CONSTITUTIONAL LAW—MENTAL HEALTH—STATE MENTAL HEALTH PATIENTS' RIGHT TO REFUSE FORCIBLE ADMINISTRATION OF MEDICATION NARROWLY CONSTRUED—*Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981).

In response to the public's growing awareness of the treatment of the mentally ill,[1] the courts have expressed increasing concern over the intrusiveness of forced administration of medication to patients in state mental health institutions.[2] The constitutional right of an individual to refuse potentially harmful antipsychotic drugs[3] is considered to be among the "penumbral right[s] to privacy, bodily integrity, [and] personal security"[4] protected by the due process clause of the

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[1] Once routinely subjected to inhuman conditions, the mentally ill were often isolated from their families in warehouse-like state institutions until federal funding in the 1950's and 1960's provided alternative modes of treatment. *See generally* Dowben, *Legal Rights of the Mentally Impaired*, 16 HOUS. L. REV. 833, 834-36 (1979); Kopesky, *Psychosurgery and the Involuntarily Confined*, 24 VILL. L. REV.. 949, 950 (1978-1979) (development of regulations concerning use of psychosurgery (lobotomy)).

[2] *See* Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979) (appeal pending); *In re* the Mental Health of K.K.B., 609 P.2d 747 (Okla. 1980); Goedecke v. State Dep't of Insts., 198 Colo. 407, 603 P.2d.123 (1979); *In re* Guardianship of Richard Roe III, No. S.J.C. 2257, slip op. at 981 (Mass. 1981) (antipsychotic medication may be forcibly administered to incompetent non-institutionalized mental health patient only when proved beyond reasonable doubt that incompetent will be harmful to himself or others).

[3] Antipsychotic drugs are "chemical agents" used in the treatment of mental illness. They are also referred to as neuroleptic and psychotropic drugs. The function of antipsychotic drugs is to reduce the level of psychotic thinking, and "it is virtually undisputed" that they are capable of altering the mind. Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981).

"Toxic" side effects frequently include temporary, muscular (extra-pyramidal) symptoms: dystonic reactions (muscle spasms, irregular flexing or writhing movements, protrusion of the tongue); akathesia (inability to stay still, restlessness, agitation); mask-like face, drooling, muscle stiffness, rigidity and shuffling gait; non-muscular effects (drowsiness, weakness, weight gain, dizziness, fainting, low blood pressure, dry mouth, blurred vision, loss of sexual desire, apathy, depression, constipation, diarrhea, and changes in the blood).

Tardive dyskinesia is the most devastating of long-term effects of antipsychotic drugs. Its symptoms often do not appear until after a considerable period of the treatment and may only manifest themselves after discontinuation of the drug. Symptoms include involuntary muscle movements of the lips and tongue, ulcerations of the mouth and incomprehensible speech. In severe cases, swallowing and breathing become impaired. Tardive dyskinesia can continue for years and is difficult to cure. Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw. U. L. REV. 461, 475-78 (1977).

[4] Rogers v. Okin, 478 F. Supp. 1342, 1362 (D. Mass. 1979) *aff'd in part, rev'd in part*, 634 F.2d 650, 653 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981). The right of privacy was enunciated by the Supreme Court in Eisenstadt v. Baird, 405 U.S. 438, 453 (1972). The right to maintain and safeguard bodily integrity was upheld in Schmerber v. California, 384 U.S. 757, 772 (1966). The due process clause guarantee was recognized in Ingraham v. Wright, 430 U.S. 651, 673 (1977) ("Among the historic liberties [protected by the due process clause] was the right to be free from . . . unjustified intrusions on personal security").

fourteenth amendment.[5] The extension of this right to mental health patients is being considered by the courts as part of the current movement toward more stringent regulation of treatment procedures in state hospitals.[6]

The right of the mentally ill to refuse forcible medication was upheld by the United States District Court for the District of Massachusetts in *Rogers v. Okin*,[7] the broadest decision on the issue thus far.[8] In 1975, seven patients[9] residing at the Boston State Hospital brought a class action seeking to enjoin medication and seclusion practices which they contended infringed upon their constitutional rights.[10] Plaintiffs also sought compensatory and punitive damages under 42 U.S.C. § 1983.[11] The state commissioner of mental health, other health officials and physicians responsible for patient care, defendants, asserted that committed patients are not competent to make treatment decisions.[12] They maintained that no patient was forcibly

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[5] Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650, 653 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981). The due process clause reads:

> No state shall make or enforce any law which shall abridge the privileges and immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV, § 1.

[6] Experimental psychosurgery (lobotomy) and electroconvulsive (shock) therapy require consent. MASS. ANN. LAW., ch. 123, § 23 (Michie/Law Co-op 1972). *See generally* Craige, *Rennie v. Klein: Constitutional Right of Privacy Protects a Mental Patient's Refusal of Psychotropic Medication*, 57 N.C. L. REV. 1481 (1979).

[7] 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981).

[8] *See* Burke, *Mental Patients Say No!*, Nat'l L.J., Jan. 26, 1981, at 10, col. 1.

[9] Plaintiffs included Rubie Rogers, Able Bolden, Betty Bybel, James Colleran, Donna Hunt, Willie Wadsworth, and Harold Warner. 478 F. Supp. at 1354. Ms. Rogers, a forty-three year old mental patient at Boston State Hospital, was so intent on avoiding further treatment with antipsychotic drugs that she set her bed on fire. While she recovered from her burns at another hospital, treatment with drugs was suspended. So desperate was Ms. Rogers to escape forcible medication that she repeated her actions three more times during the next few years. *See* note 8 *supra*.

[10] 478 F. Supp. at 1352-53. The class, certified by the district court on October 16, 1975, included " 'all persons, who are presently, or will be, patients at the May and Austin Units of Boston State Hospital and who have been or will be secluded without their consent or medicated without their consent.' " *Id.* at 1352 n.1.

[11] *Id.* at 1380. 42 U.S.C. § 1983 reads:

> Civil action for deprivation of rights. Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (1976).

[12] 478 F. Supp. at 1353.

medicated unless a "psychiatric emergency," defined as a "foreseeable deterioration of the patient absent medication," occurred.[13] Defendants contended seclusion was employed only as permitted under Massachusetts law.[14]

A temporary restraining order was issued by the district court on April 30, 1975, prohibiting the forcible administration of medication and forbidding seclusion in non-emergency situations.[15] After a fourteen month trial, the district court concluded that voluntarily and involuntarily committed mental patients may be forcibly medicated only in an emergency.[16] In an opinion by Judge Tauro, the court defined an emergency as a situation "in which a failure to [medicate] would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution."[17] Seclusion practices, provided by Massachusetts law, were limited by the court to a clearly defined emergency.[18] The district court's findings were considered sufficient for injunctive relief but did not support the plaintiffs' damage claims.[19]

Cross-appeals followed and, on November 25, 1980, Chief Judge Coffin, for the Court of Appeals for the First Circuit, affirmed in part, reversed in part, vacated, and remanded *Rogers v. Okin*[20] to the district court for further determination. The court of appeals vacated the district court's definition of an emergency situation as too restrictive to be functional.[21] Chief Judge Coffin held that mental health

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[13] *Id.*

[14] *Id.* MASS. ANN. LAWS,ch. 123, § 21 (Michie/Law Co-op 1972) provides that "restraint may be used only in cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide," if authorized in writing by the designated physician or superintendent.

[15] 478 F. Supp. at 1353.

[16] *Id.* at 1365, 1368. Patients who are voluntarily committed have volunteered to enter a mental health institution and are considered to be competent to make that decision. Involuntarily committed patients are not considered competent to decide to forego hospitalization, although there is a presumption of competency to manage their other affairs. *See* note 30 *infra* and accompanying text.

[17] 478 F. Supp. at 1365.

[18] *See* note 14 *supra.*

[19] 478 F. Supp. at 1382-83. Although the district court determined that five of the plaintiffs were forcibly medicated and that five others were secluded in a non-emergency situation prior to the issuance of the temporary restraining order in 1975, Judge Tauro denied damages to any of the plaintiffs. The court of appeals agreed with the district court that the "defendants acted in subjective good faith [without] 'an impermissible motivation,' " and they could only be held liable under 42 U.S.C. § 1983 if they clearly violated the patients' constitutional rights. Rogers v. Okin, 634 F.2d 650, 662 (1st Cir. 1980). The district court also rejected plaintiffs' attempts to recover damages under theories of false imprisonment, assault and battery, and medical malpractice. 478 F. Supp. at 1383-88. The court of appeals agreed. Rogers v. Okin, 634 F.2d 650, 663 (1st Cir. 1980).

[20] 634 F.2d 650, 664 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1981).

[21] *Id.* at 654-57.

patients cannot be medicated in a non-emergency unless found to be incompetent.[22] The district court's requirement of guardian approval of the decision to forcibly medicate an incompetent patient was held to be constitutionally unnecessary.[23] The court of appeals returned the task of balancing the interests of the individual against those of the institution to the discretion of the physician.[24] The district court was reversed on its decision allowing a patient who is voluntarily committed to a state institution to have the right to refuse forcible medication.[25] Denial of plaintiffs' damage claims was affirmed by the court of appeals.[26]

In addressing the fundamental right of a mental health patient to refuse antipsychotic drugs, the district court had concluded that most committed mental health patients, although somewhat impaired in "their relationship to reality, [could perceive] the benefits, risks, and discomfort" resulting from treatment.[27] Massachusetts law provides that a mental health patient, even though committed, is presumed competent to manage his affairs, dispose of property, vote, and even engage in a profession.[28] The district court, therefore, found no merit in defendants' argument that once admitted to a mental institution, a patient is incompetent to decide whether to accept or reject treatment.[29] The court of appeals observed, however, that some mental patients may be "dangerous to . . . themselves or others [and] are unable to make any meaningful choice as to whether they should accept treatment."[30]

The court of appeals joined the district court in recognizing that individuals have "a constitutionally protected interest in being left free by the state to decide . . . whether to submit to [a] serious and potentially harmful medical treatment."[31] Plaintiffs contended that the fact that an individual is mentally . . . and resides in an institution should not permit the disregard of those rights. The defendants, however, had argued that the interests of the mentally ill "are fundamentally different from those . . . who are not mentally ill."[32] Patients' interests could even be said to be consistent with the state's interest in

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[22] *Id.* at 656.
[23] *Id.* at 659-61.
[24] *Id.* at 655-57.
[25] *Id.* at 661.
[26] *Id.* at 662-63.
[27] 478 F. Supp. at 1361.
[28] MASS. ANN. LAWS, ch. 123, § 25 (Michie/Law Co-op 1972).
[29] 478 F. Supp. at 1361.
[30] 634 F.2d at 654.
[31] *Id.* at 653.
[32] *Id.* at 654.

forcible medication,[33] the rationale being that "[a] person must be restored to sanity, . . . before he can enjoy [his] rights."[34]

The state utilized two vehicles, its police power[35] and the doctrine of *parens patriae*,[36] as justification for forcible medication under certain circumstances. Such circumstances include the protection of persons from physical harm inflicted by a violent mental health patient or the providing of care to citizens unable to care for themselves.[37] On appeal, defendants argued that in permitting forcible medication only in an emergency situation,[38] the district court defined an emergency too narrowly. Instead, an emergency should include circumstances giving rise to the desire to treat a patient more effectively.[39] As defined by the district court, the requirement of finding a "substantial likelihood of physical harm" was claimed to be "overly rigid and unworkable,"[40] thereby not allowing the flexibility essential in dealing with patients' violent behavior.[41] The court of appeals held that the district court's standard, requiring the physician to predict the probability that violent behavior will ensue if no medication is given, was too simplistic to be functional.[42]

In the institutional environment in which many patients with a "demonstrated proclivity" toward violent behavior are involuntarily confined, the state's interest in averting violence becomes of the utmost importance.[43] This is accentuated by the possibility that the patients themselves would be the most likely victims of any violent acts. Balanced against these compelling interests is the patient's right

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[33] *Id.*

[34] Burke, *supra* note 8, at 10 (quoting Joel I. Klein who prepared the amicus curiae brief for the American Psychiatric Association).

[35] 634 F.2d at 656. Police power enables the government to make and enforce laws in the interest of the public health and safety.

[36] *Id.* at 654, 657-61. This doctrine obligates the State to protect and control incompetents, orphans, and dependent children.

[37] *Id.* at 655, 657.

[38] 478 F. Supp. at 1365. See text accompanying note 17 *supra* for district court's definition of an "emergency situation." The court of appeals found the term "substantial likelihood" unclear and pointed to the district court's explanation that the term means "more-likely-than-not." 634 F.2d at 657.

[39] 634 F.2d at 654-56.

[40] *Id.*

[41] *Id.* at 654-55.

[42] *Id.* The court of appeals took an example of the physicians' dilemma from the testimony of one director of the state hospital. When a patient who tolerated antipsychotic drugs well seemed about to become violent, the director stated that he would have forcibly administered medication as a precaution if no limits were in effect. Since the director could not clearly predict that the patient would become violent without medication, no drugs were administered. The patient later became violent and injured a staff member. *Id.* at 655.

[43] *Id.*

as a competent individual to be free from the forcible administration of antipsychotic drugs.[44] The court of appeals held that the "*individualized* estimation of the possibility and type of violence,"[45] combined with the drug's estimated effect on that individual and the evaluation of the utility of less restrictive alternatives, are within the realm of the professional judgment of the trained psychiatrist and should not be superseded by the district court's standard.[46] In sum, the court of appeals emphasized that judges are less qualified than psychiatrists to render psychiatric judgments,[47] and therefore, "courts should not 'second-guess administrators on matters on which they are better informed.' "[48]

By permitting physicians to rely upon their discretion, Chief Judge Coffin did not intend to remove all constitutional limits. In order to forcibly medicate mental health patients, the state must act within the scope of its police power; consequently, "the decision must be the result of a determination that the need to prevent violence in a particular situation outweighs the possibility of harm [from the drug administered] to the medicated individual."[49] Further safeguards mandate the elimination of any reasonable alternatives to administering antipsychotic drugs. If the patient is not adjudged to be incompetent, medication given only for treatment purposes cannot be administered over the patient's objections.[50] On remand, the district court was directed to examine and determine the existence of a less restrictive standard, but was cautioned to avoid "the creation of general, *substantive* standards for weighing the competing interests."[51]

The district court's standard, calling for a "substantial likelihood of physical harm,"[52] should not take the place of "an individualized balancing of the . . . [patient's] varying interests . . . in refusing antipsychotic medication against the equally varying interests of

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[44] *Id.*

[45] *Id.* (emphasis in original).

[46] *Id.* at 655-56. By illustration, the court of appeals surmised:

> [I]f the violence feared is potentially life-threatening, and the patient's prior experience with antipsychotics favorable, it would be patently unreasonable to require that [physicians] determine that the probability of the feared violence occurring is greater than fifty percent before they can act. By contrast, if the patient has experienced severe adverse side-effects from antipsychotics, it would only be reasonable to expect [physicians] to explore less harmful alternatives much more vigorously. *Id.*

[47] *Id.* at 656.

[48] *Id.* (quoting Bell v. Wolfish, 441 U.S. 520, 544 (1979)).

[49] 634 F.2d at 656.

[50] *Id.*

[51] *Id.* (emphasis in original).

[52] *Id.* at 654.

patients—and the state—in preventing violence."[53] Because this balancing necessarily involves complex factors, it is best left to the judgment of state physicians. The district court was directed to confine itself to designing procedures to ensure that medication is not given forcibly absent a finding that the interests of the patients are outweighed and that no reasonable alternatives are available.[54]

Under the doctrine of *parens patriae*, the existence of a legitimate state interest in providing care for persons who cannot care for themselves is well established.[55] The court of appeals observed that this doctrine has been extended to the forcible administration of medical treatment to patients in Massachusetts hospitals.[56] Treatment by antipsychotic drugs has proven effectiveness, but devastating side effects often result.[57] The court of appeals in *Rogers* held that such an intrusion upon the individual's right of privacy must occur only if the patient lacks the capacity to make competent treatment decisions.[58] Although the parties were in agreement on this issue, they conflicted over whether a determination of incapacity had been made regarding the plaintiffs.[59] Defendants argued that state proceedings for commitment are a sufficient determination of incapacity to permit forcible medication, and that it would be "illogical to accept the patients' same objections to treatment" after overriding their decision to reject voluntary hospitalization.[60] The court of appeals upheld the district court's conclusion that Massachusetts law contains no judicial determination of *incapacity*.[61] The commitment decision is then "an inadequate predicate" to justify the forcible administration of drugs under the state's *parens patriae* power.[62]

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[53] *Id.* at 655-56.

[54] *Id.* at 657.

[55] Addington v. Texas, 441 U.S. 418, 426 (1979).

[56] 634 F.2d at 657. The court of appeals cited *In re* Oakes, 8 Law Rep. 122 (Mass. 1845) (discussed in *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1209 (1974)).

[57] Plotkin, *supra* note 3, at 474-77.

[58] 634 F.2d at 657.

[59] *Id.*

[60] 634 F.2d at 657-58.

[61] *Id.* at 658 (emphasis in original).

[62] Involuntary commitment in Massachusetts necessitates a judicial finding that an individual is mentally ill, and, if not hospitalized, a "likelihood of serious harm" would be created. MASS. ANN. LAWS, ch. 123 §§ 7, 8 (Michie/Law Co-op 1972). "Likelihood of serious harm" is defined as:

> (1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm;
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> (2) a substantial risk of physical harm to other persons as manifested by evidence of

The court of appeals recognized the need for a procedure under which the state can treat a patient who lacks the capacity to accept or reject needed treatment.[63] The district court had decided that to ensure the patient's right "to be free from unwarranted government intrusion," a guardian would be appointed to manage the affairs of those adjudicated incompetent.[64] Defendants' reluctance to rely on a guardian to make medication decisions on behalf of the incompetent patient stemmed from the ineffectiveness of the necessary procedures implemented by the courts in Massachusetts.[65] The district court concluded that a guardian may exercise any rights for an incompetent, committed mental patient concerning treatment decisions in a non-emergency situation.[66]

The court of appeals modified the district court's holding requiring an adjudication of incompetency and guardian approval for non-emergency forcible medication.[67] While judicial process is certainly preferred, state officials must be able to respond to situations where a judicial determination would be neither practical nor suitable. The court of appeals remanded to the district court to devise alternative methods to determine incompetency in a "psychiatric emergency" where delay could lead to a "significant deterioration of the patient's

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homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or

(3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

MASS. ANN. LAWS, ch. 123, § 1 (Michie/Law Co-op 1972).

Only under the third definition does a sufficient nexus exist between an individual's incompetency to decide about commitment and the conclusion that involuntary commitment may render the individual incompetent to decide on his own treatment. 634 F.2d at 658. The two preceding definitions do not provide adjudication of "judgmental capacity," and it is impossible to differentiate between individuals committed under § 1(3) and those committed under § 1(1) or § 1(2). Therefore, a patient may be committed even though he may "competently [believe] that treatment was not in his best interest[s]." *Id.* MASS. ANN. LAWS,, ch. 123, § 25 (Michie/Law Co-op 1972) determines incompetency by a separate legal proceeding, a further indication that the commitment proceeding is not intended to mean that an individual lacks the capacity to make decisions about his treatment.

[63] 634 F.2d at 659. *Cf.* Boyd v. Board of Registrars of Voters, 368 Mass. 631, 635-36, 334 N.E.2d 629, 632 (1975) ("incompetence . . . was never equated with commitment or admission to a mental health facility").

[64] 478 F. Supp. at 1362.

[65] *Id.* at 1362-63. The district court redirected defendants' dissatisfaction to the legislature for redress and declared that any delay in acquiring guardians was a matter for the attention of the Massachusetts Supreme Judicial Court. Additionally, the district court did not require full scale probate proceedings. *Id.*

[66] 478 F. Supp. at 1364.

[67] 634 F.2d at 661.

mental health."[68] Chief Judge Coffin also rejected the notion, implicit in the district court's holding, that once a patient is adjudicated incompetent, all treatment involving antipsychotic drugs must be made by a traditional guardian.[69] The court of appeals regarded this requirement as impractical since it would include not only decisions to administer drugs, but also decisions *not* to medicate, which would be difficult to enforce.[70]

To be constitutionally correct, state action derived from the *parens patriae* power must approach the treatment decision as if it was being decided by the individual patient himself.[71] In *Superintendent of Belchertown v. Saikewicz*,[72] the guardian ad litem of a mentally incompetent patient who suffered from leukemia decided that treatment by chemotherapy would not be in the patient's best interest. The doctrine of "substituted judgment," utilized by the *Saikewicz* court, determined that had he been competent, a patient who was in fact mentally incompetent and terminally ill would not elect not to undergo a painful medical treatment.[73] Once a patient has been adjudged incompetent, Chief Judge Coffin held that treatment decisions must be made as though the patient were competent to make them himself.[74] As a further precaution, on remand, the court of appeals in *Rogers* suggested that some procedural requirements be instituted by the district court such as a "periodic review by nontreating physicians."[75]

Finding no distinction between those voluntarily and involuntarily committed, the district court held that voluntarily committed patients have the right to refuse medication absent an emergency.[76] Defendants' contention that patients can be made to choose between accepting the medication prescribed or leaving the hospital was rejected.[77] The court of appeals found that the effect of the district

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[68] *Id.* at 660.

[69] *Id.* The implication of the district court's ruling may be that defendants must consult a guardian when they decide to withhold medication from an incompetent patient. Since a failure to medicate an incompetent patient may result in the "unnecessary and possibly irreversible continuation of his illness," the decision not to medicate must also be seriously considered. *Id.*

[70] *Id.*

[71] *Id.* at 661.

[72] 373 Mass. 728, 753, 370 N.E.2d 417, 431 (1977).

[73] *Id.* at 746-53, 370 N.E.2d at 428-31.

[74] 634 F.2d at 661.

[75] *Id.*

[76] 478 F. Supp. at 1368.

[77] *Id.* Defendants' position was that patients who are voluntarily committed "implicitly agree" to accept whatever treatment is prescribed, and under a contract theory, would waive any right of refusal. The district court held that the consent form that patients signed did not give clear evidence that the right to refuse existed and was therefore inadequate. *Id.* at 1367-68.

court's decision was to give voluntarily committed patients "a constitutional right . . . to dictate to the hospital staff the treatment that they are given."[78] No authority was cited for this holding and the court of appeals reversed, stating that Massachusetts law does not give voluntarily committed patients the right to choose their own treatment. Instead, the statute suggests a treatment regimen that the hospital staff determines is best. Patients who do not agree have the option of leaving the hospital.[79]

In conclusion, the court of appeals emphasized that the plaintiffs, defendants, and *amici curiae*[80] were aligned in their efforts to achieve a common goal—adequate care for patients in state hospitals.[81] Chief Judge Coffin stated that the procedural devices necessary to reach an acceptable balance between "deference to professional judgment and respect for competent individual judgment"[82] must be more closely suited to the institutional setting than to the judicial format. In its effort to determine the circumstances under which mental health patients may be forcibly medicated without constitutional violation, the court of appeals may have arrested the trend toward further definition of this right of the mentally ill.

The current movement within the legal community to invoke constitutional protection for the right of the mentally ill to refuse treatment is prompted by concern that the state has conferred "too much naked authority" on psychiatrists in the exercise of control over the involuntarily committed person.[83] Psychiatrists often oppose legal procedures because of possible delay before treatment and consistently view the choice of treatment as outside the scope of the judiciary. An improper distinction has developed between the concept of "health," as the exclusive domain of the medical profession, and the concept of "liberty," in which the Supreme Court includes the freedom to make decisions regarding one's health.[84]

The physician's proper role is to recommend treatment alternatives to the patient. If no threat to the public welfare exists, the

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[78] 634 F.2d at 661.

[79] *Id.*

[80] *Amici curiae* included the American Psychiatric Association, the American Orthopsychiatric Association, the Mental Health Association, the Civil Liberties Union of Massachusetts, the Mental Patients' Liberation Front, the Mental Health Legal Advisors Committee, and the Massachusetts Hospital Association, Inc.

[81] 634 F.2d at 664.

[82] *Id.*

[83] Plotkin, *supra* note 3, at 462.

[84] *Id.* at 463. See, e.g., Justice Douglas' concurring opinion written for both Roe v. Wade, 410 U.S. 113 (1973), and Doe v. Bolton, 410 U.S. 179 (1973) (opinion reported in *Bolton*). *See also* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

individual has the final authority to select among these various alternatives.[85] Sole dependence on a physician's best judgment, however, is a dangerous precept because it presumes certainty of diagnosis, adequacy of judgment, and sufficiency of resources for proper care.[86] In reality, state institutions "are overcrowded, understaffed and underfinanced."[87] The duty clearly rests with the legal community, not the medical profession, to protect the rights of civilly committed patients and to determine precisely when they may be medicated against their will. The court of appeal's decision to return this determination to the discretion of the psychiatrist acted to further remove much needed judicial scrutiny of treatment practices in state hospitals.[88]

In *Rennie v. Klein*,[89] district court Judge Brotman recognized a qualified right of patients to refuse treatment and held that due process requirements must be met before a patient can be forcibly medicated.[90] In a subsequent action,[91] in which plaintiff Rennie was joined by a class of mental health patients, the New Jersey district court defined an emergency situation, which would justify forcible medication, as a "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital."[92] Forced drugging of patients was considered to be just "as intrusive as the involuntary confinement resulting from commitment."[93] The potential for permanent "deprivation of a protected liberty interest" should not be ignored.[94]

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[85] Plotkin, *supra* note 3, at 463.

[86] *Id.* at 463 & n.8. "There can be little responsible debate regarding 'the uncertainty of diagnosis in this field and the tentativeness of professional judgment.' " O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring) (quoting Greenwood v. United States, 350 U.S. 366, 375 (1956)).

[87] Plotkin, *supra* note 3, at 463. Fifty-eight percent of full-time physician staff positions are occupied by graduates of foreign medical schools, "forty-three of whom are not fully licensed to practice in that state." *Id.* at 463-64.

[88] Incidents involving forcible medication detailed in Rennie v. Klein, 476 F. Supp. 1294, 1300-03 (D.N.J. 1979), demonstrate the need for greater judicial involvement in regulating hospital treatment practices.

[89] 462 F. Supp. 1131 (D.N.J. 1978). *See also* Craige, *supra* note 6.

[90] 462 F. Supp. at 1144-45. Four factors must be weighed prior to granting the right to refuse medication:

(1) the patient's physical threat to other patients and staff at the institution,
(2) the patient's capacity to decide on his particular treatment,
(3) the existence of any less restrictive treatments, and
(4) the risk of permanent side effects from the proposed treatment.

*Id.*

[91] Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979) (appeal pending).

[92] *Id.* at 1313.

[93] *Id.* at 1307.

[94] *Id.*

The effectiveness of using antipsychotic drugs to treat all types of mental illness is currently being questioned.[95] The district court in *Rennie* was persuaded that many patients who would ordinarily receive antipsychotic drugs could improve without them. Findings presented to that court included the possibilities that antipsychotic drugs might frustrate the ability of the patient to develop social skills necessary for a full recovery. In addition, there is a possibility that the drugs may cause cancer.[96] A history of forcible medication, coupled with the "vulnerability and helplessness" of mentally ill patients, led the court in *Rennie* to hold that the constitutional right to refuse treatment can only realistically exist if the hospital obtains written consent from informed patients prior to medication.[97] Permitting the use of antipsychotic drugs on patients who are uninformed about their potentially dangerous long-term effects, as were plaintiffs in *Rogers*, is a practice the judicial system should prohibit.

In *Rogers v. Okin*, the court of appeals reversed the district court's determination that voluntarily committed patients have a right to refuse treatment and held that they may leave the hospital if they choose to reject the physician's suggestions.[98] While correct in theory, this position does not allow for the possibility that voluntarily committed patients may be unaware of their right to leave the institution. Voluntary admission has been viewed as a form of entrapment which serves "to avoid the inconvenience of involuntary hospitalization."[99] Mentally ill patients make very few important decisions themselves. The fact that they rely almost entirely on their physicians and the staff is cause to question whether any "element of voluntariness" is present at all.[100] Denial of the right to refuse treatment to voluntarily committed patients should be reconsidered in light of the *de facto* involuntariness that is part of the total environs of the mental health institution.

The historical concept of a merger between the commitment decision and a determination of incompetency has finally been abandoned by both the courts and the medical profession.[101] In *In re*

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[95] 476 F. Supp. at 1298.

[96] *Id.* at 1299.

[97] *Id.* at 1307. Voluntary patients at Boston State Hospital sign a consent form that reads, "I understand that during my hospitalization and any after care, I will be given care and treatment which may include the injection of medicines." Rogers v. Okin, 478 F. Supp. at 1367. The district court held that this language was inadequate to constitute a waiver of the right to refuse because it was unclear that the patient understood that such a right existed. *Id.* at 1368.

[98] 634 F.2d at 661.

[99] Plotkin, *supra* note 3, at 464 n.13.

[100] *Id.* at 487.

[101] *Id.* at 488-89 & nn.169 & 170.

*Boyd*,[102] the Court of Appeals for the District of Columbia concluded that, even after civil commitment, the decision to refuse treatment by a mentally ill adult cannot be disregarded unless he is adjudicated incompetent.[103] The distinction between incompetency and involuntary commitment has been recognized by the court of appeals in *Rogers*, and must be preserved by prohibiting the psychiatrist's discretion and authority to become the sole basis upon which the bodily integrity of the individual may be violated.

Recognition that constitutionally protected liberties should extend to the mental health patient is an essential part of the progression of the courts out of the past era of judicial restraint. Professor Laurence Tribe warns against too cursory an evaluation of procedural protections when the bodily integrity of the individual is in danger of being violated.[104] The concern is that intrusions, such as forcible medication, like the "most awful tortures . . . can be cloaked with such clockwork logic that many become persuaded of their perverse justice."[105] The logic of the court of appeals, in returning a large part of the decision to forcibly medicate to the physician, calls for special safeguards to prevent diminution of the newly emerging rights of the mental health patient.

Psychiatric treatment is within the realm of social actions that must be measured by appropriate judicial standards to ensure that treatment does not encroach upon individual freedoms. Professor Tribe cautioned that "turning square corners . . . must never become a substitute for respecting the humanity of each individual."[106] In fashioning appropriate procedures for the protection of these new found rights, the objective of the judiciary must continue to be the protection of the individual against the temptation to peer too infrequently behind the walls of the mental health institution.

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[102] 403 A.2d 744 (D.C. 1979).

[103] *Id.* at 749. In Rogers v. Okin, the court noted that there was a " 'profound' distinction between commitment and determination of incompetency." 634 F.2d at 659 (quoting Boyd v. Board of Registrars of Voters, 308 Mass. 631, 635-36, 334 N.E.2d 629, 632 (1975)).

[104] L. TRIBE, AMERICAN CONSTITUTIONAL LAW, § 15-9, at 916 (1978).

[105] *Id.* at 915-16. *See* F. KAFKA, *The Penal Colony*, in PENAL COLONY: STORIES AND SHORT PIECES (Schocken ed. 1948).

[106] L. TRIBE, *supra* note 104, at 916.