iowa 1976)).

201. *See, e.g., Schrempf v. State of New York*, 66 N.Y.2d 289, 487 N.E.2d 883, 496 N.Y.S.2d 973 (1985); *Bell v. N.Y.C. Health & Hospital Corp.*, 90 A.D.2d 270, 456 N.Y.S.2d 787 (App. Div. 1982).

202. *Clites v. Iowa*, 322 N.W.2d 917, 920-21 (Iowa Ct. App. 1982).

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.* *See also Rennie*, 653 F.2d 836, 844-48 (3d Cir. 1981)(The least intrusive means standard will not preclude all intrusions. Rather, "it merely directs attention to and requires

the major tranquilizers which the plaintiff received were "designed as a convenience or expediency program rather than a therapeutic program," constituting "substandard medical conduct."²⁰⁷

Finally, under Iowa state law, defendants were obliged to "make a reasonable disclosure to [a] patient [or his guardians] of the nature and probable consequences of the suggested or recommended treatment."²⁰⁸ This was not done in *Clites*. On this point, the court cited the trial court's opinion in *Rogers*: "The concept of a therapeutic alliance between doctor and patient presumes a communication of information as to the pros and cons of a particular treatment program."²⁰⁹

Although obtaining informed written consent was a "recognized industry standard,"²¹⁰ the plaintiff's parents were "never informed of the potential side effects of the use, and prolonged use, of major tranquilizers, nor was consent to their use obtained."²¹¹ On the issue of damages, the court again found "substantial evidence" to support the jury's verdict.

Before Timothy was administered the major tranquilizers, he exhibited little aggressive or self-abusive behavior. Timothy could adequately communicate his needs to others, could dress himself, comb his hair, brush his teeth and make his bed. After the major tranquilizer began, a marked change occurred. Timothy became aggressive and self-abusive. He began uncontrolled movements of his arms and legs. There is evidence of deterioration in the results of Timothy's psychological summaries and I.Q. testing. His hygiene habits worsened. In the words of the trial court, Timothy was, after the effects of tardive dyskinesia manifested themselves, "only a fraction of his former self."²¹²

While it has been predicted balefully that *Clites* would lead to "increased litigation for psychiatrists,"²¹³ and while there have been

avoidance of those which are unnecessary or whose cost benefit ratios, weighted from the patient's standpoint, are unacceptable." *Id.* at 847.

207. *Clites*, 322 N.W.2d at 920-21.

208. *Id.* at 922 (quoting *Grosjean v. Spencer*, 258 Iowa 685, 140 N.W.2d 139, 144 (1960)).

209. *Id.* (quoting *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979)).

210. *Clites*, 322 N.W.2d at 922; (the court cited, in a *cf.* reference, *Rennie v. Klein*, 462 F. Supp. 1131, 1147 (D.N.J. 1978), for the proposition that "patients must be informed of and participate in the decision-making aspects of their treatment").

211. *Clites*, 322 N.W.2d at 922. The court here relied on *Rogers*, 478 F. Supp. at 1366, 1377, for the proposition that the decision to accept or refuse such medication is a "basic right of privacy and [that] the physician-patient relationship presumes the communication of the pros and cons of any particular treatment."

212. *Id.* at 923.

213. Klein and Glover, *Psychiatric Malpractice*, 6 INT'L J. L. & PSYCHIATRY 131, 137 (1983) [hereinafter cited as Klein and Glover].

reports of increased filings in the case's aftermath,²¹⁴ the expected "flood"²¹⁵ has not yet materialized.²¹⁶ Although *Clites* was characterized as "disquieting" by Drs. Paul Appelbaum and Robert Wettstein,²¹⁷ those authors also suggested that it was "premature" to use the case as a standard by which to assess the general direction of case law developments in this area.²¹⁸ They suggested that the development of "appropriate written policies and procedures for the systematic monitoring of patients being treated with antipsychotic medication, *whether or not tardive dyskinesia . . . [is] present*" would be the first step in limiting the future litigation risk of mental health professionals in the field.²¹⁹

Subsequently, Dr. Appelbaum and other colleagues raised the intriguing possibility that tardive dyskinesia should be viewed in the same context as a "mass accident," for which there are specially-

214. See Baker, *Expect a Flood of Tardive Dyskinesia Malpractice Suits*, Clinical Psychiatry News, Jan. 1984, at 3.

215. *Id.*

216. For a non-institutional tardive dyskinesia case incorporating constitutional principles through state statute, see *Barclay v. Campbell*, 704 S.W.2d 8, 10-11 (Tex. 1986) (construing TEX. REV. CIV. STAT. ANN. art. 5547-80(a) (Vernon 1985) guaranteeing mentally ill persons all rights provided by state and federal statutes and constitutions — to provide plaintiff with the right to make his own "medical decisions" as an aspect of the federal constitutional right to privacy, citing, inter alia, *Roe v. Wade*, 410 U.S. 113, 152 (1973); new trial ordered, to consider the question of whether a "'reasonable person' could have been influenced in making a decision whether to give or withhold consent to [administration of prescribed neuroleptic drug] had he known of the risk [of tardive dyskinesia]").

Cf. *Faigenbaum v. Oakland Medical Center*, 143 Mich. App. 303, 306, 373 N.W.2d 161, 164 (Ct. App. 1985) (subunit of state mental hospital which functioned as a general care medical hospital immune from plaintiff's medical malpractice tort claim in tardive dyskinesia case, applying *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984), retroactively).

217. Wettstein and Appelbaum, *Legal Liability for Tardive Dyskinesia*, 35 HOSP. & COMMUNITY PSYCHIATRY 992, 993 (1984).

218. *Id.*

219. *Id.* (emphasis added). Suggested the authors:

Such policies could be included under existing guidelines with regard to the appropriate use and dosage of antipsychotic and antiparkinsonian medications, but would also address the need for periodic evaluation for tardive dyskinesia; the use of standardized dyskinesia-assessment instruments; the role of consulting neurologists in screening, diagnosis and treatment of tardive dyskinesia; the availability of costly neurological diagnostic procedures ([EEG] or computerized tomography, for example); and the method of securing and periodically reviewing a meaningful informed consent from the patient or his or her guardian both on the use of antipsychotic medication and the management of tardive dyskinesia. The formulation of such a policy demands a consensus among clinical (psychiatric and neurologic), administrative, legal, financial, and ethical agendas.

Id.

created judicial remedies.²²⁰ These potential remedies run a full gamut from strict liability (to be enforced against "either drug manufacturers or (less likely) prescribing physicians"),²²¹ to alternative "market-share liability" (in the same manner done by manufacturers in the Agent Orange suits),²²² to a new type of social insurance program (not unlike workers' compensation),²²³ to allowing the patient to bear the burden (either as a result of an expanded assumption-of-risk theory, a comparative negligence doctrine, or in the same manner as the state-of-the-art defense used in some asbestosis cases).²²⁴

While these ideas do not appear to have percolated past the journal commentary stage, they are all certainly provocative, and all are worthy of further exploration. The inescapable reality, however, is that all of the suggestions have one factor in common: a recognition that traditional tort remedies may not be appropriate in tardive dyskinesia litigation. Although these ideas are intriguing, it is premature to rush headlong into any such extraordinary compensation scheme, especially given the near total absence of pertinent case law. Also, psychiatric malpractice will be difficult to prove except in grossly negligent situations (such as the Iowa case), due to problems of causation and the inevitability of some side effects even where medication is "responsibly and competently prescribed."²²⁵ Beyond this, of course, tort recoveries are solely remedies; their prophylactic value is open to question, and they cannot restore an injured plaintiff to the *status quo ante*.²²⁶ The fact that Dr. Appelbaum has raised the issue, and that the *American Journal of Psychiatry* has published his ideas as a lead article, should make it quite clear that this is an issue which will be the focus of increased attention in mental health circles in both the near and distant future.

Somewhat obscured in all of this is another inescapable reality: the body of constitutional law which has developed over the past eight years may well be incorporated into tort law cases, with the additional overlay of traditional tort liability principles. Paradoxically, the expansion of this body of constitutional rights of patients may actually be a financial panacea to mental health professionals

220. Appelbaum, Schaffner and Meisel, *Responsibility and Compensation for Tardive Dyskinesia*, 142 AM. J. PSYCHIATRY 806, 807 (1985).

221. *Id.* at 808.

222. *Id.* at 809.

223. *Id.*

224. *Id.* at 809-10.

225. Note, *Antipsychotic Drugs: Regulating Their Use in the Private Practice of Medicine*, 15 GOLDEN GATE 331, 368 (1985).

226. *Id.*

(institutional and otherwise): if the constitutional rights of patients are enforced in accordance with the decisions discussed previously, then it may be logical to infer that much otherwise-tortious behavior will be prevented and suits will be minimized.²²⁷ Although this topic has not yet been written about (or litigated) extensively,²²⁸ it seems logical that further developments in this area can be expected.

CONCLUSION

Mental health professionals need to be able to predict how courts will respond to new sets of fact situations in a whole variety of legal areas. Although the law still remains in a state of flux,²²⁹ it is now clearer that most of the lower courts that have considered the question agree that the Supreme Court is comfortable "with the theoretical underpinnings of the right"²³⁰ to refuse treatment. While the ultimate definition of the scope of the right to refuse treatment remains open²³¹ unless and until the Supreme Court decides to hear the issue again, it appears that the right is far from "extinguished."²³² In most jurisdictions, it is, rather, alive and well.

In addition, cases such as *Clites* indicate that these principles will now have a double life: in constitutional litigation involving equitable and broad-based institutional relief, and in tort cases involving the compensation of individuals for damages suffered because of the misuse of the very same medications. In either circumstance, to paraphrase the playwright Arthur Miller in *Death of a Salesman*, "attention must be paid."

227. Cf. Rosenberg and Yohalem, *Litigation on Behalf of Mentally Disabled Children: Target of Opportunity, Part I*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 70, 72 (1986) (large monetary judgments send shock waves through a state system; investigations may be launched, culpable staff fired, staff training improved, and quality-assurance procedures implemented).

228. But see Klein and Glover, *supra* note 213, at 136; Slovenko, *On the Legal Aspects of Tardive Dyskinesia*, 7 J. PSYCHOLOGY & L. 295 (1980); Halleck, *Malpractice in Psychiatry*, in 6 *Psych. Clinics of North America* 567 (Sadoff, ed. 1983).

229. See *Patients' Rights*, *supra* note 26, at 6.

230. *Id.*

231. *Mental Hospital Drugs*, *supra* note 14, at 1728 n.27.

232. See *Common Law Remedy*, *supra* note 27.