The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process

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THE RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS: SAFEGUARDING THE MENTALLY INCOMPETENT PATIENT'S RIGHT TO PROCEDURAL DUE PROCESS

INTRODUCTION

In the early 1950s, a new class of drugs was developed to assist psychiatrists in the treatment of psychoses. Since their introduction, antipsychotic drugs have revolutionized the mental health profession. Although antipsychotic drugs alleviate the major disruptive manifestations of mental illness, they have equally disruptive side effects. Within the psychiatric profession, the use of these drugs to treat psychotic patients remains controversial as psychiatrists debate the benefits and long term risks of antipsychotic drug administration.

The most recent controversy is whether a patient has the right to refuse treatment with antipsychotic drugs. The debate revolves around whether the patient or the doctor should decide when the patient should receive treatment. The irony of the situation is that competent patients allowed to refuse treatment remain in the institution because the lack of treatment renders them too dangerous to be released. Thus, the question of whether in-


4. See infra notes 26-28 and accompanying text.

5. For a discussion of the side effects of psychotropic medication, see infra notes 30-41 and accompanying text.

voluntarily committed mental patients have the right to refuse such treatment has created much legal controversy.  

More than seventy years ago, Judge Cardozo proclaimed that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." More recent writings have echoed this principle. Additionally, federal courts in the 1970s relied on the four-

7. When the state seeks to involuntarily commit a person for mental care, it must establish a fair procedure for determining that the person is dangerous to himself or herself or others due to a mental illness. J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW § 13.9, at 500 (1982). The legitimacy of civil commitment was upheld in Addington v. Texas, 441 U.S. 418 (1979), where the Supreme Court held that the fourteenth amendment requires a "clear and convincing" standard of proof in a civil proceeding brought under state law to involuntarily commit an individual to a mental hospital for an indefinite period. Id. at 433.


teenth amendment in order to fashion a limited constitutional right to refuse antipsychotic medication. Most state and federal courts are now in agreement that a competent, involuntary mental patient possesses the right to make decisions regarding his or her own treatment.

When the United States Supreme Court granted certiorari in *Rennie v. Klein*, *Rogers v. Okin*, and a case involving the rights of the mentally retarded, *Youngberg v. Romeo*, medical professionals were hoping for a final ruling on the constitutional rights of hospitalized mentally ill and mentally retarded patients. Instead, the Supreme Court left the status of the federal right to refuse antipsychotic medication uncertain. As a result, individuals must look to the state courts to fashion a method by which a patient may refuse antipsychotic medication.

This Comment begins with an examination of antipsychotic drugs and addresses the inherent struggle they create as a result of their intrusiveness and efficacy. Next, a background of the right to refuse medical treatment is presented which discusses the doctrine of informed consent and traditional tort theories that may provide a basis for challenging forcibly administered medication. This Comment next argues that although incompetent patients are unable to give the informed consent necessary to refuse treatment, guardians ought to be appointed to insure that the decision to administer drugs is reviewed. An assessment of the competing state interests which may override a patient's decision to refuse follows. After concluding that common law remedies inadequately recognize a right to refuse antipsychotic medication, an analysis of the various constitutional guarantees that may lead to a successful objection to forcible medication will be discussed. Finally, this Comment concludes with a call to the federal courts and legislature to implement procedural due process protection for incompetent, mentally ill patients.


12. For a discussion of competence and incompetence, see *infra* notes 48-58 and accompanying text.


16. The Supreme Court in *Mills v. Rogers*, 457 U.S. 291, 302 (1982), suggests that federal procedural due process protection will be applied when state law provides a substantive right to refuse antipsychotic medication for treatment purposes. *Id.* at 303-04.

17. For purposes of this Comment, the phrases "forcibly medicate" and "forcibly administer" refer not only to the injection of the patient with a drug against his or her will, but also to the patient's consent to treatment through undue influence, coercion, or duress by hospital staff.
I. ANTIPSYCHOTIC DRUGS IN THE TREATMENT OF PSYCHOSIS

A. Historical Development of Psychiatric Care

Societies have cast aside the mentally ill throughout history. As late as 1840, a majority of committed patients were confined to cages, locked rooms and outhouses. The only treatments available were the following: barbiturates, bromides, narcotics and drugs for sedation; soothing baths, shock therapy with insulin, atropine or convulsant drugs; and neurosurgery that included prefrontal leucotomy.

Over time, the attitude of society has shifted and the overriding concern has become one of public safety and humane conditions. Since most of the controversy regarding the right to refuse medication has centered around the forcible use of antipsychotic drugs, their effects and side effects have received the greatest attention. In the 1950s, a new era began in the treatment of psychiatric disorders with the introduction of psychotropic drugs. Since then, they have become the most frequently prescribed medication for institutionalized patients. Antipsychotic drugs are most commonly used

18. In 1785, a French physician wrote about the mentally ill as follows:
Thousands of deranged are locked up in prisons without anyone's thinking of administering the slightest remedy; the half-deranged are mixed with the completely insane, the furious with the quiet; some are in chains, others are free in the prison; finally, unless nature comes to their rescue and cures them, the term of their misery is that of their mortal days, and unfortunately in the meantime the illness but increases instead of diminishing.


22. Psychotropic drugs are classified into four categories: (1) antipsychotic drugs (major tranquilizers), used to treat schizophrenia and related psychosis; (2) antidepressant drugs; (3) lithium, used to treat manic-depressive psychosis; and (4) antianxiety drugs (minor tranquilizers), used to treat situational and neurotic anxiety. Symonds, Mental Patient's Rights to Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment, 7 Hastings Const. L.Q. 701, 704 (1980). Many courts limit their definition of psychotropic drugs to antipsychotic drugs because the latter have severe side effects. See, e.g., Rogers v. Okin, 634 F.2d 650, 653 n.1 (1st Cir. 1980). Most of the litigation has revolved around antipsychotics. For this reason, the term "antipsychotics" will be used throughout this Comment. Lay people are most familiar with antipsychotic medication by their brand names: Prolixin (brand of fluphenazine), Haldol (brand of haloperidol), Stelazine (brand of trifluoperazine). Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 Nw. U.L. Rev. 461, 474 n.77 (1977) (citing Crane, Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient, 36 Transactions N.Y. Acad. Sci. 644, 656 n.1 (1974)).

23. Symonds, supra note 22, at 705. Psychotropic drugs are the most "firmly established of all the pharmacotherapies in the treatment of mental disorders." Plotkin, supra note 22, at 474. See also Davis v. Hubbard, 506 F. Supp. 915, 926 (N.D. Ohio 1980). After noting that approxi-
in the treatment of psychoses, particularly schizophrenia. "The drugs, by influencing chemical transmissions in the brain, sedate the schizophrenic and suppress psychotic symptoms such as delusions, hallucinations, and other disorders." 

Although antipsychotic drugs cannot cure mental illness, they can limit some of the most oppressive symptoms, thus allowing patients to function outside a mental hospital. Additionally, because administration of antipsychotic drugs is the preferred method of treating mental illness, patients have had shorter hospital stays and have been able to return to work and to live a more meaningful existence. One authority maintains that with proper drug maintenance therapy, relapse can be prevented for a substantial number of schizophrenic patients. Although the advent of psychotropic...
B. The Intrusive, Hazardous and Uncertain Nature of Antipsychotic Drugs

Judicial opinions recognizing a right to refuse treatment focus on the temporary and permanent nature of the side effects that accompany the use of antipsychotic drugs. Some temporary side effects, such as akathesia, dystonia, and a Parkinsonian syndrome disappear when medication is discontinued. Akathesia, dystonia, and Parkinsonian syndrome can be minimized by lowering the dosage, withdrawing the patient from antipsychotic drugs, or through the use of anti-Parkinsonian drugs. For many patients, long-term use of antipsychotic medication will result in tardive dyskinesia, an irreversible disorder characterized by involuntary, rhythmic movements of the face, mouth, tongue, and jaw. There is no treatment for this devastating side effect. It is apparent that antipsychotic

a more humane place. And schizophrenic patients who become ill today can often be treated effectively by antipsychotic medication without hospitalization.

Id. at 704 n.21 (citing Davis, Antipsychotic Drugs, in A. FREEDMAN, H. KAPLAN & B. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1921-22 (2d ed. 1975)). For a discussion of the likelihood that a patient given antipsychotic medication will improve, see generally Dubose, supra note 3.


30. Commonly known as “the jitters,” akathesia is a temporary condition and gives the patient a feeling of restlessness in which he or she cannot remain still but feels compelled to move and pace. E. MAGGIO, THE PSYCHIATRY-LAW DILEMMA 225 (1981). The research on akathesia indicates that it is frequently misdiagnosed as a psychotic symptom. As a result, an increase in the very medication that caused the akathesia may be prescribed. Note, supra note 8, at 1727.

31. Dystonia refers to “bizarre muscular spasms, primarily in the head and neck, often combined with facial grimaces, involuntary spasms of the tongue and mouth interfering with speech and swallowing, convulsive movements of the arms and head, bizarre gaits, and difficulty in walking.” Symonds, supra note 22, at 707 n.37.

32. The Parkinsonian syndrome has many of the same symptoms as Parkinson’s Disease. It is characterized by a mask-like face, rigidity, retarded volitional movements, drooling, and tremors. Id. at 707 n.35.

33. The immediate effect on the patients is sedative. Byck, Drugs and the Treatment of Psychiatric Disorders, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 158 (L. Goodman & A. Gilman eds. 1975). However, many side effects do not appear until two or three weeks after the administration. Rhoden, supra note 3, at 378.

34. Symonds, supra note 22, at 707-08.

35. Tardive dyskinesia strikes between five and thirty percent of those taking antipsychotic medication over a period of years. No one antipsychotic medication is more or less likely to cause tardive dyskinesia than any other. Psychiatrists generally believe that the risk of tardive dyskinesia increases as the patient’s lifetime dose increases. One psychiatrist recommends using anti-
drugs produce effects that are independent of the volition of the patient and in this respect can be labeled intrusive.\(^3\)

In addition to the hazardous side effects, other factors contribute to the danger of prescribing antipsychotic drugs. Current diagnostic approaches are imprecise and imperfect,\(^3\) and psychiatrists have difficulty determining the proper drugs to prescribe for the various illnesses.\(^3\) Misdiagnosis is as high as fifty percent.\(^3\) Consequently, antipsychotic drugs are prescribed not only to those suffering from schizophrenia, but also inappropriately to those exhibiting symptoms of the illness. As a result, patients must contend

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psychotic drugs only when indicated, and in the lowest possible effective doses. Beck, supra note 24, at 371 n.2.

Another concern of tardive dyskinesia is that the first symptoms do not appear until treatment is long underway. Sudden withdrawal at this point may be too late to prevent the disease, and a change in medication may not prevent the symptoms from appearing. E. MAGGIO, supra note 30, at 228-29.

36. Comment, supra note 27, at 534. "A mental health treatment may be called 'intrusive' when the treatment does not involve the patient as a participant so much as it involves him as a passive recipient of procedures and substances that can change his thinking processes, personality, or behavior patterns." Id. (citation omitted).

One recipient of a psychotropic injection depicts his experience this way:

There is no other feeling like it. Nothing to relate it to, no experience anyone would normally go through in their life. It affects you mentally and physically and you feel suicidal. The physical effects are so bad you can't stand it. . . . You get so tired (as if you've been up three days in a row) you lie down. But you can't stay down for more than three or four minutes because your knees begin to ache, an itching type ache. . . . Your thoughts are broken, incoherent; you can't hold a train of thought for even a minute. You're talking about one subject and suddenly you're talking about another. . . . Your mind is like a slot machine, every wheel spinning a different thought.


The attorney for the plaintiff in Jones v. Gerhardtstein, 141 Wis. 2d 710, 416 N.W.2d 883 (1987), preserved the plea of his client in his notes and describes the feelings of a man who would rather take the chance of returning to the state of schizophrenia than experience "the living death of being on major tranquilizers." Zander, A Committed Patient's Right of Informed Consent, 61 Wis. Bar Bull. 45, 46 (Nov. 1988).

37. For a review of studies concerning the validity and reliability of psychiatric evaluations, see Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CALIF. L. REV. 693, 699-734 (1974). One psychiatrist describes a set of standards for evaluating the quality of a psychotropic drug regimen in the form of fourteen questions. He also suggests that in some mental health institutions, antipsychotic drug therapy is not always prescribed in a prudent manner. Sovner, Assessing the Quality of a Psychotropic Drug Regimen, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 48 (American Bar Association, 1986).

38. In those patients properly diagnosed, the antipsychotic drugs produce only temporary symptomatic relief. However, an accurate diagnosis is rare and the correct prescription is even more uncertain. See Rennie v. Klein, 462 F. Supp. 1131, 1139-40 (D.N.J. 1978).

with the prevalent misuse of the potent medication and cope with the several side effects resulting from inappropriate prescriptions.

An additional problem associated with antipsychotic drugs is their improper control and abuse. Because society offers few incentives for those working in mental institutions, the result is often the employment of less qualified psychiatrists. The typical setting is one of an overworked, underpaid staff with insufficient resources to care for the patients. The district court in Davis v. Hubbard found that antipsychotic drugs are often used for purposes other than treatment, such as for the convenience of the staff and as a means of punishment. Due to inadequate staffing and resources, as well as the number of difficult patients, antipsychotic drugs have been used for control rather than therapy.

Considering the severe side effects and other problems associated with the administration of antipsychotic drugs, it is easy to comprehend why many mental patients wish to refuse these drugs and instead elect to suffer from the psychoses.

II. THE ORIGIN OF THE RIGHT TO REFUSE

Courts that have confronted the issue of a patient's right to refuse antipsychotic drugs have closely examined the competing interests of both the patient and the state. The state has an interest in administering treatment pursuant to commitment while the patient has an interest in remaining free from bodily intrusion.

The institutionalized mentally ill were traditionally unable to seek redress under common law remedies because they were deemed to be incapable of consenting to treatment. Thus, most of the litigation in this area was brought on a constitutional basis. Before analyzing the constitutional

40. Davis, 506 F. Supp. at 926-27. The district court noted that the drugs are freely prescribed by both licensed and unlicensed physicians who may prescribe them regardless of whether the patient is assigned to that physician or whether that physician has seen the patient. Id. at 926.


43. See, e.g., Howard v. Howard, 87 Ky. 616, 623, 9 S.W. 411, 413 (1888); Denny v. Tyler, 85 Mass. (3 Allen) 225, 227 (1861) (patient is "incapable of forming a judgment concerning his own condition or the means requisite for his... restoration"); In re Bakes, 8 L. Rep. 122, 125 (Mass. 1845); Price v. Sheppard, 307 Minn. 250, 239 N.W.2d 905 (1976).
basis for a right to refuse antipsychotic medication, it is useful to examine
the common law origin of treatment refusals and the state interests that
conflict with that right.

A. Common Law Analysis of Forcible Medication

1. Doctrine of Informed Consent as Applied to Involuntarily
   Committed Patients

   The right of an individual to decide whether to undergo medical treat-
   ment has long been recognized by common law under the doctrine of in-
   formed consent. Underlying this doctrine is the principle that individuals
   ought to be protected from "unjustified intrusions on personal security." How-
   ever, the concept of informed consent for institutionalized mental pa-
   tients has been controversial.

   Non-mentally ill persons are generally protected from forcibly adminis-
   tered medication. However, in the case of involuntarily committed mental
   patients, early opinions held that such patients were "ipso facto" incompe-
   tent to make decisions regarding treatment. Such determinations implic-
   itly equated civil commitment with a determination of legal
   incompetency. This attitude shifted as courts began to apply the doctrine
   of informed consent to mental patients subjected to unwanted treatment.
   Although the analytical subtleties of informed consent are beyond the scope
   of this Comment, it is important to understand the elements of informed
   consent: voluntariness, knowledge, and competency.

44. W. Keeton, D. Dobbs, R. Keeton, D. Owen, Prosser & Keeton on Torts § 18
(5th ed. 1984) [hereinafter Prosser & Keeton]. The doctrine of informed consent was first
170 (1957). For a discussion of the origins of this doctrine, see Meisel, The Expansion of Liability
for Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent, 56 Neb.
L. Rev. 51, 74-86 (1977). For a critique of the development of the informed consent doctrine, see
45. Ingraham v. Wright, 430 U.S. 651, 673 (1977); Union Pacific Ry. Co. v. Botsford, 141
U.S. 250, 251 (1891). The Supreme Court in Botsford stated that "[n]o right is held more sacred,
or is more carefully guarded . . . than the right of every individual to the possession and control of
his own person, free from all restraint or interference of others, unless by clear and unquestionable
authority of law." Id.
46. See Comment, supra note 1, at 743; see also supra note 43.
47. Id.
48. See Kaimowitz v. Dept. of Mental Health, Civ. No. 73-19434-AW (Cir. Ct. Wayne

"To date, relatively few empirical studies have evaluated the elements of informed consent,
particularly the adequacy of the information needed for mentally ill patients to make informed
medical choices." (citing Lidz, Meisel, Zerubavel, Carter, Sestag, & Roth, Informed
Consent: A Study of Decisionmaking in Psychiatry 24-32 (1984)). The most comprehensive
study suggests that patients are not receiving adequate information and that many patients
First, the issue of voluntariness becomes significant in a mental hospital because so many factors undercut the voluntary nature of the consent in a mental hospital setting.\textsuperscript{49} Threat of force, fraud, coercion, deceit and duress jeopardize the element of voluntariness.\textsuperscript{50} The judge or jury must decide whether actions taken in a hospital constitute sufficient negative influences on the patient to legally invalidate the voluntariness of the decision.\textsuperscript{51}

Secondly, knowing consent is required before administration of treatment.\textsuperscript{52} There are two contrasting standards used to determine whether the consent is knowledgeable. The first, known as the community standard, was established in \textit{Natanson v. Kline}.\textsuperscript{53} The standard looks to what other doctors in that area of specialization and geographical area would do under similar circumstances.\textsuperscript{54} The second standard is interpreted in \textit{Canterbury v. Spence}.\textsuperscript{55} It emphasizes the right of patients to make their own medical decisions based on sufficient information provided to them to facilitate their understanding of the risks and benefits of a proposed treatment.\textsuperscript{56} The quality of the information given is critical.\textsuperscript{57}

The third element of informed consent, which varies among jurisdictions, is competency. Although competency has been defined in many ways, one author has identified two elements common to most definitions: "the capacity to assimilate relevant facts, and an appreciation or rational understanding of one's situation as it relates to the facts."\textsuperscript{58} Most state statutes no longer equate civil commitment with incompetency but view the two as separate and distinct concepts. To do otherwise interferes with the princi-
ple behind informed consent, which allows the patient to decide the manner in which his or her treatment will proceed. Merging the two concepts needlessly deprives a patient of essential personal rights.

One final aspect of consent remains: the issue of substitute consent for incompetent patients. This situation arises when a person has been adjudicated incompetent to make specific medical decisions, and the court authorizes a guardian to give substitute consent. A guardian is authorized to assist the patient in properly exercising his or her right of self-determination and personal autonomy. Unfortunately, a guardian is not always appointed. Even when a guardian is appointed, often there is no review of his or her decision to insure that it is consistent with what the patient would have favored if competent. Failure to provide a guardian after incompetency has been determined to be a violation of due process. Furthermore, if self-determination is to be maintained for an incompetent person, a guardian must be appointed, and review of that decision should be made.

2. A Tort Theory for Refusing Treatment

Under the common law of torts, the right to refuse medical treatment has emerged from the doctrines of trespass and battery, which apply to an unauthorized touching by a physician. Consent is a defense to battery or trespass, and, therefore, physicians must obtain consent before commencing treatment. Except where the state has acted pursuant to a privilege arising from its parens patriae authority or police power, the common law protection of bodily autonomy has protected persons from compelled treatment. However, in the case of an involuntarily committed mental patient, early decisions reflected the attitude that these individuals were incompe-

59. See infra notes 221-41 and accompanying text.
60. PROSSER & KEETON, supra note 44.
61. A battery is a harmful or offensive contact with a person, resulting from an act intended to cause the person or third party to suffer such a contact, or apprehension that such a contact is imminent. RESTATMENT (SECOND) OF TORTS § 13 (1965).
62. PROSSER & KEETON, supra note 44.
63. See infra notes 84-99 and accompanying text.
64. See infra notes 100-09 and accompanying text.
65. See Note, supra note 8, at 1736-37. In Pratt v. Davis, 118 Ill. App. 161, 166 (1905), aff'd, 224 Ill. 300, 79 N.E. 562 (1906), the court noted:

[U]nder a free government at least, the free citizen's first and greatest right, which underlies all others - the right to the inviolability of his person, in other words, his right to himself - is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent... to violate without permission the bodily integrity of his patient by a major or capital operation...
tent to make treatment decisions. Despite the fact that this presumption has been refuted by federal court decisions, modern psychiatric literature and recent state statutory enactments, involuntarily committed patients are often denied relief under common law battery actions. Thus, it is not surprising that involuntarily committed mental patients began to challenge forced medication on constitutional grounds.

Additional tort theories may apply to the patient's dilemma. Recently, many malpractice suits have involved instances in which either the physician was negligent in obtaining informed consent, or the treatment itself was performed in a negligent fashion regardless of whether consent had been obtained. Traditional torts, such as intentional infliction of emotional distress and invasion of privacy, may provide a patient with grounds to object to forcible medication with antipsychotic drugs.

B. Balancing Competing Interests May Override a Patient's Individual Liberties

The same interests that justify a state's power to commit apply when subjecting a patient to treatment without his or her consent. These interests are divided into two categories and must be balanced against the individual's liberty before any forcible medication can be administered. State

66. See supra notes 44-59 and accompanying text for a discussion of the relationship between competence and informed consent.


68. See, e.g., ALASKA STAT. § 47.30.825 (1986); FLA. STAT. ANN. § 393.12(2)(a) (West Supp. 1988); IND. CODE ANN. § 16-14-1.6-7 (Burns 1983); KAN. STAT. ANN. § 59-2929 (Supp. 1987); TENN. CODE ANN. § 33-3-104(5) (Supp. 1986).

69. See Comment, Psychiatry With a Conscience, supra note 3, at 92. The hospitals claim that tort liability would severely disrupt, if not immobilize, the administration of an institution. Id.

70. See infra notes 131-219 and accompanying text for a constitutional analysis of the right to refuse antipsychotic drugs.


72. See Winick, The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond, 7, 8 THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION (American Bar Association 1986). The good faith of the physician would not defeat such a claim even if the jurisdiction recognized such a qualified immunity for intentional torts. Failure to divulge potential risks of antipsychotic drugs may also constitute malpractice as it frustrates a fully informed consent. Id.; see also Rogers v. Okin, 634 F.2d 650, 663 (1st Cir. 1980).

73. See Winick, supra note 72, at 8; see also Friedman, Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons, 17 ARIZ. L. REV. 39, 55 (1975).

74. See Note, supra note 8, at 1738. For an excellent analysis of civil commitment standards, see Comment, Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190 (1974).
interests include the authority to act as \textit{parens patriae}\textsuperscript{75} and to enforce its police power.\textsuperscript{76} The state's authority to act as \textit{parens patriae} enables it to care for those persons unable to care for themselves.\textsuperscript{77} The doctrine of \textit{parens patriae} was employed in an attempt to justify compulsory education in the landmark case of \textit{Wisconsin v. Yoder}\textsuperscript{78} and has been applied to the involuntary commitment of those unable to survive in the community.\textsuperscript{79} Under the police power, the state has authority to protect the community,\textsuperscript{80} to enforce compulsory vaccination laws,\textsuperscript{81} and to commit dangerous mentally ill people.\textsuperscript{82} The distinction between the two interests is useful because the factors that are relevant to the assessment of state activity to provide care for the helpless differ from those that compel the state to protect the community from danger.\textsuperscript{83}

1. \textit{Parens Patriae} as a Basis to Compel Treatment

The \textit{parens patriae} interest grew out of English common law prerogatives of the king who had the power to act as "the general guardian of all

\textsuperscript{75} "\textit{Parens patriae,} [literally] 'parent of the country,' refers traditionally to the role of the state as sovereign and guardian of persons under legal disability." BLAcK's LAW DIcTIONARY 1003 (5th ed. 1979).

\textsuperscript{76} See \textit{infra} notes 100-09 and accompanying text.

\textsuperscript{77} See, e.g., Winters v. Miller, 446 F.2d 65 (2d Cir. 1971). In \textit{Winters}, a 59-year-old woman, who had never been found incompetent, was involuntarily admitted to a hospital, and given medication despite her objections that her Christian Scientist background forbade such treatment. Because there was never any finding of legal incompetency, the state could not validly undertake to treat her using its \textit{parens patriae} authority. \textit{Id.} at 70-71.

\textsuperscript{78} 406 U.S. 205, 229-31 (1972). In \textit{Yoder}, the respondents were Amish parents who objected to Wisconsin's compulsory school-attendance law because their children's attendance at a private or public school would be contrary to the Amish way of life. The state's interest in universal education is not totally free from a balancing process when it impinges upon other fundamental rights such as the free exercise clause and the parents' interest in the religious upbringing of their children. The state's \textit{parens patriae} power could not be sustained. \textit{Id.}

\textsuperscript{79} See Comment, \textit{supra} note 74, at 1207-22 and sources cited therein.

\textsuperscript{80} Addington v. Texas, 441 U.S. 418 (1979). In \textit{Addington}, appellant was committed to various institutions and later arrested on a misdemeanor charge of assault by threat. "[T]he state ... has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill." \textit{Id.} at 426. See also Davis v. Hubbard, 506 F. Supp. 915, 934-35 (N.D. Ohio 1980); \textit{Rennie}, 462 F. Supp. at 1145.

\textsuperscript{81} Jacobson v. Massachusetts, 197 U.S. 11, 24-25 (1905) (small pox vaccination). The police power of a state embraces such reasonable regulations established by legislative enactments to protect the public health and safety. \textit{Id.} In \textit{Cude v. State}, 237 Ark. 927, 377 S.W.2d 816 (1964), the Supreme Court of Arkansas held that parents had no legal right to prevent the vaccination of their children who would be prohibited from attending school, notwithstanding good faith religious beliefs of the parents. \textit{Id.} at 821.

\textsuperscript{82} Note, \textit{supra} note 8, at 1738.

\textsuperscript{83} \textit{Id.; see, e.g., Addington}, 441 U.S. at 426 (discussing the dichotomy of state interests).
infants, idiots, and lunatics.”

Although the basic function of the doctrine has been accepted in the United States, the Supreme Court has enlarged its scope beyond the original common law purpose. Thus, while a state may not use its *parens patriae* authority to shield its citizens from federal law, it may exert the power to assure the benefits of federal law are not denied to its citizens.

The doctrine is used as the basis for state laws that protect the custody, care and education of children; the regulation of child labor; and the prosecution and detention of juvenile delinquents. Each instance involves a situation in which the community has recognized that, but for the state protecting these individuals’ interests, their future well-being would be jeopardized. Society also has placed voluntary commitment of individuals and appointment of a guardian under the guise of the *parens patriae* authority.


85. The enlargement of the purpose of *parens patriae* first became apparent in Louisiana v. Texas, 176 U.S. 1 (1900). Louisiana sought injunctive relief against Texas officials who were prohibiting Louisiana merchants from distributing their goods in Texas under the guise of a quarantine statute designed to combat yellow fever. Id. at 8.

86. Massachusetts v. Mellon, 262 U.S. 447, 485 (1923). The Supreme Court stated that “[i]t cannot be conceded that a State, as *parens patriae*, may institute judicial proceedings to protect citizens of the United States from the operation of the statutes thereof.” Id.; see also Massachusetts v. Laird, 400 U.S. 886 (1970) (a state has no right to challenge the draft).

87. Alfred L. Snapp & Son v. Puerto Rico ex. rel. Barez, 458 U.S. 592, 607-08 (1982) (Puerto Rico had standing to sue to enjoin preferential hiring and treatment of foreign laborers vis-a-vis Puerto Ricans; a state may seek to assure its residents that they will have full benefit of federal laws).


89. See, e.g., People ex rel. Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952) (blood transfusion of eight day old daughter was allowed over objections by parents due to their religious beliefs).

90. See, e.g., *Yoder*, 406 U.S. 205 (Wisconsin’s compulsory school attendance law as applied to Amish children would gravely impair the free exercise of their religious beliefs).

91. See, e.g., Prince v. Massachusetts, 321 U.S. 158 (1944) (statute forbidding minors to work did not violate a fundamental right in a case in which a parent furnished religious literature to be distributed in the streets).

92. See, e.g., Kent v. United States, 383 U.S. 541, 554-55 (1966) (although a state stands in *parens patriae* to a juvenile detainee, this is not an invitation to procedural arbitrariness).

Although limited to some extent, the doctrine of *parens patriae* empowers a state to administer treatment to a patient without obtaining consent and thus conflicts with the patient's liberty interest to refuse such treatment. This vestige of *parens patriae* authority, although broad, is limited in order to safeguard common law bodily autonomy rights against state intrusion. For example, *parens patriae* does not allow the state to order treatment for a patient who is able to make treatment decisions for himself or herself, unless that person has been determined legally incompetent, no matter how foolish or irrational the behavior may be. In the absence of a life-threatening emergency, courts have refused to order treatment having a substantial risk or uncertain prognosis.

### 2. State's Police Power to Compel Treatment

A state's police power to protect its citizens from harm also has been used to justify forcible administration of antipsychotic drugs to mentally ill patients. The police power also extends to situations within a mental institution to ensure the safety of staff and other patients.

In *Rogers v. Okin* the court held that a hospital could forcibly medicate in an emergency situation "in which a failure to do so would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution." On appeal the First Circuit Court of Appeals upheld the state's police power in administering antipsychotic medication, holding that it outweighed the patient's liberty interest in refusing medication. However, the First Circuit criticized the lower court's reasoning by using both terms, "violence threatening" and "health threatening." The court has confused the concept of *parens patriae* and police power; *parens patriae* refers only to the latter.

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95. *See, e.g.*, *Winters*, 446 F.2d at 71.

96. *See supra* notes 44-59 and accompanying text for a discussion of legal competency.

97. *See, e.g.*, *Winters*, 446 F.2d at 71; Lane v. Candura, 6 Mass. App. Ct. 377, 383-85, 376 N.E.2d 1232, 1235-36 (1978) (a senile and competent woman who refuses an operation which is required to save her life cannot be compelled to submit to it); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978) (man with gangrene in both legs cannot be forced to consent to amputation).

98. Courts have defined emergency as both "violence threatening" and "health threatening." *Rogers*, 634 F.2d at 660. By using both terms, the court has confused the concept of *parens patriae* and police power; *parens patriae* refers only to the latter.


100. *See, e.g.*, *Jones v. Gerhardstein*, 141 Wis. 2d 710, 718, 416 N.W.2d 883, 886 (1987); *Davis*, 506 F. Supp. at 934.


102. *Id.* at 1365.
opinion as being too simplistic. The court favored, instead, a balancing approach overseen by qualified state physicians. Forcible medication would take place only when the need to prevent violence outweighed the possibility of harm to the medicated patient, and the "reasonable alternatives to the administration of antipsychotics [are] ruled out."

Other decisions reflect the idea that the state may justify exerting its police power in order to protect the hospital staff and other patients by administering antipsychotic drugs in emergency situations. On remand the Third Circuit Court of Appeals in Rennie v. Klein held that antipsychotic drugs may be constitutionally given to patients "whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others."

It is undisputed that the state has an interest in preventing a patient's condition from deteriorating under the parens patriae authority and an interest in protecting society from those dangerous mentally ill persons. However, a due process consideration arises when determining the scope of a state's interest in overriding the patient's refusal. Without considering these questions, a mentally ill patient's right to bodily autonomy would be severely curtailed. Although there is agreement that the inherent power of a state includes protection of its citizens, the police power may be improperly invoked to justify forcible medication in situations which are less than an emergency. Additionally, states do not agree on the scope of the parens patriae power to care for those unable to care for themselves. Nevertheless,

103. Rogers, 634 F.2d at 656-57.
104. Id.
105. Id. at 656.
106. Gilliam v. Martin, 589 F. Supp. 680, 682 (W.D. Okla. 1984) (prisoner's right to be free from being subjected to antipsychotic medication was overridden by a clear indication that failure to take medication would result in regression and reappearance of dangerous, psychotic behavioral tendencies); Weiss v. Missouri Dep't of Mental Health, 587 F. Supp. 1157, 1161 (E.D. Mo. 1984) (when a forensic patient in a mental health facility became hostile and made threatening remarks to other patients, he was determined to pose a danger to others); Project Release v. Prevost, 551 F. Supp. 1298, 1309 (E.D.N.Y. 1982), aff'd, 722 F.2d 960 (2d Cir. 1983) (legitimate state interests including the patient's treatment needs and the safe and orderly operation of the institution supported a finding that the right to refuse treatment is not absolute); People v. Medina, 705 P.2d 961, 973-74 (Colo. 1985) (state must embellish the likelihood that the patient, due to his condition, will cause serious harm to himself or others in the institution, the fact that a patient may have been violent on some occasion in the past is not sufficient); Opinion of the Justices, 123 N.H. 296, 301, 465 A.2d 484, 489 (1983) (finding of probable cause for involuntary hospitalization "does not indicate that [a patient] will continue to present a threat to himself or others after he has been hospitalized"; such a threat would have allowed the hospital to utilize antipsychotic medication).
107. 720 F.2d 266 (3d Cir. 1983).
108. Id. at 269.
federal cases hold that a qualified constitutional right exists for competent, involuntary patients, and it is hoped that other courts will recognize that right. 109

3. The Least Restrictive Alternative Doctrine

The least restrictive alternative standard provides that if less restrictive means are available, which would accomplish the government's purpose in a manner that intrudes less on the fundamental right at issue, then the least restrictive alternative must be chosen. 110 Thus, in the context of an involuntarily committed patient's right to refuse antipsychotic medication, the existence of a less restrictive treatment 111 must be considered in order to determine whether the right to refuse such drugs overrides the state's interests and powers. 112 Under this standard, less intrusive therapies must be contemplated when a patient refuses antipsychotic drugs, before more intrusive means are administered.

In Rennie v. Klein 113 the Third Circuit was confronted with the issue of a mental patient's right to refuse antipsychotic drugs and the task of defining the scope of that right. 114 It concluded that a constitutional right exists "to be free from treatment that poses substantial risks to [one's] well being . . . " 115 Recognizing that such a right is not absolute, 116 but must be limited by legitimate governmental concerns, five members of the court concluded that the loss of liberty suffered by a patient forcibly medicated can-

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109. See infra notes 150-99 and accompanying text for a discussion of the federal right to refuse antipsychotic medication.
110. See Winick, supra note 72, at 16.
111. Alternative treatments that may be less detrimental or restrictive include smaller dosages, a different drug entirely, different therapy, or perhaps physical restraints such as a straight-jacket to prevent abusive patients from harming themselves or others. Rennie v. Klein, 653 F.2d 836, 847 (3d Cir. 1981). Various alternatives are available to psychiatrists when treating a mentally ill patient. These therapies include non-intrusive counseling or behavior modes, such as milieu therapy, psychotherapy and behavior modification. Note, Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients, 45 S. CAL. L. REV. 616, 619-33 (1972).
112. Comment, The Scope of the Involuntary Committed Mental Patient's Right to Refuse Treatment With Psychotropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine, 28 VILL. L. REV. 101, 129-30 (1982). The enforcement of the state's interest in these cases is manifested in the state's parens patriae and police power. Id. at 130.
113. 653 F.2d 836 (3d Cir. 1981).
114. Id. at 844-45.
115. Id.
116. Application of the principle does not demand "hourly or daily judicial oversight," but rather a "balance [struck] between efficiency and intrusiveness." Id. at 847. The court favored applying the principle to a treatment program rather than individual dosages of medication. Id. at 847-48.
not exceed that required by needed care or legitimate administrative concerns, and must be the "least intrusive infringement" available.\textsuperscript{117}

In \textit{Price v. Sheppard}\textsuperscript{118} the Minnesota Supreme Court applied the least restrictive alternative test and held that the court must determine the reasonableness and necessity of the proposed treatment before more intrusive forms of treatment, such as electroshock therapy or psychosurgery, may be administered to non-consenting patients.\textsuperscript{119} In \textit{Youngberg v. Romeo}\textsuperscript{120} the Third Circuit implemented the doctrine in the case of an institutionalized mentally retarded patient.\textsuperscript{121} The patient alleged that the hospital improperly shocked him, did not protect him from other dangerous residents, and afforded him inadequate treatment.\textsuperscript{122} The Third Circuit indicated that "[w]here the issue turns on which of two or more major treatment approaches is to be adopted, a 'least intrusive' analysis may well be appropriate."\textsuperscript{123} Recognizing that both the effectiveness of a course of treatment and its side effects must be considered, the court advised the State to err in favor of the patient's safety.\textsuperscript{124}

The applicability of the least restrictive alternative principle, in the context of the right to refuse antipsychotic medication, remains in doubt after \textit{Romeo}. However, where the intrusion is more serious than the short term use of physical restraints, the application of a less restrictive alternative is

\begin{footnotes}
\item \textsuperscript{117} \textit{Id.} at 845. The court defined the least intrusive means standard not as prohibiting all intrusions into a patient's personal liberty, but rather avoiding those intrusions "which are unnecessary or whose cost benefit ratios, weighed from the patient's standpoint, are unacceptable." \textit{Id.} at 847. The court found support for this standard in congressional and state legislation and in a decision by a federal court of appeals. \textit{Id.} at 846-47 n.13 (citing the Mental Health Systems Act, 42 U.S.C. \$ 9401-9503 (Supp. 1981); S. Rep. No. 712, 96th Cong., 2d Sess. 77, \textit{reprinted in} 1980 U.S. CODE CONG. & ADMIN. NEWS 3372, 3444); \textit{Rogers}, 634 F.2d 650.

\item \textsuperscript{118} \textit{Id.} at 250, 239 N.W.2d 905 (1976).

\item \textsuperscript{119} \textit{Id.} at 262-63, 239 N.W.2d at 913.

\item \textsuperscript{120} \textit{644 F.2d 147} (3d Cir. 1980), \textit{vacated and remanded}, 457 U.S. 307 (1982).

\item \textsuperscript{121} \textit{Id.} The Supreme Court did not expressly address the least restrictive alternative doctrine in its disposition of the case. \textit{Id.} at 313-14 n.14. Therefore, this Comment suggests that the Third Circuit's acceptance of the doctrine cannot be considered vacated.


\item \textit{Romeo}, 644 F.2d at 154-56. The patient suffered from physical attacks by other patients resulting in a broken arm, a fractured finger, and other injuries. \textit{Id.} at 155. The defendants kept plaintiff shackled to a bed or chair for long periods of time and failed to give him adequate medical attention after initiation of the suit. \textit{Id.}

\item \textit{Id.} at 166.

\item \textit{Id.} at 166 n.45.
\end{footnotes}
demanded.\textsuperscript{125} For example, in \textit{Winston v. Lee}\textsuperscript{126} the Supreme Court held that a proposed surgery to remove a bullet from a criminal suspect violated the fourth amendment’s ban on unreasonable searches and seizures.\textsuperscript{127} By applying a “compelling need” standard,\textsuperscript{128} the Court found the individual’s interest in maintaining “personal privacy and bodily integrity”\textsuperscript{129} outweighed the state’s interest in finding evidence of guilt, where the state had alternative means at its disposal to accomplish the desired end.\textsuperscript{130}

III. A CONSTITUTIONAL BASIS TO REFUSE ANTIPSYCHOTIC DRUGS

After experiencing little success with common law remedies, involuntarily committed patients began to challenge forcible medication on constitutional grounds. The United States Constitution and state constitutions are the most important bases for the right to refuse antipsychotic drugs. A growing body of case law recognizes that a qualified constitutional right to refuse intrusive mental health treatment is essential to an individual’s retention of personal liberty. Personal liberty is protected by a variety of constitutional guarantees: the first amendment’s protection of freedom of speech and free exercise of religion;\textsuperscript{131} the eighth amendment ban on cruel and unusual punishment;\textsuperscript{132} the right to privacy;\textsuperscript{133} and the fourteenth amendment limitations on the state’s power to deprive any person of life or liberty without due process of law.\textsuperscript{134} The foregoing are capable of limiting governmental imposition of unwanted therapy.

In the late 1970’s and early 1980’s, state district courts held that competent patients have a qualified right to refuse treatment with antipsychotic

\textsuperscript{125} It has been suggested that the reason the least restrictive alternative doctrine was not required in \textit{Romeo} was because of the temporary nature of the intrusion. The liberty in being free from restraints may not rise to the level of interest in being free from the binds of mental intrusions presented by antipsychotic drugs. \textit{See} Winick, \textit{supra} note 72, at 20. This is particularly worthy of extreme caution in light of the side effects of the drugs.

\textsuperscript{126} 470 U.S. 753 (1985).

\textsuperscript{127} \textit{Id.} at 767.

\textsuperscript{128} \textit{Id.} at 766.

\textsuperscript{129} \textit{Id.} at 764.

\textsuperscript{130} \textit{Id.}

\textsuperscript{131} The first amendment guarantees in part that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.” U.S. CONST. amend. I.

\textsuperscript{132} The eighth amendment guarantees that “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. CONST. amend. VIII.

\textsuperscript{133} \textit{See} Griswold v. Connecticut, 381 U.S. 479 (1965).

\textsuperscript{134} The fourteenth amendment reads in part “nor shall any State deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV.
drugs. The subsequent litigation in the courts of appeal modified and refined the substantive remedy, significantly limiting the basic right. In 1982 it was further limited by the Supreme Court. As a result, state courts have responded by instituting due process protection for the involuntarily committed competent mental patient. Now states must protect the rights of an incompetent patient.

A. The Eighth Amendment Is No Longer Applicable

Since many of the early decisions dealing with the right to refuse medication were based on criminal cases, the ban on cruel and unusual punishment provided the first real basis for challenging forcible medication. Problems arose when medication was given as punishment in response to belligerent or uncooperative behavior. An example of this was presented in Knecht v. Gillman, where the vomit-inducing drug apomorphine was given to patients for "not getting up, for giving cigarettes against orders, for


137. See, e.g., Goedecke v. State, 198 Colo. 407, 603 P.2d 123, 124 (1979) (Colorado due process clause prevented a patient who was not irrational or unreasonable in his refusal to submit to treatment with antipsychotic medication, from being forced to undergo treatment with drugs having serious deleterious side effects); In re Guardianship of Roe, 383 Mass. 415, 421 N.E.2d 40 (1981); Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986) (the right of a competent adult to refuse medical treatment was determined to be a fundamental common law right, coextensive with the patient's liberty interest protected by the due process clause of the New York Constitution); Jones v. Gerhardtstein, 141 Wis. 2d 710, 416 N.W.2d 883 (1987).


139. See Scott v. Plante, 532 F.2d 939, 946-47 (3d Cir. 1976); Nelson v. Heyne, 491 F.2d 352, 357 (7th Cir. 1974); Mackey v. ProCNier, 477 F.2d 877, 878 (9th Cir. 1973); Knecht v. Gillman, 488 F.2d 1136, 1140 (8th Cir. 1973); Welsch v. Likins, 373 F. Supp. 487, 503 (D. Minn. 1974) (court held a determination was to be made of whether particular practices and conditions violated a patient's right to treatment); Sawyer v. Sigler, 320 F. Supp. 690, 694 (D. Neb. 1970) (court held that the requirement by prison officials that a patient take his medication in crushed or liquid form, which would cause nausea, was sufficiently unusual and arbitrary to constitute both cruel and inhumane punishment). But see Osgood v. District of Columbia, 567 F. Supp. 1026, 1032-33 (D.D.C. 1983) (treatment does not inflict unnecessary or wanton pain); Rennie, 462 F. Supp. at 1143 (psychotropic drugs are effective and therapeutic and therefore are not punishment).

140. 488 F.2d 1136 (8th Cir. 1973).
talking, for swearing, or for lying."\textsuperscript{141} The Eighth Circuit Court of Appeals rejected the state's contention that the injection was "treatment" and held that such a practice constituted cruel and unusual punishment when administered without informed consent.\textsuperscript{142}

In 1976 the Supreme Court broadened the traditional eighth amendment concept of "punishment" in \textit{Estelle v. Gamble}.\textsuperscript{143} An inmate of a Texas state prison brought suit against prison officials for depriving him of medical treatment.\textsuperscript{144} The Supreme Court held that by ignoring the inmate's medical needs, the officials had violated the eighth amendment protection guarantee against infliction of pain.\textsuperscript{145} Thus, deprivation of treatment, or inaction, was considered to be an infliction of pain, and, therefore, punishment.\textsuperscript{146} Difficulty resulted when the eighth amendment was applied in the context of a mental hospital setting. As courts began to recognize a more human condition for mental health patients and hospitals improved the conditions for patients the connection between treatment and punishment became more strained, and eighth amendment challenges became less successful.\textsuperscript{147}

Using the eighth amendment as a basis for recovery created problems since institutions have an obligation to provide treatment. The problem intensified with evidence of the effectiveness of psychotropic drugs in treating psychoses.\textsuperscript{148} How could the patient claim an infliction of punishment when the institution was carrying out its duty to treat?\textsuperscript{149} Unless the unnecessary administration of drugs for punitive purposes can be demon-

\textsuperscript{141.} Id. at 1137.
\textsuperscript{142.} Id. at 1138-40. The Ninth Circuit Court of Appeals also applied the eighth amendment to ban the use of succinycholine which causes sensations of suffocation in prisoners as part of an adverse conditioning program in \textit{Mackey}, 477 F.2d at 877. Similarly, in \textit{Nelson}, 491 F.2d at 356, the Seventh Circuit held that antipsychotic drugs used in a juvenile correctional institution were not "part of an ongoing psychotherapeutic program, but for the purpose of controlling excited behavior." Id.
\textsuperscript{143.} 429 U.S. 97 (1976).
\textsuperscript{144.} Id.
\textsuperscript{145.} Id. at 103-04.
\textsuperscript{146.} Id. at 104-05. For an argument in favor of the eighth amendment as a measure to ensure committed patients the right to refuse medication, see Symonds, \textit{supra} note 22, at 717.
\textsuperscript{147.} Comment, \textit{supra} note 29, at 417. Because of the emerging right to treatment, mental hospitals were under an obligation to improve the institutional conditions. Therefore, a claim of cruel and unusual punishment was increasingly difficult to prove. Id. at 417 n.47. A patient had to prove that the treatment amounted to "indifference or intentional mistreatment," or that it was "sufficiently unusual, exceptional and arbitrary." \textit{Sawyer}, 320 F. Supp. at 694-96. Such a showing became impossible as the atmosphere in most institutions was improving.
\textsuperscript{148.} See \textit{supra} notes 26-28 and accompanying text for a discussion of the positive effects of antipsychotic drugs.
\textsuperscript{149.} Comment, \textit{supra} note 29, at 417-19.
strated, an eighth amendment basis for a right to refuse antipsychotic medication is difficult to establish. Therefore, patients challenging forcible medication must now premise their claim on the right to privacy as given by the fourth amendment and the first amendment, not the eighth amendment.

B. A Federal Constitutional Right to Refuse Antipsychotic Drugs Recognized Under the Right to Privacy and the First Amendment

Although earlier cases had suggested the existence of a constitutional right to refuse treatment in dictum and commentary, the first cases to actually recognize the right to refuse antipsychotic drugs as treatment were *Rennie v. Klein* in 1978 and *Rogers v. Okin* in 1979. While the results in the courts were the same, there are striking differences between the procedures for ensuring the right to refuse in *Rennie* and *Rogers*.


The federal district court in *Rennie* based a patient's right to refuse antipsychotic drugs on the individual's right to protect his mental processes from governmental intrusions and the right to bodily autonomy. In the absence of an emergency, the court found these rights to be protected by the constitutional right to privacy. John E. Rennie was a diagnosed paranoid schizophrenic whose behavior had been controlled by forcibly ad-

150. A right to refuse treatment has been advanced on a variety of constitutional grounds. See, e.g., *Scott*, 532 F.2d at 946-47 (forcible medication may violate first, eighth or fourteenth amendments); *Knecht*, 488 F.2d at 1139 (eighth amendment); *Mackey*, 477 F.2d at 878 (first or eighth amendment); *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir. 1971) (first amendment), cert. denied, 404 U.S. 985 (1971); *Souder v. McGuire*, 423 F. Supp. 830, 832 (M.D. Pa. 1976) (first or eighth amendment); *Kaimowitz v. Dept. of Mental Health*, Civ. No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973) (first amendment); Comment, *supra* note 74, at 1194-95 and n.12 (right to privacy); Note, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMP. L.Q. 354 (1975) (first and fourteenth amendment).

151. 462 F. Supp. 1131 (D.N.J. 1978). This case arose in New Jersey where the state superior court held that involuntarily committed mental patients had no right to refuse antipsychotic medication. *Id.* at 1145; *In re B.*, 156 N.J. Super. 231, 383 A.2d 760 (1977).


153. For the procedural safeguards set forth in *Rennie*, see *infra* notes 155-179 and accompanying text.

154. For the procedural safeguards set forth in *Rogers*, see *infra* notes 180-199 and accompanying text.


156. *Id.*
ministering a host of psychotropic, as well as antipsychotic, drugs. Suit was brought under the federal Civil Rights Act which prohibits governmental officials from interfering with the civil rights of citizens. Because the hospital was already administering the least restrictive alternative treatment, the district court denied Rennie's motion for a preliminary injunction.

After analyzing the constitutional issues, the district court found no violation of the eighth amendment and no violation of the first amendment's "freedom of expression." However, the constitutional right to privacy was considered broad enough to protect mental processes from governmental interference and to establish an individual's autonomy over his own body. Only where the state can show a "strong countervailing interest can the right to refuse to be qualified." The court also held that in the absence of an emergency, some form of a due process hearing is required prior to the forcible administration of drugs. The court further concluded that Mr. Rennie had received all the process to which he was due.

In a subsequent class action in Rennie, the district court repeated its holding that mental patients had a right to refuse antipsychotic drugs and granted a preliminary injunction that required a state hospital to hold hearings to determine whether patients may be medicated against their will.

157. Id. at 1135-40.
159. Id.
160. Rennie, 462 F. Supp. at 1146-47. Rennie's physician testified that the best treatment for him was both antipsychotic medication and lithium. Id. at 1140.
161. Id. at 1143. The court rejected Rennie's argument to enjoin the use of medication based on the eighth amendment ban on cruel and unusual punishment. The court noted that the use of drugs had been proven effective and that the staff had justifiably administered the drugs as treatment, not as a punishment. Id.
162. Id. Inclusive within the first amendment is both the right to think and to communicate. The court stated that since the side effects of the drugs were temporary, the dulling of the senses which the drugs caused did not rise to first amendment violations. Id. at 1143-44.
163. Id. at 1144 (citing Stanley v. Georgia, 397 U.S. 557, 565 (1969) and Mackey, 477 F.2d at 878).
164. Id.
165. Id. at 1147. The court set forth the factors which constitute due process: (1) patients must be informed and partake in the decision-making process regarding their treatment; (2) a lawyer must be present to assist patients; (3) an independent psychiatrist to evaluate the need for medication (a hospital-retained psychiatrist is not sufficient); (4) patient's lawyer and psychiatrist must have access to hospital records. Id. at 1147-48.
166. Id. at 1147. One author suggests that Judge Brotman believed that second opinions by qualified psychiatrists were necessary to improve the quality of care in state hospitals. The court was attempting to transform the right to refuse treatment into a right to assure proper and necessary treatment for involuntary mentally ill patients. See Stone, supra note 71, at 360.
The court broadened this right to include both voluntary and involuntary patients.\textsuperscript{168} Because the court recognized that the right to refuse was not absolute, Judge Brotman reiterated his earlier holding that the decision must be an individualized one based on several factors:

(1) The patient's physical threat to others;
(2) The capacity of the patient to decide on the particular treatment;
(3) The existence of any less restrictive alternatives; and
(4) The risk of permanent side effects on the patient.\textsuperscript{169}

Concentrating on procedural aspects, the court reasoned that a decision based on these factors would amount to an appropriate balancing of the risks and benefits of a proposed treatment.\textsuperscript{170}

The court next outlined minimum procedures that are required to protect a patient's constitutional rights. First, the state must provide a written consent form containing information on drugs and patient rights. Second, a state must implement a system of patient advocates, given the dual responsibility of representing patients at hearings and retaining independent psychiatrists to make the ultimate determination at those hearings. Next, an informal review by an independent psychiatrist is required before medication can be given to an involuntary patient. Finally, a state must enforce a voluntary patient's right to refuse treatment if necessary.\textsuperscript{171} Medication can only be given without consent in three circumstances: (1) When there is a sudden and significant change in the patient's condition which creates a danger to the patient or others; (2) When the involuntary patient is declared legally incompetent;\textsuperscript{172} or (3) When an involuntary patient is functionally incompetent.\textsuperscript{173} Any of these situations negates the necessity of a due process hearing.\textsuperscript{174}

\textsuperscript{168} \textit{Id.} at 1307.
\textsuperscript{169} \textit{Id.} at 1297 (citing \textit{Rennie}, 462 F. Supp. at 1145-48).
\textsuperscript{170} In the earlier case, an examination of these four factors indicated that an injunction should not be issued. The court found Mr. Rennie's capacity to be severely limited and that the present administration of thorazine was the least restrictive means of stabilizing his condition. \textit{Rennie}, 462 F. Supp. at 1151-53.
\textsuperscript{172} However, the court was careful to provide that when a decision to medicate an incompetent patient has been made, the decision must be referred to a patient advocate. That person is to assess the patient's feelings about the drug, its side effects, failure to consistently take medication and the use of force or threat by hospital staff to administer the drug. \textit{Id.} at 1314.
\textsuperscript{173} "Functionally incompetent" describes a person who is unable to provide knowledgeable consent to treatment. There has been no declaration of legal incompetence by a court for a functionally incompetent person. These cases must also be referred to a patient advocate to review the case. \textit{Id.}
\textsuperscript{174} \textit{Id.} at 1313-14.
In 1981 the United States Court of Appeals for the Third Circuit affirmed the district court’s holding in *Rennie*, agreeing that there is a right to refuse medication based on the due process clause of the fourteenth amendment.175 The court began its discussion by recognizing that “[t]he state cannot ignore due process and simply seize a person and administer drugs to him without his consent.”176 The court next emphasized the importance of this liberty interest as a right of “personal security” that could only be overcome by a compelling state purpose.177

The constitutional right to refuse antipsychotic drugs, as it survived the Third Circuit Court of Appeals, permitted refusal unless either of the following two situations occurred: (1) A physician certified that forcible medication was essential to prevent “serious consequences to a patient;” or (2) After completely discussing the patient’s treatment plan and an examination of that patient by the hospital director, the hospital decided the patient should be treated with antipsychotic drugs.178 Review by an independent psychiatrist was not necessary but could be ordered by the medical director at his or her discretion.179

2. *Rogers v. Okin*: A Right to Privacy and the First Amendment

In *Rogers v. Okin*,180 the district court in Massachusetts also held that patients had a right to refuse medication absent a medical emergency.181 The plaintiffs, who were voluntary and involuntary patients at the Boston State Hospital, challenged the policies of forcible medication in non-emergency circumstances in a class action182

The court first addressed the state’s contention that once a patient was admitted to an institution, he or she should not be considered competent to decide whether to receive treatment. The court held that unless and until there is an adjudication of incompetency, the presumption of competency prevails.183 The *Rogers* court based the right to refuse treatment on the constitutional right to privacy rooted in the first amendment.184

176. *Id.* at 843. The court noted that despite commitment, a patient still retains a “residuum of liberty” protected by the fourteenth amendment. *Id.* at 845.
177. *Id.* at 845.
178. *Id.* at 852-53.
179. *Id.* at 854.
181. *Id.* at 1367-68.
182. *Id.* at 1352. The plaintiffs also alleged forced involuntary seclusion; however, this issue is beyond the scope of this Comment and will not be discussed.
183. *Id.* at 1361.
184. *Id.* at 1366-67.
Unlike the Rennie decision, Rogers found a first amendment basis for the right to refuse antipsychotic drugs for involuntary patients.\(^{185}\) The court noted that the first amendment protects the communication of ideas\(^{186}\) and held that "[a]s a practical matter . . . the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection."\(^{187}\) Thus, the right to decide important matters pertaining to one's life is a basic right, necessarily entailing the decision whether to submit to the treatment with antipsychotic medication.\(^{188}\) The court did not hold this right to be absolute, but stated that in an emergency situation a patient may be forcibly medicated.\(^{189}\) Emergency was defined as a situation in which failure to forcibly medicate "would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution."\(^{190}\)

On appeal the district court held that a person has constitutionally protected bodily integrity and privacy interests in deciding whether to take antipsychotic drugs.\(^{191}\) The question of whether a first amendment basis for refusal of treatment existed was not dealt with on appeal since the First Circuit expressly declined to address the issue.\(^{192}\) The court did, however, take a more tolerant view of the state's interests in forcibly medicating

\(^{185}\) Id. The court also found the right to refuse for voluntary patients, but this Comment is narrowly focused on the involuntary patient's rights.

\(^{186}\) Id. at 1367.

\(^{187}\) Id. The court further wrote:

The right to produce a thought - or refuse to do so - is as important as the right protected in Roe v. Wade to give birth or abort. Implicit in an individual's right to choose either abortion or birth is an underlying right to think and decide. Without the capacity to think, we merely exist, not function. Realistically, the capacity to think and decide is a fundamental element of freedom. . . . Whatever powers the Constitution has granted our government, involuntary mind control is not one of them. . . . The fact that mind control takes place in a mental institution in the form of medically sound treatment of mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being.

\(^{188}\) Id. at 1367. This line of reasoning comports with other courts of appeals and federal district courts' decisions: Mackey, 477 F.2d at 878 (drug induced condition may constitute an impermissible interference with mental process); Kaimowitz, Civ. No. 73-19434-AW (psychosurgery impairs power to generate ideas thus violating the first amendment).

\(^{189}\) Rogers, 478 F. Supp. at 1365. The shortcoming of the court's treatment of this issue is its failure to outline procedures for determining an emergency situation. This apparently leaves the determination of whether to treat patients up to the physicians or hospital staff who may be very liberal in their interpretation of an "emergency." Id.

\(^{190}\) Id.

\(^{191}\) Rogers, 634 F.2d at 653.

\(^{192}\) Id. at 654 n.2.
mental patients. Although privacy interests were constitutionally protected, the First Circuit identified two state interests that can override the patient's right to privacy in the context of treatment refusal: (1) The *parens patriae* power in preventing a deterioration in the patient's mental condition; and (2) The police power in preventing harm to the patient or others. The court criticized the district court for its attempt to "fashion a single 'more-likely-than-not' standard" as a substitute for balancing these state interests against the varying interests of the patients. After weighing these factors, the First Circuit required a case by case balancing of the state's interest versus the patient's interest in bodily autonomy.

Perhaps the most blatant disregard for the interests of an incompetent patient was the court's holding that as a constitutional matter, a state is not required to seek guardian approval for decisions to treat incompetent patients with antipsychotic drugs. Denial of the right to a guardian suggests that an adjudication of incompetency automatically authorizes the administration of antipsychotic drugs, arguably a violation of due process.

C. *The Supreme Court Leaves Incompetent Patients Unprotected*

After two decades of avoiding constitutional issues of hospitalized mentally ill and mentally retarded patients, the Supreme Court granted certiorari in *Rennie*, *Rogers*, and a case involving the rights of the mentally

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193. *See Comment, supra* note 29, at 422.
195. *Id.* at 654-57. The court held that a state, under its police powers, may forcibly administer medication only upon a determination that "the need to prevent violence in a particular situation outweighs the possibility of harm to the medicated individual” and that “reasonable alternatives to the administration of antipsychotics must have been ruled out.” *Id.* at 656. On remand, the district court was left with the task of developing mechanisms to ensure that the staff decisions accorded adequate procedural protection to the "interests of the patients." *Id.*
196. *Id.* at 656-57.
197. *Id.* at 657.
198. *Id.* at 660-61. The court based its conclusion on the presumption that to require physicians to consult a guardian every time they choose to medicate would also lead to the opposite result: physicians would consult a guardian in every instance they chose not to treat with antipsychotics. *Id.* at 660 (emphasis added). The court further suggested that physicians would be deterred from recommending drug treatment due to the need to seek approval of a guardian. *Id.* at 660 n.9. The court readily admits that such a result is not certain to occur. *Id.* at 661. The following question necessarily arises: Why dismiss a right fundamental to due process for incompetent patients if the unsupported result created by the court is fiction? A much better system is that followed by the district court in granting a guardian to make those treatment decisions when a patient is declared incompetent. *Rogers,* 478 F. Supp. at 1364.
199. *See infra* notes 220-41 and accompanying text.
retarded, *Youngberg v. Romeo*. Because the Supreme Court did not decide the cases on their merits, the status of the federal right to refuse treatment after the disposition of these three cases remains uncertain.

1. *Youngberg v. Romeo*

Nicholas Romeo was a profoundly retarded, institutionalized adult with the mental capacity of an eighteen-month old child. Suit was brought on his behalf against officials at a Pennsylvania state institution for violating his constitutional rights to safe conditions of confinement, freedom from bodily confinement and minimal habilitation. The Supreme Court held that Romeo had substantive rights that were protected by the fourteenth amendment. These liberty interests include reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by those rights.

After having defined the substantive rights due Romeo, the Court considered the proper standard for determining whether a state has adequately protected the rights of an involuntarily committed mentally retarded individual. The Court utilized a professional judgment standard to determine whether a patient has been deprived of substantive rights. The Court reasoned that this standard adequately reflects the proper balance between the legitimate interests of the state and the rights of the patients. Under this standard the courts must show deference to the judgment exercised by a qualified professional, which is presumed to be valid.

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204. *Id.* at 310-11. Romeo had been injured on at least sixty-three occasions, restrained for long periods of time on a regular basis and lost some basic skills he had at the time of his admission. *Id.*

205. *Id.* at 314-19. Such substantive rights included the right to treatment while institutionalized and the corresponding affirmative duty on the part of the institution to provide such treatment. *Id.* at 317. However, this affirmative duty was seriously undermined in a recent Supreme Court decision. *DeShaney v. Winnebago County Dep't of Social Services*, 489 U.S. 189 (1989). The Court held that a physically abused child was not denied due process because the agency was not required by the due process clause to provide protective services. Justice Brennan argues in his dissent that in light of *DeShaney*, the personal liberty rights granted in *Romeo* are left unclear. *Id.* at 210-11.


207. *Id.* at 321. The Court added in a footnote, "[b]y 'professional' decision-maker, we mean a person competent, whether by education, training or experience, to make the particular decision at issue." *Id.* at 323 n.30.

208. *Id.* at 323.
Since *Romeo* considered a mentally retarded patient's rights, it is not clear whether *Romeo* is controlling over the issue of an involuntary mental patient's right to refuse treatment with antipsychotic drugs. However, in light of the fact that the Supreme Court vacated the *Rennie* decision, and remanded it for reconsideration due to *Romeo*, it appears that the decision by a professional to forcibly medicate a patient is also presumed to be valid.  

2. *Mills v. Rogers*

The Supreme Court left the question of the constitutional right of an involuntary patient to refuse antipsychotic medication undecided in *Mills v. Rogers*.  

While the case was pending, *In re Guardianship of Roe* was decided by the Massachusetts Supreme Court. It held that, absent an overwhelming state interest, a judicial determination is required before a non-institutionalized but mentally incompetent person can be forcibly medicated with antipsychotic drugs.  

*Roe* further held that a person does not forfeit his protected liberty interest by virtue of becoming incompetent, but is entitled to have his "substituted judgment" exercised on his behalf.

Justice Powell, writing for a unanimous Court in *Rogers*, indicated that the Massachusetts court, as a matter of state law, recognizes greater liberty...
interests than those protected by the United States Constitution. Further, the Court added this would require the Massachusetts court to grant greater protection to the liberty interests of a patient than the federal constitution's due process clause. Thus, the Supreme Court declined to resolve the constitutional issues raised in Rogers, vacating and remanding it until state law questions had been determined. After Rogers the ultimate fate of the right of patients to refuse antipsychotic drugs on a federal level is uncertain. Romeo articulated standards to deal with the profoundly mentally retarded in institutions and is arguably inapplicable to institutionalized patients who may be competent to make their own treatment decisions. However, because the Supreme Court vacated Rennie in light of Romeo, it is likely that the court will adopt a different standard for mental institutions. Since the Supreme Court uses the professional judgment standard for competent parties, it is improbable that it will afford greater liberty interests to an incompetent mentally ill patient refusing drugs. Thus, the incompetent patient's rights to due process may be denied.

IV. THE NEED FOR DUE PROCESS PROTECTION OF INCOMPETENT PATIENTS

It is well settled law that involuntarily committed individuals are constitutionally entitled to refuse antipsychotic medication when they have not been declared incompetent to refuse such drugs, nor pose immediate danger to themselves or others. However, the Supreme Court, as well as many state courts, is silent concerning procedural safeguards for an incompetent patient. Once the decision to administer antipsychotic drugs has been made, the incompetent patient is forcibly medicated regardless of his or her

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216. Rogers, 457 U.S. at 303.
217. Id.
218. Id. at 306. The case was remanded to the Massachusetts Supreme Court to settle state law issues. 390 Mass. 489, 458 N.E.2d 308 (1983). Thereafter, the First Circuit held that Massachusetts' procedural rules regarding forcible medication created federally protected liberty interests under the due process clause because they "rise well above the minima required by any arguable due process standard." Rogers v. Okin, 738 F.2d 1, 8 (1984). The procedural due process protection in Massachusetts are as follows: (1) A requirement of a judicial decision-maker; (2) Adversary proceedings; and (3) Detailed regulations governing the use of chemical restraints. Id. at 7.
219. This is not the case with mentally ill prisoners. In Washington v. Harper, — U.S. —, 110 S. Ct. 1028 (1990), the Supreme Court upheld the prison policy of administering medication to a competent, nonconsenting inmate only if, in a judicial hearing at which the inmate had procedural protections, the State could prove that it was necessary for furthering a compelling state interest. The state interest in this case was to prevent a mentally ill inmate from endangering himself or others. Id. at 1038-39.
220. See Note, supra note 8, at 1735.
refusals. There is a need to monitor the drug administration and a need to review the physician’s initial decision to medicate. The argument does not center around the question of whether incompetent patients have a right to refuse antipsychotic drugs, because they cannot give informed consent to waive treatment. Rather, the courts and legislature should devise a due process procedure whereby incompetent, involuntary mentally ill patients are guaranteed dignity and liberty.

The first issue that must be examined is whether the liberty interest of an incompetent patient is recognized under the Constitution. Second, if such an interest is constitutionally recognized, it is necessary to analyze the procedural safeguards available to protect a patient’s interest from bodily intrusion. Finally, this Comment suggests various proposals for the administration of due process once the patient has been found incompetent.

A. The Personal Liberty Interests of an Incompetent Patient Deserve Recognition

There exist legitimate governmental concerns to justify treating the mentally ill differently from mentally healthy individuals with respect to treatment decisions. However, the distinctions between mentally ill patients are less certain concerning the interests accorded competent and incompetent patients. For instance, federal courts have recognized inherent liberty interests of a competent patient and have found a right to refuse antipsychotic drugs absent an emergency. Because federal courts have limited the right to refuse antipsychotic drugs to competent patients, it can be implied that the liberty afforded to incompetent individuals is subject to limitation. While incompetent patients are denied the right to partake in the medical decision-making process on the federal level, the federal courts need to recognize the liberty interests of such persons by assuring the proper administration of drugs.

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221. An incompetent person is incapable of exercising informed consent. See supra notes 44-59 and accompanying text.

222. For example, Wisconsin appoints guardians for non-institutionalized persons who are declared incompetent to consent to psychotropic medication. Wis. Stat. §§ 880.33(4m), 880.01(7m) (1987-88). While this is a step toward securing liberty for incompetent patients, more legislation is needed to protect institutionalized, incompetent mental patients’ liberty from careless drug administration.

223. The state’s police power and parens patriae provide justification for forcible medication of individuals in certain circumstances. See supra notes 84-109 and accompanying text.


225. The state court in Rogers recognized the right for incompetent patients to refuse antipsychotic drugs. "The recognition of that right must extend to the case of an incompetent, as
One argument asserted to defeat an incompetent patient's liberty interests is that such person lacks an appreciation of his or her actions and as a result, society should be less concerned about protecting that individual's liberty. This argument fails for two reasons. First, nothing suggests that because a person cannot articulate the advantages and disadvantages of a proposed treatment plan the or she does not value and appreciate their freedom from antipsychotic drugs. Second, measuring the entitlement to personal liberty based on an individual's level of functioning would entail difficult decisions regarding the weight and merits of the liberty interests of competent and incompetent patients.\footnote{226}

Another argument propounded to justify limiting an incompetent patient's liberty interest is that procedural safeguards would constitute too great an intrusion on the medical profession. Society hesitates to burden the medical profession with rules, fearing that to do so will disserve the patient's best interests. However, the medical practice is already subject to outside constraints, such as the requirement of informed consent before certain medical procedures can be carried out.\footnote{227} Since incompetent patients are incapable of giving informed consent, the argument for alternative safeguards to guarantee the protection of their liberty interests is heightened. The methods set forth below need not excessively intrude upon the psychiatrist's judgment, rather, they will monitor it.

\section*{B. The Need for a Temporary Guardian for Incompetent Patients}

The Constitution requires that no individual be singled out for a deprivation of a constitutional liberty without due process.\footnote{228} If the forcible administration of drugs to mentally incompetent individuals is to receive judicial sanction, the court should require more than a physician's professional judgment. A strong due process argument can be made that an adjudication of incompetency should not automatically authorize the administration of antipsychotic drugs, but, instead, should transfer decision-making authority to a guardian.\footnote{229}

\footnotesize{well as a competent, patient because the value of human dignity extends to both...” Rogers v. Comm’r of Dept. of Mental Health, 390 Mass. 489, 499-500, 458 N.E.2d 308, 315 (1983) (quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 745-46, 370 N.E.2d 417, 427 (1977)). This Comment argues that this standard ought to be recognized on a federal level. 226. Saks, The Use of Mechanical Restraints in Psychiatric Hospitals, 95 YALE L.J. 1836, 1849 (1986). In O’Connor v. Donaldson, 422 U.S. 563 (1975), the Court rejected the argument that the liberty of mentally ill people is any less valuable than that of others in society. Id. at 575. 227. Saks, supra note 226, at 1849. 228. “No State shall... deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, § 1. 229. See Zander, supra note 36, at 72.}
The professional judgment standard articulated in *Romeo* should not be presumed valid in mentally incompetent patient's cases for two reasons. First, the professional judgment standard did not directly apply to an involuntarily committed mentally ill patient, but rather to a mentally retarded individual. Second, although professional judgment is necessary in every medical decision, presuming it to be valid does not adequately protect the liberty interests of an incompetent patient. A guardian would better secure due process protection for the incompetent patient refusing antipsychotic drugs.

The professional judgment standard of *Romeo* was developed to balance the state’s interests and a mentally retarded individual’s interest in proper institutional care. In *Romeo* the patient was faced with the concern of poor institutional conditions. However, in the case of a mentally ill patient, the concern is the forcible use of intrusive antipsychotic drugs. Because mental retardation differs greatly from a mental illness such as schizophrenia, insofar as the latter is not always permanent, professional judgment should not be presumed valid for mentally ill patients. Furthermore, a psychiatrist may or may not look to alternative treatments if he or she knows the choice of antipsychotic treatment will be presumed valid.

Guardianship offers better procedural due process protection than the professional judgment standard. Regardless of the guardianship’s particular form, due process is its historical and theoretical foundation. A patient must be declared incompetent before the court may authorize a guardian to act. Although guardians are appointed for incompetent patients to manage their affairs, presently there is no federal mandate to appoint guardians for incompetent patients refusing antipsychotic drugs.

231. Id.
232. Procedural due process guarantees that each individual shall be accorded a certain process if they are deprived of life, liberty, or property. For a general discussion of procedural due process, see J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 7, at 451-72.
233. There are four basic types of guardianship arrangements. The first is plenary guardianship which involves the entire set of decision-making rights that can be implicated by an incompetency adjudication. Secondly, guardianship of the estate involves those rights dealing with an incompetent’s financial and property interests. Next, guardianship of the person involves the remaining interests having to do with personal decision-making. The final type, limited guardianship, is a modern convention that individualizes the decision-making structure to the needs of the individual; only decisions affected by the person’s incompetence are made part of the guardianship order. Parry, *Selected Recommendations From the National Guardianship Symposium At Wingpread*, 12 MENTAL & PHYSICAL DISABILITY L. REP. 398, 399 (1988). For purposes of this Comment, when referring to guardianship, limited guardianship will be the type implied.
234. Id. at 398.
235. Id.
Incompetent patients desperately need a guardian to act as a shield against imprudent decisions by psychiatrists. The physician's role in the treatment of competent patients is merely to provide medical information, which a patient has a right to act upon. That function should not be accorded presumptive validity based on the patient's incompetent status.\(^{236}\)

The state may argue that by holding medical decisions "presumptively valid"\(^{237}\) the institutions will be spared a long, arduous, and costly process. However, speedy adjudication should not be the only goal of judicial reasoning. Rather, adequate protection of the valid liberty interest in being free from unnecessary antipsychotic medication should be given equal consideration. By forcibly medicating an incompetent patient, absent review of that decision and without a guardian to assure proper administration of the drug, the patient's procedural due process rights are violated.\(^{238}\)

C. Proposals to Ensure Procedural Due Process Protection for Incompetent Patients

Thus far, this Comment has suggested that the court should appoint a guardian which would allow the incompetent patient to properly exercise his or her right of self-determination. The following sections outline procedures that will safeguard an incompetent patient's liberty interests.

1. Separate Competency Hearing at the Time of Refusal

Because the patient's level of competency may change from the time of the commitment hearing to the time when antipsychotic medication is prescribed, a separate competency hearing should be held to determine if the patient could exercise informed consent and legally refuse treatment at that time. The danger in foregoing a separate hearing is that the time span between the initial commitment hearing and the decision to medicate may be too great. To be accurate, competency should be measured at the time the decision to administer antipsychotic drugs is made.\(^{239}\)

2. Review the Decision to Administer Antipsychotic Drugs

Since antipsychotic drugs carry with them potentially dangerous side effects, every decision to administer this type of drug needs review by a


\(^{237}\) Romeo, 457 U.S. at 323.

\(^{238}\) The suggested duties of a guardian to ensure adequate due process is discussed infra notes 240-41 and accompanying text.

\(^{239}\) See Parry, supra note 48, at 35.
physician outside the mental health facility. Although this may seem like a clinical impracticability, the guardian could secure the second opinion, thus alleviating the burden on the attending physician. Anything less than a review of this nature compromises the incompetent patient’s due process interests by presuming that antipsychotic drugs best treat the illness.

If the second physician suggests alternative treatment plans, the guardian would be required to exhaust all least restrictive alternatives. On the other hand, if antipsychotic drugs are found to be the desired course of treatment, the guardian would be delegated the following responsibilities: (1) Monitor the dosage and reduce if necessary; (2) Observe patient for signs of tardive dyskinesia and either substitute with another drug, or terminate treatment completely; and (3) Demand timely check-ups by the attending physician to evaluate treatment progression. Strict adherence to the preceding guidelines will ensure the patient’s guarantee of self-determination to the greatest extent possible.

3. Substitute Decision-Making

The modern trend with respect to the guardian’s role is that of substitute decision-making. It guides the court and guardian by the values and choices the incompetent person would have made had he or she been competent. This standard determines a course of treatment according to the best interests of the patient.

One final point regarding the decision-making authority of a guardian needs to be addressed. The courts must institute a process whereby guardianship can be limited or terminated if the above proposals are not followed. While this may overburden the courts, this final proposal is the only way to protect an incompetent patient from arbitrary decision-making by a physician or a guardian.

V. CONCLUSION

The right to refuse antipsychotic medication is an essential civil liberty for thousands of institutionalized mental patients throughout the country. These drugs are highly intrusive and often cause serious and sometimes irreversible side effects. Because an incompetent patient is unable to make

240. For a discussion of the least restrictive alternative doctrine see supra notes 110-30 and accompanying text.

241. In July 1988, the American Bar Association’s Commission on the Mentally Disabled and Legal Problems of the Elderly held a National Guardianship Symposium. The purpose of the symposium was to draft recommendations for reforming the due process and monitoring failures in 2,200 guardianships nationwide. Parry, supra note 233, at 398.
treatment decisions, that patient's right to control his or her own treatment decision should also include access to a guardian who would make decisions concerning medication.

The decisions in *Rennie, Rogers,* and *Romeo* obscure the real nature of the drug issue and yield too much discretion to medical professionals. There is evidence to suggest an excess in prescribing antipsychotic medication within mental institutions. In addition, the courts have propounded a belief that decisions made by the professionals will, necessarily, produce decisions consonant with constitutional values such as procedural due process. Until the use of antipsychotic medication can be replaced with an equally effective mode of treatment without the debilitating side effects, both psychiatry and law must deal with the difficulty of weighing the patient's right to refuse against the state's desire to do what is best for its citizens. During this balancing process, it is imperative that the personal liberty rights of incompetent mentally ill citizens are especially safeguarded.

The appointment of a guardian can serve as an important instrument for patients and advocates of mental patients' rights working to restore to such patients the due process protection by avoiding the inescapable effects of antipsychotic drugs. Such due process protection should be considered a basic personal liberty interest and fundamental concept of human dignity and should no longer be denied to incompetent patients. Although the law cannot cure mental illness, it can prevent the unnecessary imposition of intrusive drugs and give credence to the patient's best interests and due process rights.

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