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NOTE

Constitutional Law—*Rennie v. Klein*: Constitutional Right of Privacy Protects A Mental Patient's Refusal of Psychotropic Medication

Involuntarily committed mental patients have been subjected to a wide variety of organic therapies,¹ ranging in intrusiveness² from minor tranquilizers to psychosurgery.³ Until very recently, mental institutions and their psychiatrists were permitted virtually unlimited authority to impose any of these treatments on unconsenting patients. A growing recognition of mental patients' rights has caused some legislatures and courts to take tentative steps to curb psychiatric discretion. Several states have enacted legislation⁴ restricting the use of electroconvulsive therapy,⁵ psychosurgery,⁶ and other "extreme" forms of treatment.⁷ In

1. "Organic therapies" are "procedures which affect or alter through electrochemical or surgical means a person's thought patterns, sensations, feelings, perceptions, . . . or mental activity generally" or "conditioning techniques using the effects of electrical or chemical intervention into mental functioning as part of the conditioning program." Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CALIF. L. REV. 237, 244 n.8 (1974).

2. It has been suggested that the "intrusiveness" of a therapy or program is a function of the following criteria: (1) the extent to which the effects of the therapy are reversible; (2) the extent to which the resulting psychic state is "foreign" to the subject, rather than simply a restoration of his prior psychic state; (3) the rapidity with which the effects occur; (4) the scope of the change in the total "ecology" of the mind's functions; (5) the extent to which one can resist acting in ways impelled by the psychic effects of the therapy; (6) the duration of the change. *Id.* at 262.

3. See Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 465-82 (1977). See also Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CALIF. L. REV. 616 (1972).

4. For a comprehensive statutory survey, see Plotkin, *supra* note 3, at 504 app. The inadequacies of existing regulatory schemes are discussed in *id.* at 498-500.

5. See, e.g., CAL. WELF. & INST. CODE §§ 5325(f), 5326.7-.95 (West Cum. Supp. 1979); N.J. STAT. ANN. § 30:4-24.2(d)(2) (West Cum. Supp. 1978); N.C. GEN. STAT. § 122-55.6 (Cum. Supp. 1978). See generally Note, *Regulation of Electroconvulsive Therapy*, 75 MICH. L. REV. 363 (1976).

6. See, e.g., CAL. WELF. & INST. CODE §§ 5325(g), 5326.6 (West Cum. Supp. 1979); N.J. STAT. ANN. § 30:4-24.2(d)(2) (West Cum. Supp. 1978); N.C. GEN. STAT. § 122-55.6 (1974); OR. REV. STAT. §§ 426.385(2), 426.700-.760 (1977).

7. See, e.g., MONT. REV. CODES ANN. § 38-1322 (Cum. Supp. 1977) (prohibits subjecting patients to "lobotomy, adverse [sic] reinforcement conditioning, or other unusual or hazardous treatment procedures without their express and informed consent"); VA. CODE § 37.1-84.1(5) (1976) (confers right to impartial review prior to implementation of "hazardous treatment or irreversible surgical procedures").

In early 1978, the California Assembly passed a bill providing that "voluntarily admitted mental patients shall have the right, except in emergencies, to refuse treatment with psychotropic drugs." The bill failed to pass the State Senate. See Flynn, *Psychotropic Drugs and Informed Consent: A Report from California*, 30 HOSPITAL & COMMUNITY PSYCH. 51 (1979).

the absence of statutory protection, courts have adumbrated a right to refuse treatment based on either common-law or constitutional grounds.⁸ Most cases supporting a right to refuse treatment for mental patients have concerned "therapies" that were highly intrusive and experimental or punitive in nature.⁹ In *Rennie v. Klein*,¹⁰ however, the federal district court in New Jersey was presented with a mental patient's refusal of psychotropic¹¹ medication, the "conventional" treatment for his diagnosed disorder. The court held that mental patients have, in the absence of an emergency, a right to refuse treatment, including drug therapy, which is founded on the constitutional right of privacy.¹²

Plaintiff John E. Rennie, a "highly intelligent" middle-aged man, was first admitted to Ancora Psychiatric Hospital, a New Jersey state institution, in 1973. Depressed and suicidal, he was diagnosed as a paranoid schizophrenic, treated with an antipsychotic drug and released. During the next three years, Rennie was readmitted eleven times, sometimes voluntarily, sometimes under compulsion. His behavior during confinement was erratic: he was alternately depressed and suicidal, then manic and homicidal. At various times hospital psychiatrists tried both anti-psychotic medication and lithium, a drug used in the treatment of mania. Rennie sometimes refused to take the prescribed medication; at other times, he cooperated.¹³

Rennie's most recent and lengthy stay was initiated through an involuntary commitment proceeding in August 1976.¹⁴ In early December 1977, the hospital staff had concluded that Rennie was highly homicidal, and that his general condition was deteriorating. A decision was made to administer psychotropic medication without his consent.¹⁵

8. See notes 50-54 and accompanying text *infra*.

9. See notes 57-59 and accompanying text *infra*.

10. 462 F. Supp. 1131 (D.N.J. 1978).

11. "Psychotropic" is a general term describing drugs affecting the mind, behavior, intellectual functions, perception, moods and emotion. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 AM. B. FOUNDATION RESEARCH J. 769, 771 n.8. The court in *Rennie* used the term to refer to a particular class of psychotropic drugs: those used to treat schizophrenia and related psychoses. 462 F. Supp. at 1134-36, 1139. It is more accurate to refer to drugs in this group as "antipsychotics" or "neuroleptics." See Winick, *supra*, at 779-84. See also S. HALLECK, *THE TREATMENT OF EMOTIONAL DISORDERS* 193-210 (1978). The more precise terminology will be used in this Note, where appropriate.

12. The court also declared that, absent an emergency, some due process hearing is constitutionally required prior to the forced administration of medication. See note 39 *infra*.

13. 462 F. Supp. at 1135-36.

14. *Id.* at 1136.

15. After meeting with Rennie's treatment team, the Medical Director of Ancora sought and received permission from the Attorney General's Office to forcibly treat the patient. *Id.* at 1139.

The purpose was to prevent Rennie from harming other patients, staff, and himself and to "ameliorate his delusional thinking pattern."¹⁶ Two weeks after a prolixin¹⁷ regimen was initiated, Rennie filed a motion for a preliminary injunction to prevent defendant psychiatrists and hospital officials from forcibly administering drugs to him in the absence of an emergency.¹⁸ The complaint was grounded on section 1983 of the Civil Rights Act.¹⁹

The court conducted fourteen days of hearings, during which both parties presented extensive,²⁰ and frequently conflicting,²¹ psychiatric testimony. The court made the following findings of fact: (1) "[P]sychotropic²² drugs are widely accepted in current psychiatric practice. . . . They are the treatment of choice for schizophrenics today."²³

The hospital's caution was apparently inspired by the prior involvement of the Public Advocate's Office in Rennie's case. *Id.* at 1136.

16. *Id.* at 1139.

17. Prolixin is the brand name for the generic fluphenazine, a psychotropic drug belonging to the phenothiazine family of neuroleptics. S. HALLECK, *supra* note 11, at 195 (Table 1). The drug is available in oral or injectable forms. Two of the injectable compounds, fluphenazine enanthate and fluphenazine decanoate, are effective for an extended duration, sometimes as long as six weeks. "Because of their prolonged effects, the enanthate and the decanoate forms are primarily used in treating chronic patients unwilling or unable to take regular oral medication." *Id.* at 198-99. See generally Zander, *Prolixin Decanoate: Big Brother by Injection?*, 5 J. PSYCH. & L. 55 (1977).

18. 462 F. Supp. at 1134.

19. 42 U.S.C. § 1983 (1976).

20. Testimony was taken from three Ancora psychiatrists, the Director of the State Division of Mental Health and Hospitals, three psychiatrists from outside the state system produced by plaintiff, and two outside psychiatrists produced by defendant. 462 F. Supp. at 1134.

21. On the threshold issue of the patient's diagnosis, disagreement among the experts was particularly intense. The court summarized the testimony as follows:

Drs. Heller [defendant's outside consultant] and Bugoan [hospital psychiatrist] believe plaintiff is schizophrenic. . . . Drs. Ortanez and Pepernik [hospital psychiatrists] give a diagnosis of schizophrenia, affective type. . . . Ortanez agrees that plaintiff has also shown a manic depression symptoms [*sic*] at times. . . . Dr. Stinnett [defendant's most prestigious outside consultant] diagnoses plaintiff as manic depressive, but offers schizoaffective disorder as a possible alternative diagnosis. . . . Finally, Drs. Limoges and Pepper [plaintiff's psychiatrists] feel that plaintiff suffers only from manic depression.

Id. at 1139.

On the unreliability of psychiatric diagnosis, see Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). See also O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring) ("There can be little responsible debate regarding 'the uncertainty of diagnosis in this field and the tentativeness of professional judgment.'" (citing Greenwood v. United States, 350 U.S. 366, 375 (1956)).

22. Note that here, and in the other findings of fact, the court is using the general term "psychotropics" to refer to antipsychotic drugs, a particular class of psychotropics. See note 11 *supra*.

23. 462 F. Supp. at 1137. *Accord*, P. MAY, TREATMENT OF SCHIZOPHRENIA 258 (1968); Winick, *supra* note 11, at 780-81. *Cf.* S. HALLECK, *supra* note 11, at 183 (antipsychotic drugs are the preferred biological treatment under carefully delineated circumstances); DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the*

(2) "[A]ll of the psychotropic drugs cause dysfunctions of the central nervous system . . . as well as other side effects. . . . A potential permanent side effect of prolixin and other antipsychotic medication is tardive dyskinesia."²⁴ (3) "Plaintiff is acutely psychotic at times."²⁵ Aside from [plaintiff's] adverse reaction to psychotropics, the best course of treatment . . . would combine psychotropic medication with lithium and an antidepressant. However, the position that he has no fixed delusions, thus making use of a psychotropic unnecessary, is, at the least, a reasonable proposition."²⁶ (4) Rennie suffers from many of the side effects associated with psychotropic medication, including preliminary symptoms "possibly indicative that tardive dyskinesia may develop if medication is continued."²⁷ (5) "[P]sychotropic drugs are less efficacious in a hostile or negative environment."²⁸ (6) Rennie's refusal of prolixin is "not a product of his mental disorder."²⁹

The language of the New Jersey statutes, as interpreted in a recent state court decision,³⁰ implicitly denied the right of an involuntarily confined mental patient to refuse medication.³¹ Thus plaintiff's section

Patient Justify Involuntary Treatment?, 60 MINN. L. REV. 1149 (1976) (benefits of treatment have been overstated; hazards have been disregarded).

24. 462 F. Supp. at 1137-38. For a description of the side effects of antipsychotic drugs, including tardive dyskinesia, see text accompanying notes 92-97 *infra*.

25. 462 F. Supp. at 1140.

26. *Id.* The court had earlier found that lithium carbonate, in conjunction with an antidepressant, is the preferred treatment for bipolar manic depression. *Id.* at 1138. *Accord*, L. GOODMAN & A. GILMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* (5th ed. 1975); S. HALLECK, *supra* note 11, at 217-21. Rennie's condition was diagnosed as manic depression by several of the examining psychiatrists. See note 21 *supra*.

27. 462 F. Supp. at 1140-41. The court noted the following side effects experienced by the plaintiff: blurred vision, dry mouth, decreased blood pressure, uncontrollable tremors, involuntary wormlike movements of the tongue. The latter dysfunction is associated with tardive dyskinesia.

28. *Id.* at 1141. *Accord*, O'Connor v. Donaldson, 422 U.S. 563, 579 (1975) (Burger, C.J., concurring).

29. 462 F. Supp. at 1141. Psychiatric testimony on this question was conflicting. The court's summary reflects the difficulty of the capacity issue:

John Rennie's psychiatric problems are of a cyclical nature, so that on some days he is psychotic. Dr. Pepper [plaintiff's expert] testified that plaintiff's refusal of prolixin is not a product of his mental disorder. . . . However, Dr. Stinnett [defendant's expert] found that during his examination on February 25, 1978, Mr. Rennie was not capable of making a decision on treatment in his best interests. . . . The court feels that Dr. Pepernik's [*sic*] assessment is most accurate, and that Mr. Rennie's wishes should be taken into account on any treatment decision. But the court finds that his capacity to participate in the refusal of medicine or the choice of medicine is somewhat limited, depending on the day.

Id. (citations omitted).

30. *In re Hospitalization of B.*, 156 N.J. Super. 231, 383 A.2d 760 (1977).

31. The 1975 amendments to the civil commitment statute include an enumeration of the rights of mental patients. One provision specifically regulates the use of drugs:

Each patient in treatment shall have the following rights . . . :

1983 action was premised on the unconstitutionality of the state scheme. The court considered three substantive rights under the United States Constitution allegedly violated by New Jersey's system of coercive drug treatment: a right to be free from cruel and unusual punishment under the eighth amendment; a right to freedom of thought and expression under the first amendment; and a right to privacy. In the circumstances of the case before it, the court found that forced medication would not infringe Rennie's eighth³² or first amendment³³ rights. The court did find, however, that the right to privacy protected his refusal of medication, in the absence of an emergency.³⁴

The court noted that "[t]he constitutional right to refuse treatment cannot be absolute."³⁵ In appropriate circumstances, the state's interest

(1) To be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. . . . Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. Voluntarily committed patients shall have the right to refuse medication.

N.J. STAT. ANN. § 30.4-24.2(d) (West Cum. Supp. 1978). The New Jersey Superior Court interpreted the last sentence to mean, by clear implication, that "[i]nvoluntarily committed patients . . . do not have the right to refuse medication." *In re Hospitalization of B.*, 156 N.J. Super. 231, 236, 383 A.2d 760, 763 (1977).

32. Rennie's eighth amendment claim failed because defendants were able to show that prolixin, a drug of proven effectiveness, was "an integral component of an overall treatment program. While the side effects of prolixin are serious, they are not *unnecessarily* harsh in light of the potential benefits Prolixin was justifiably administered as treatment, not punishment." 462 F. Supp. at 1143. The court distinguished this case from those that involved drugs with no proven therapeutic value and unnecessarily harsh side effects, *e.g.*, *Knecht v. Gillman*, 488 F.2d 1136, 1138, 1140 (8th Cir. 1973) (apomorphine), and those in which drugs were used for punitive rather than therapeutic purposes, *e.g.*, *Nelson v. Heyne*, 491 F.2d 352, 356-57 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974); *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976). *Cf.* *Welsch v. Likins*, 373 F. Supp. 487, 503 (D. Minn. 1974) (excessive use of tranquilizing medication as a means of controlling behavior, not mainly as a part of therapy, may be eighth amendment violation).

33. The court found no evidence that the hospital administered the drugs in order to suppress statements critical of the institution. Nor did the court consider the alleged interference with Rennie's thought processes and freedom to generate ideas a first amendment violation. Rennie's ability to perform on intelligence tests was unimpaired even though he complained that prolixin dulled his senses and made it difficult for him to speak. The court contrasted these temporary but relatively minor complications with the drastic effects of psychosurgery. 462 F. Supp. at 1143-44.

34. *Id.* at 1144-45. "Emergency" was not defined in the original opinion. In response to requests by both parties, the court explained the concept in a supplemental opinion.

Emergency signifies a sudden, significant change in the plaintiff's condition which creates danger to the patient himself or to others in the hospital. While restraints can always eliminate this danger, . . . this is a realistic alternative only if a few hours' confinement are adequate to calm the plaintiff. Otherwise the hospital is not required to place the plaintiff in permanent restraints rather than medicate.

If normal administrative channels fail to provide the plaintiff relief, he may, after 72 hours, seek a temporary restraining order to halt the forcible medication. After the restraining order is issued, the court will immediately schedule a preliminary injunction hearing. *Id.* at 1154 (citations omitted).

35. *Id.* at 1145.

in treatment will override the patient's right to refuse medication. The court listed a number of factors relevant to the inquiry. First, the state's police power may justify forcible treatment when a failure to treat would endanger other patients and staff.³⁶ Second, if, after a hearing, the patient is found to be incompetent to make a decision about treatment, the state may use its *parens patriae* authority as a basis for medication.³⁷ Third, the court should consider whether any less intrusive treatment methods are available.³⁸ Fourth, the court must weigh the risks of permanent side effects from the proposed treatment.³⁹

In holding that a mental patient has a constitutional right, in the absence of an emergency, to refuse psychotropic medication, the *Rennie* court moved beyond established precedent. Yet the decision follows logically from the emerging right of privacy recognized by courts and commentators. The privacy right protects bodily as well as mental autonomy, both of which are infringed by the state's forcible administration of psychotropic drugs.

The right to bodily autonomy is perhaps the core of the privacy concept.⁴⁰ Nonconsensual touching of the body has long been a tort at common law.⁴¹ Further, the Supreme Court has indicated that the fourth and fourteenth amendments may prohibit unwarranted bodily intrusions by the state.⁴² The Constitution, however, does more than shield the person from physical invasions; it affirmatively protects the individual's right to make fundamental decisions about his or her body,

36. *Id.*

37. *Id.* at 1145-46.

38. *Id.* at 1146-47.

39. *Id.*

In dictum, the court found merit in plaintiff's due process challenge to the state's procedures for forcible medication, and specified that before coercive drug treatment is initiated, the state provide "some due process hearing." At this hearing, "patients must be informed of and participate in the decision-making aspects of their treatment"; patients are entitled to the assistance of a lawyer and an independent psychiatrist, which the state must provide if the patient cannot afford them; and the patient's lawyer and psychiatrist must have access to hospital records. *Id.* at 1147-48.

40. See Gerety, *Redefining Privacy*, 12 HARV. C.R.-C.L. L. REV. 233, 263-66 (1977).

41. W. PROSSER, HANDBOOK OF THE LAW OF TORTS 34-37 (4th ed. 1971).

42. *Terry v. Ohio*, 392 U.S. 1, 9 (1968) (stop and frisk) (quoting *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) ("No 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."); *Schmerber v. California*, 384 U.S. 757, 772 (1966) (blood sample) ("The integrity of an individual's person is a cherished value of our society."); see also *Breithaupt v. Abram*, 352 U.S. 432, 442, 443-44 (1957) (blood sample) (Warren, C.J., dissenting; Douglas, J., dissenting); *Rochin v. California*, 342 U.S. 165, 172 (1952) (forcible administration of emetic).

without state interference. The Supreme Court, in *Griswold v. Connecticut*,⁴³ thus held that a constitutional right of privacy prevents the state from interfering with a married couple's decision to use contraceptives. In *Eisenstadt v. Baird*, the Court extended *Griswold's* protection to the unmarried.⁴⁴ Then, in *Roe v. Wade*, the Court proclaimed that the "right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."⁴⁵

The right to mental autonomy or mental privacy is intimately associated with the first amendment. In *Stanley v. Georgia*,⁴⁶ the Court struck down a state statute making mere possession of obscene matter a crime. The statute was held to violate the defendant's "fundamental" rights to "receive information and ideas, regardless of their social worth" and "to be free . . . from unwarranted governmental intrusions into one's privacy."⁴⁷ The Court quoted the memorable passage from Justice Brandeis' dissent in *Olmstead v. United States*: "The makers of the Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man."⁴⁸ "Our whole constitutional heritage," Brandeis declared, "rebels at the thought of giving government the power to control men's minds."⁴⁹

The constitutional right of privacy, as a safeguard of the individual's bodily autonomy, is clearly implicated by state-imposed medical intervention. At common law, the physician normally may not treat

43. 381 U.S. 479, 485-86 (1965).

44. 405 U.S. 438, 453 (1972).

45. 410 U.S. 113, 153 (1973). *Roe* barred state interference with the abortion decision during the first trimester of pregnancy, but permitted state regulation in the second and third trimesters. *Id.* at 164-65. The court in *Roe* traced the evolution of a constitutional right of personal privacy as far back as *Union Pac. Ry. v. Botsford*, 141 U.S. 250 (1891). 410 U.S. at 152. But note the Court's limiting language:

"The privacy right . . . cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past.

Id. at 154 (citing *Buck v. Bell*, 274 U.S. 200 (1927) (sterilization); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (vaccination)).

46. 394 U.S. 557 (1969).

47. *Id.* at 563.

48. *Id.* at 564 (quoting *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

49. *Id.* at 565 (quoting *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

the patient without first obtaining his or her informed consent;⁵⁰ when those seeking to impose treatment are officers of the state, the common-law prohibition takes on constitutional dimensions. With increasing frequency, courts have found a right to refuse treatment for physical disorders based implicitly or explicitly on the constitutional privacy right. Such a right has been held to protect a prisoner's refusal of medically indicated surgery⁵¹ or a competent patient's decision to decline a life prolonging operation, even if the decision was considered "irrational"⁵² or "unwise, foolish, or ridiculous."⁵³ In the highly publicized "right-to-die" cases, the constitutional right of privacy was interpreted to permit or even to compel the termination of unwanted life-support systems.⁵⁴

The weight of authority thus supports a general constitutional right to refuse medical treatment, based on the right of privacy. With one exception,⁵⁵ however, no court has squarely faced the more specific

50. 61 AM. JUR. 2d *Physicians, Surgeons, and Other Healers* § 152 (1972). Failure to secure the patient's consent may expose the treating physician to liability for negligence, *id.* at § 154, or battery, *id.* at § 155. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 116-18 (4th ed. 1971). See also *Scott v. Plante*, 532 F.2d 939, 946 (3rd Cir. 1976); *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir. 1971); *Szasz, Involuntary Psychiatry*, 45 U. CIN. L. REV. 347, 357 (1976).

51. *Runnels v. Rosendale*, 499 F.2d 733 (9th Cir. 1974) (hemorrhoidectomy).

52. *Lane v. Candura*, — Mass. App. Ct. —, 376 N.E.2d 1232, 1235 (1978) (amputation of leg afflicted with gangrene). *Accord, In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978) (amputation of both legs).

53. *In re Yetter*, 62 Pa. D. & C.2d 619, 623 (C.P., Northampton County, June 6, 1973) (biopsy and surgery for cancer). See also *In re President of Georgetown College, Inc.*, 331 F.2d 1010, 1017 (D.C. Cir. 1964) (denial of rehearing) (Burger, J., dissenting).

Where minor children are not involved, courts have refused, on first amendment grounds, to order blood transfusions over the religious objections of a competent adult, even though death was imminent. See, e.g., *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976). Cf. *In re President of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.) (single judge), *cert. denied*, 377 U.S. 978 (1964) (emergency blood transfusion ordered over patient's religious objections; patient had infant child and was apparently incompetent). *But cf. John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (transfusion ordered for unconscious 22-year old, over mother's religious objections). See generally *Annot.*, 9 A.L.R.3d 1391 (1966).

54. *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). See also *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. App. 1978).

55. Two Minnesota county probate courts have rendered conflicting decisions on whether a patient has a right to refuse prolixin treatment. The Minnesota Supreme Court had previously held that a hearing was constitutionally required before "more intrusive forms of treatment" could be imposed on an unconsenting patient. *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976). Finding the use of prolixin decanoate an "intrusive form of psychiatric treatment," one probate court upheld the patient's right to refuse prolixin treatment, based on the constitutional right of privacy. *In re Cleo Lundquist*, No. 140151 (Ramsey County, Minn. P. Ct., April 30, 1976), *reprinted in Zander, supra* note 17, at 73-75. Less than two months later, another probate court reached the opposite conclusion. *In re Paul Fussa*, No. 66110 (Hennepin County, Minn. P. Ct.). The Minnesota Supreme Court refused to review the decision. See *Zander, supra* note 17 at 65-66.

issue presented in *Rennie* of whether an involuntarily committed mental patient has a constitutional right to refuse psychotropic medication.⁵⁶ In extending the privacy protection to Rennie's refusal, the New Jersey District Court made two critical affirmations: first, that the constitutional right to refuse treatment survives involuntary commitment to a mental institution; and second, that the right encompasses the refusal of a widely accepted form of therapy.

Several courts have found that the right of privacy protects an involuntarily confined mental patient's decision to refuse certain kinds of psychiatric treatment. In the 1972 landmark case of *Wyatt v. Stickney*,⁵⁷ a federal district court in Alabama proclaimed that mental patients have a constitutional right "not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, aversive [*sic*] reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent."⁵⁸ Chief Judge Johnson did not, however, indicate which constitutional rights were affected by nonconsensual treatment. Other courts, building on *Wyatt*, have been more specific: they have tried to anchor the mental patient's right to refuse highly intrusive or experimental therapies in particular constitutional guarantees, including the right of privacy.⁵⁹

56. Two cases in the Third Circuit had raised the issue without resolving it. In *Scott v. Plante*, 532 F.2d 939 (3rd Cir. 1976), the court of appeals held that a mental patient had stated a claim for relief when he alleged that his constitutional rights had been violated by forcible treatment with psychotropic drugs. Plaintiff's constitutional claims paralleled those subsequently made by Rennie, but the *Scott* court, unlike the *Rennie* court, was reluctant to base its decision on the right of privacy. It suggested three "conceivable constitutional deprivations" arising from plaintiff's alleged forced treatment: (1) interference with first amendment rights; (2) denial of due process; and (3) cruel and unusual punishment. In a footnote, the court cautiously added: "A possible fourth constitutional deprivation might include invasion of the inmate's right to bodily privacy. . . . The scope of such a right, however, remains ill-defined." 532 F.2d at 946. A subsequent opinion by a Federal district court in Pennsylvania was only slightly less circumspect. In denying defendant's motion to dismiss, the court stated: "[W]e believe that involuntary administration of drugs which have a painful or frightening effect can amount to cruel and unusual punishment, in violation of the Eighth Amendment. . . . It has also been suggested that such medication amounts to an unwarranted governmental intrusion into the patient's thought processes in violation of his constitutional right to privacy." Souder v. McGuire, 423 F. Supp. 830, 832 (M.D. Pa. 1976) (citing *Scott v. Plante* and *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973)). Cf. *Naughton v. Bevilacqua*, 458 F. Supp. 610, 617-18 (D.R.I. 1978) (administration of phenothiazines to voluntarily confined mentally retarded patient after repeated instruction by patient's parents regarding patient's adverse reactions to drugs and directions by patient's parents not to administer the drugs, constitutes violation of patient's constitutional right to safe and humane environment) (dictum).

57. 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

58. *Id.* at 380.

59. See *Mackey v. Procunier*, 477 F.2d 877, 877-78 (9th Cir. 1973) (forcible administration of succinylcholine, a "breath-stopping and paralyzing 'fright drug'" could "raise serious constitutional questions respecting cruel and unusual punishment or impermissible tinkering with the

These decisions implicitly reject the traditional view that involuntarily confined mental patients are presumptively incompetent to make choices about treatment. According to the conventional wisdom,⁶⁰ the psychiatrist's judgment is properly substituted for the patient's because the latter's ability to make decisions is impaired by mental illness. Cases upholding the nonpsychiatric patient's right to decline treatment for physical disorders,⁶¹ premised as they are on a *competent* refusal,⁶² are seen as irrelevant.

Yet modern statutes explicitly distinguish the judicial commitment order from a finding of legal incompetency.⁶³ In New Jersey, for example, "[n]o patient may be presumed to be incompetent because he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received."⁶⁴ The legislative trend reflects the consensus of modern psychiatric and legal opinion⁶⁵ that mental illness requiring hospitalization does not in itself indicate incapacity to make rational decisions.⁶⁶

mental processes") (citing *Eisenstadt v. Baird*, *Stanley v. Georgia*, and *Roe v. Wade*) (emphasis added); *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976) (electroconvulsive treatment); cf. *Kaimowitz v. Michigan Dept. Mental Health*, No. 73-19434-AW (Mich. Cir. Ct., Wayne Cty., July 10, 1973) (involuntarily confined mental patient unable to give informed consent to experimental psychosurgery).

60. See, e.g., *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968). The court in that case rejected the defense, proffered by hospital officials, to a psychiatric inmate's claim that he had not been given proper drug treatment. "We find that the reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional and not consonant with prevailing medical standards." *Id.* at 707, 290 N.Y.S.2d at 501. See also *Anonymous v. State*, 17 App. Div. 2d 495, 236 N.Y.S.2d 88, *appeal denied*, 13 N.Y.2d 598, 245 N.Y.S.2d 1025 (1963).

61. See cases cited notes 51-54 *supra*.

62. See *Schloendorff v. Society of N.Y. Hosps.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . .").

63. AMERICAN BAR FOUNDATION, *THE MENTALLY DISABLED AND THE LAW* 254 (rev. ed. S. Brakel & R. Rock 1971). See Plotkin, *supra* note 3, at 504 app. (statutory survey as of Dec. 1, 1977).

64. N.J. STAT. ANN. § 30:4-24.2(c) (West Cum. Supp. 1978).

65. R. ALLEN, E. FERSTER & H. WEIHOFEN, *MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY* 49-50 (1968); AMERICAN BAR FOUNDATION, *supra* note 63, at 253; Plotkin, *supra* note 3, at 489 n.170; *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1214 nn.80 & 81 (1974) [hereinafter cited as *Civil Commitment*]; accord, *Vecchione v. Wohlge-muth*, 377 F. Supp. 1361, 1372 (E.D. Pa. 1974); *McAuliffe v. Carlson*, 377 F. Supp. 896, 905 (D. Conn. 1974); *Wyatt v. Stickney*, 344 F. Supp. 387, 399 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

66. Civil commitment, while not equivalent to an adjudication of general incompetency, arguably implies a finding that the patient is unable to make a *specific* kind of decision—his or her need for treatment. By this reasoning, the state is justified in exercising its *parens patriae* authority to override the patient's incompetent refusal.

This argument was adopted by the Minnesota Supreme Court in rejecting a section 1983

A presumption of incapacity, based solely on a commitment order, not only conflicts with the express language of most statutes, it also fails to withstand constitutional scrutiny. Because of the lack of congruence between mental illness and inability to make rational decisions about one's welfare, due process requires at a minimum a judicial finding of incapacity before the patient is deprived of his fundamental right to refuse treatment.⁶⁷ In *Winters v. Miller*,⁶⁸ the United States Court of Appeals for the Second Circuit found that forcible medication of an involuntarily committed Christian Scientist could constitute a violation of the patient's first amendment rights.⁶⁹ Coercive treatment might be permissible if the state stood in a *parens patriae* relationship to the pa-

claim against state officials who had administered twenty electroshock treatments to an involuntarily confined minor, over the express objections of his natural guardian. The court observed:

The state's interest in assuming the [treatment] decision is in acting as *parens patriae*, fulfilling its duty to protect the well-being of its citizens who are incapable of so acting for themselves. . . . [T]hat interest can be articulated as the need for the state to assume the decision-making role regarding the psychiatric treatment for one who, presumptively, based on the fact of commitment on the ground of mental illness, is unable to *rationaly* do so for himself. If that interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision.

Price v. Sheppard, 307 Minn. 250, 258-59, 239 N.W.2d 905, 911 (1976) (footnotes omitted).

In support of its position, the court cited an influential *Harvard Law Review* survey of the law on civil commitment:

Inherent in the adjudication that an individual should be committed under the state's *parens patriae* power is the decision that he can be forced to accept the treatments found to be in his best interest; it would be incongruous if an individual who lacks capacity to make a treatment decision could frustrate the very justification for the state's action by refusing such treatments.

Id. at 259, 239 N.W.2d at 911 (citing *Civil Commitment*, *supra* note 65, at 1344). The citation is disingenuous. The quoted passage refers to a proposed revision in the current system of civil commitment that would make an explicit judicial finding of incapacity a threshold requirement for commitment under the *parens patriae* power. *Id.* at 1212-19. Yet the Minnesota statutes flatly provide that "[c]ommitment . . . is not a judicial determination of legal incompetency." MINN. STAT. ANN. § 253A.18(1) (West 1971). While commitment in Minnesota *may* be based on an individual's incapacity to provide for his basic needs, including medical care, such a finding is not a necessary prerequisite to institutionalization. *See id.* § 253A.07(17)(a) (West Cum. Supp. 1978).

For a discussion of the origins and nature of the *parens patriae* power, see *Civil Commitment*, *supra* note 65, at 1207-12. *See also* O'Connor v. Donaldson, 422 U.S. 563, 582-83 (1975) (Burger, C.J., concurring).

For an excellent discussion of the standards for evaluating a patient's capacity to make treatment decisions, see Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCH. 279 (1977).

67. *Civil Commitment*, *supra* note 65, at 1213-15, 1350-51. Civil commitment to a mental hospital necessarily results in a drastic curtailment of the individual's liberty and privacy. Involuntary confinement does not, however, entitle the state to further deprive the patient of his or her fundamental rights, in the absence of a strong governmental interest. Forcible treatment is a significantly greater invasion of privacy than mere institutionalization and therefore must be specifically justified in an appropriate hearing. *See* Clonce v. Richardson, 379 F. Supp. 338 (W.D. Mo. 1974) (transfer of prisoner to involuntary behavior modification program requires hearing).

68. 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971).

69. The decision could be construed narrowly in view of the special first amendment consid-

tient, but, the court insisted, such a relationship can only be created by a judicial determination of incompetency.⁷⁰

The limits on state action suggested in *Winters* have been clearly recognized in the Third Circuit. In *Scott v. Plante*,⁷¹ the court of appeals found that the forcible administration of drugs to an involuntarily committed mental patient could constitute a violation of due process.

[O]n this record we must assume that Scott, though perhaps properly committable, has never been adjudicated an incompetent who is incapable of giving an informed consent to medical treatment. Under these circumstances due process would require in the absence of an emergency, that some form of notice and opportunity to be heard be given to Scott or to someone standing *in loco parentis* to him before he could be subjected to such treatment.⁷²

Thus, the right to refuse treatment is not lost by the mere fact of involuntary commitment. But it has been suggested that the sweep of the privacy right, while encompassing the most intrusive treatments, is not so broad as to preclude forcible administration of "conventional" therapies.⁷³ The case cited most frequently in support of a constitutional right against treatment, *Kaimowitz v. Michigan Department of Public Health*,⁷⁴ involved a drastic form of medical intervention. After seventeen years of confinement under a criminal sexual psychopath statute, "John Doe" consented to experimental psychosurgery aimed at treating "uncontrollable aggression." Plaintiff Kaimowitz, a civil liberties attorney, asked for a declaratory judgment on the legality of the

erations. Yet the language clearly suggests that a broader application was intended. See *id.* at 71 (discussion of the need for a prior competency determination).

70. *Id.* See also *N.Y. City Health & Hosp. Corp. v. Stein*, 70 Misc. 2d 944, 335 N.Y.S.2d 461 (1972).

71. 532 F.2d 939 (3rd Cir. 1976).

72. *Id.* at 946 (citing *Winters*).

Forcible treatment premised on the mere fact of civil commitment, without an explicit finding of incompetency, may also violate the requirements of equal protection. The physically ill are free to decline treatment, even if intervention is medically indicated. Since mental illness does not necessarily imply any impairment of the ability to make competent decisions about treatment, the state cannot, without more, deny that right to the involuntarily committed. *Civil Commitment*, *supra* note 65, at 1215-16. See *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir. 1971). See also *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972) (dictum) (three-judge court), *vacated and remanded on other grounds*, 414 U.S. 473 (1974).

73. See, e.g., *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976) (judicial hearing required before state may administer "the more intrusive forms of treatment," including psychosurgery or electroshock therapy); A. STONE, *MENTAL HEALTH AND LAW* 97-108 (1976) (full protection for right to refuse only for the "more severe" therapies, including psychosurgery and electroshock, but excluding psychotropic drugs).

74. No. 73-19434-AW (Cir. Ct., Wayne County, Mich., July 10, 1973), *reprinted in* A. BROOKS, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 902 (1974) *and* 2 *PRISON L. REP.* 433 (1973).

proposed operation.⁷⁵ Emphasizing the intrusiveness of the procedure, the high risks and uncertain benefits,⁷⁶ and the erosion of the subject's decisionmaking capabilities caused by years of institutionalization,⁷⁷ a three-judge county court held that an involuntarily detained mental patient cannot give informed and legally adequate consent to experimental psychosurgery.⁷⁸ The court found compelling constitutional reasons to support its conclusion. Experimental psychosurgery on involuntarily confined mental patients conflicted with the first amendment guarantee of freedom to think and generate ideas.⁷⁹ It also violated the constitutional right of privacy.⁸⁰

In *Rennie*, defendants argued strenuously that *Kaimowitz* was entirely inapposite: the use of widely accepted antipsychotic drugs for legitimate therapeutic purposes could not be equated with experimental psychosurgery. The court, finding the distinction persuasive in the first amendment context, held that forcible drug treatment did not seriously interfere with Rennie's freedom of expression or mentation.⁸¹

The court could have adopted the same distinction in response to Rennie's privacy claim. A narrow reading of the privacy right would protect the unconsenting patient from the most "intrusive" therapies, but leave psychiatrists complete discretion to administer "conventional" treatments. In *Roe v. Wade*, the Supreme Court cautioned that "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' are included in this guarantee of personal privacy."⁸² When the intrusion is minor or fleeting, no constitutional rights are implicated.⁸³

75. See A. BROOKS, *supra* note, 74 at 902-03.

76. *Id.* at 906-10.

77. *Id.* at 914.

78. *Id.* at 916.

79. *Id.* at 916-19.

80. If one is not protected in his thoughts, behavior, personality, and identity, then the right of privacy becomes meaningless. . . .

To hold that the right of privacy prevents laws against dissemination of contraceptive material as in *Griswold v. Connecticut*, or the right to view obscenity in the privacy of one's home as in *Stanley v. Georgia*, but that it does not extend to the physical intrusion in an experimental manner upon the brain of an involuntarily detained mental patient is to denigrate the right. In the hierarchy of values, it is more important to protect one's mental processes than to protect even the privacy of the marital bed.

Id. at 920.

81. 462 F. Supp. at 1143-44. See note 29 *supra*.

82. 410 U.S. 113,152 (1973); *cf.* *Doe v. Commonwealth's Attorney*, 403 F. Supp. 1199 (E.D. Va. 1975), *aff'd mem.*, 425 U.S. 901 (1976) (homosexual acts not protected by right of privacy).

83. See, e.g., *Whalen v. Roe*, 429 U.S. 589 (1977) (computerized storage of data on patients receiving prescriptions for dangerous drugs); *Kelly v. Johnson*, 425 U.S. 238 (1976) (length of policeman's hair); *Paul v. Davis*, 424 U.S. 693 (1976) (damage to reputation); *cf.* *Zablocki v.*

Especially stringent controls for certain intrusive treatments may indeed be appropriate for legislative regulation of coercive therapy.⁸⁴ The *Rennie* court was correct, however, in not limiting the constitutional privacy protection to a narrow range of therapeutic interventions. While psychosurgery, electroshock and aversive conditioning have generally been considered the most drastic forms of treatment,⁸⁵ clinical studies suggest that treatment with psychotropic drugs, especially the neuroleptics, may be equally "intrusive."⁸⁶ The extensive side effects of psychotropics, in conjunction with the uncertainty of psychiatric diagnoses⁸⁷ and doubts about the long-term effectiveness of drug therapy,⁸⁸ compel the conclusion that forcible medication, in the absence of an emergency, infringes the patient's constitutionally protected zone of privacy.⁸⁹

Developed in the early 1950s, psychotropic drugs achieved rapid acceptance as the treatment of choice for a wide variety of mental disorders.⁹⁰ The pharmacological revolution in psychiatry has enabled many previously untreatable patients to live outside the institution.⁹¹ Yet, in some cases, the cost of treatment outweighs the benefit.

Redhail, 434 U.S. 374 (1978) (substantial interference with right to marry); *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977) (restrictions on distribution of contraceptives); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (state regulation of abortion).

84. See generally Plotkin, *supra* note 3, at 497-502; Shapiro, *supra* note 1; see also Atkins & Lauriat, *Psychosurgery and the Role of Legislation*, 54 B.U.L. REV. 288 (1974); Note, *supra* note 5, at 396-412 (regulation of electroconvulsive treatment).

85. See, e.g., statutes cited notes 5-7 *supra*.

86. For a review of the research concerning the side effects of antipsychotic drugs, see DuBose, *supra* note 23, at 1202-09. See also studies cited in Plotkin, *supra* note 3, at 474-78. Cf. S. HALLECK, *supra* note 11, at 225-26 (comparing risks of electroconvulsive and drug therapy); Gardos & Cole, *Maintenance of Antipsychotic Therapy: Is the Cure Worse than the Disease?*, 133 AM. J. PSYCH. 32 (1976).

87. See note 21 *supra*.

88. See DuBose, *supra* note 23.

89. See, e.g., DuBose, *supra* note 23 (substantive due process); Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA L. REV. 447, 473 (1973); Plotkin, *supra* note 3, at 493; Schwartz, *In the Name of Treatment: Autonomy, Civil Commitment, and Right to Refuse Treatment*, 50 NOTRE DAME LAW. 808, 841 (1975); Shapiro, *supra* note 1, at 273-76; Note, *supra* note 3, at 661-65; Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 ST. LOUIS U.L.J. 100, 104-05 (1975); Note, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMPLE L.Q. 354 (1975); Note, *The Constitutional Right to Treatment for Involuntarily Committed Mental Patients—What Limitations?*, 14 WASHBURN L.J. 291, 305 (1975). See also Op. Cal. Atty Gen., No. CV 74-327 (Dec. 17, 1975), summarized in 1 ABA MENTAL DISABILITY L. REP. 17 (1976) (refusal of medical treatment falls within zone of privacy protected by first, fourth, fifth and ninth amendments). But see A. STONE, *supra* note 73, at 97-108 (right to refuse should not extend to "conventional" therapies, including psychotropic drugs).

90. Winick, *supra* note 11, at 778-89.

91. *Id.* at 780-81.

All psychotropics cause numerous side effects, some of them extremely serious. Common autonomic effects of neuroleptics include blurred vision, constipation, decreased blood pressure and skin rashes.⁹² Extrapyramidal dysfunctions, or disorders of movement, also accompany treatment with antipsychotics.⁹³ The most common of these disorders is the parkinsonian syndrome, characterized by akinesia (loss of mobility) and muscular rigidity.⁹⁴ Other such disorders include acute dystonia, described as "bizarre-appearing muscle spasms" in the head and neck area,⁹⁵ and akathisia, which is characterized by agitation, restlessness, inability to sit still and insomnia.⁹⁶ Most of these disorders are temporary, however, and can be treated with other drugs.

On the other hand, tardive dyskinesia, the most severe extrapyramidal dysfunction, is generally irreversible. Usually occasioned by prolonged use of psychotropics at high dosages, this syndrome is characterized by chronic, bizarre and involuntary movement of the face, mouth and tongue, and may also involve writhing of the arms, trunk and pelvis. It is estimated that between twenty and forty percent of those who have been treated with neuroleptics develop tardive dyskinesia.⁹⁷

CONCLUSION

Rennie v. Klein represents a significant and controversial⁹⁸ advance in the recognition of rights for mental patients. The New Jersey District Court has articulated a sound constitutional rationale for the right of an involuntarily confined patient to refuse psychotropic medication.

Of course, the definition of a constitutional right does not determine the issue; it merely establishes the context in which the interests of the state and the individual are weighed by a neutral arbiter.⁹⁹ To

92. S. HALLECK, *supra* note 11, at 201-02.

93. L. GOODMAN & A. GILMAN, *supra* note 26, at 169; S. HALLECK, *supra* note 11, at 203.

94. The syndrome places severe restrictions not only upon the patient's mobility but also on psychological behavior, interpersonal relationships, and mental processes. The patient moves slowly and stiffly, speech is monotonous in tone, with difficulty in raising its volume. In severe forms there is major loss of arm movement, a stooped shuffling gait, pill-rolling movements of the hands, and excessive salivation.

S. HALLECK, *supra* note 11, at 203.

95. *Id.* at 204.

96. *Id.*

97. *Id.* at 204-05. See L. GOODMAN & A. GILMAN, *supra* note 26, at 170, 172.

98. See Roth, *Judicial Action Report*, PSYCH. NEWS, Feb. 2, 1979, at 15; Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 AM. J. PSYCH. 273, 278 (1977).

99. The arbiter need not be the judiciary. An independent review panel, with psychiatrists and nonpsychiatrists as members, could be given broad discretionary authority. *Rennie* explicitly

override a patient's refusal of medication, the state must demonstrate that it has a strong interest in treatment¹⁰⁰ and that it has exhausted all less intrusive alternatives.¹⁰¹ The arbiter must consider the state's interests in the light of the patient's capacity to make a competent treatment decision and the risk of permanent side effects from the proposed therapeutic intervention.¹⁰² The difficulty that the court experienced in trying to apply its constitutional standards to Rennie's case¹⁰³ exemplifies the hazards of judicial involvement in complex treatment issues. Yet, in the absence of adequate protection by statute, the courts have a duty to safeguard the patient's right to refuse treatment. Other courts will confront the issue of forcible treatment with psychotropic drugs in

contemplates the possibility of a state-created "independent administrative board to review treatment decisions." 462 F. Supp. at 1147.

100. Governmental invasions of bodily privacy require more than a minimal justification. *L. TRIBE, AMERICAN CONSTITUTIONAL LAW* 914-15 (1978). Whether the state interest must be not only strong, but "compelling," surely depends on the extent of the intrusion.

101. 462 F. Supp. at 1146-47. The classic exposition of this concept was rendered by the Supreme Court in *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) (footnotes omitted):

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

See O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (principle applied to confinement of the mentally ill); *Price v. Sheppard*, 307 Minn. 250, 257, 239 N.W.2d 905, 910 (1976) (principle applied to choice of treatment for the unconsenting patient).

102. 462 F. Supp. at 1148. Similar balancing tests have been proposed elsewhere. *See Price v. Sheppard*, 307 Minn. 250, 262-63, 239 N.W.2d 905, 913 (1976); Note, *supra* note 3, at 658.

103. In its November 9 opinion, the court ordered the hospital to give Rennie a "fair trial" on a voluntary regimen of lithium and an antidepressant before seeking to treat him involuntarily with antipsychotic drugs. 462 F. Supp. at 1146. Claiming to be unaware of the patient's current status, the court declined to rule on Rennie's motion for a preliminary injunction. *Id.* at 1148.

After the opinion was issued, Rennie's mental and physical condition rapidly deteriorated. He refused to take the medication to which he had previously consented. In response to the patient's "floridly psychotic" condition the hospital began forcible administration of thorazine, a neuroleptic, on December 2. *Id.* at 1151-52. After a one-day hearing, the court denied the motion for a preliminary injunction and declared its decision to be conclusive for at least two months, "barring any significant evidence of tardive dyskinesia or drastic change in any other relevant factor." *Id.* at 1154.

Finally, in *Rennie v. Klein*, 48 U.S.L.W. 2211 (D.N.J. Sept. 14, 1979), the court fashioned the procedural due process necessary to protect the right to refuse treatment. The court held that before a mental patient is given medication he must furnish affirmative written consent on a form that contains information on drugs and patient rights. If a physician certifies that a patient is incapable of giving informed consent, the state must provide a "patient advocate"—a person trained in the effects of psychotropic medication and the principles of legal advocacy, but not necessarily an attorney—to represent the interests of the patient. The court's order "precludes medication of any voluntary patient who does not sign a consent form or who orally refuses, except in emergency situations." *Id.* Before a hospital may forcibly medicate an involuntary patient, there must be an informal review by an independent psychiatrist at which the patient is represented by a patient advocate, or, if the patient prefers, by private counsel. The independent psychiatrist is required to "issue a written decision in each case, basing any decision to override the patient's privacy right on the four factors outlined" in the court's earlier opinion. *Id.*; *see* 462 F. Supp. at 1145-47.

the near future.¹⁰⁴ If *Rennie's* lead is followed, the states will be compelled to design formal review procedures in accord with constitutional standards.

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104. A class action to secure the right of state mental hospital inmates to refuse drug treatment has been before a federal district court in Boston for four years. Plaintiffs obtained a temporary injunction against the use of forcible medication at Boston State Hospital. *Rogers v. Okin*, __ F. Supp. __ (D. Mass.), *aff'd without opinion sub nom. Rogers v. Macht*, 566 F.2d 1166 (1st Cir. 1977). See 2 ABA MENTAL DISABILITY L. REP. 192 (1977). The lengthy trial on the merits was nearing completion as this Note went to press.

After a prisoner's section 1983 complaint against prison officials who forcibly treated him with antipsychotic drugs was dismissed by a North Carolina federal district court on defendants' motion for summary judgment, the United States Court of Appeals for the Fourth Circuit remanded the case for an evidentiary hearing to consider the plaintiff's constitutional claim. *Sweezy v. Jones*, No. 78-6034 (4th Cir. Dec. 5, 1978) (unpublished opinion).

