Article

# Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard

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In the past ten years, widely disparate federal due process cases—ranging from challenges by institutionalized people to involuntary administration of psychotropic medication, to class actions on behalf of children in foster care, to litigation by students dismissed from graduate school—have been resolved by application of the same rule, the professional judgment standard. Use of the professional judgment standard entitles people in certain situations to minimally adequate services. However, the use of the standard also allows state professionals to violate an individual's rights in the *name* of treatment, because

it equates the vindication of constitutional liberties with the fulfillment of professional standards.

The United States Supreme Court adopted the professional judgment standard in 1982 in *Youngberg v. Romeo*,[1] a damages action on behalf of a severely mentally retarded man institutionalized at the Pennhurst State School and Hospital in Pennsylvania. During two years at Pennhurst, Nicholas Romeo had suffered over seventy injuries, including broken bones, damaged sexual organs and lacerations.[2] Some injuries "became infected, either from inadequate medical attention or from contact with human excrement that the Pennhurst staff failed to clean up."[3] After Romeo's mother filed suit, Romeo was transferred to the institution's hospital for treatment of a broken arm, where he was restrained daily for long periods of time. Romeo's mother's complaints ultimately charged that her son's rights to safety and personal security were violated and asked both for relief from excessive restraint and for treatment and programs for his mental retardation.[4]

As the Court recognized, Romeo's constitutional claims fell into two categories: traditional due process claims alleging state infringement of individual liberty (the claims involving restraint and personal security), and a claim affirmatively seeking state-provided services (the claim for treatment). "Respondent's first two claims," the Court said, "involve liberty interests recognized by prior decisions of this Court, interests that involuntary commitment proceedings do not extinguish. . . . Respondent's remaining claim [for habilitation] is more troubling."[5] The Court thus distinguished between Romeo's right to freedom from state interference, which all citizens enjoy and which survives institutionalization, and the right to treatment, an affirmative right to adequate services from the state that arises out of institutionalization.

The case presented the Supreme Court with the opportunity to decide for the first time whether institutionalized individuals had a right to treatment and to clarify the standard by which it should be applied. The Court held that individuals confined in state institutions have a right to treatment "which is reasonable in light of [each individual's] identifiable liberty interest" in freedom

1. 457 U.S. 307 (1982). The Court adopted the standard suggested by Chief Judge Seitz in his concurrence in the Third Circuit opinion below, Romeo v. Youngberg, 644 F.2d 147, 178 (3d Cir. 1980), *vacated*, 457 U.S. 325 (1982).

2. Romeo v. Youngberg, 644 F.2d at 155. Some of these injuries were self-inflicted during times when Romeo was unsupervised, others were the results of attacks by fellow residents, and some may have been inflicted by staff. *Id.* at 162.

3. *Id.* at 155.

4. Because mental retardation is not a treatable disability, Romeo claimed a right to "training" or "habilitation" rather than treatment. The term "habilitation" refers to "that education, training and care required by retarded individuals to reach their maximum development." Halderman v. Pennhurst State Sch. & Hosp., 446 F. Supp. 1295, 1298 (E.D. Pa. 1977) (citation omitted), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979) (en banc). Since *Romeo*, courts have not distinguished between a right to treatment and a right to habilitation, although there is a conceptual difference between treatment, which can cure a patient, and habilitation, which serves to improve the ability of the individual to function independently.

5. 457 U.S. at 315-16.

from unnecessary governmental restraint.[6] In Romeo's case, because the parties had stipulated that Romeo would never be able to leave the confines of the institution and the record showed that his "primary needs" were "bodily safety and a minimum of restraint,"[7] he was entitled to "training to ensure safety and freedom from undue restraint."[8] Individuals in other situations, the Court noted, might have different liberty interests and thus require different levels of treatment.[9] As noted above, the Court held that all individuals retain their right to personal security and freedom from unreasonable bodily restraint.

Having made the crucial distinction between negative rights against state intrusion and affirmative rights to government services, however, the Supreme Court proceeded to adopt the same standard, the professional judgment standard, to determine whether there had been a violation of both types of rights. The Court held that a professional's decision is presumptively valid, whether it is challenged as providing inadequate services or as state intrusion on the individual. Professional decisions in the institutional setting are only unconstitutional if "the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[10]

Although the professional judgment standard may be appropriate to measure the level of services that a state is constitutionally bound to provide to individuals in its custody, the standard is inappropriate to justify the imposition of unwanted government "services" that restrict constitutional liberty, such as forcible medication, prolonged restraint, and prohibitions on patients' family visitation. The crucial distinction between an individual's affirmative right to a certain quality of care from the government, and an individual's negative right against invasive state action, is lost under the professional judgment standard, as is the court's crucial role in our constitutional system. By applying the professional judgment standard to negative rights cases, courts cease to protect the "realm of personal liberty which the government may not enter,"[11] and

6. *Id.* at 319 n.25. The scope of the treatment required is directly related to the particular liberty interests being vindicated. Because Romeo "seem[ed]" to seek only "training related to safety and freedom from restraints," the Court declared that the case did "not present the difficult question of whether a mentally retarded person, involuntarily committed to a state institution, has some general constitutional right to training per se, even when no type or amount of training would lead to freedom." *Id.* at 318. In fact, Romeo left Pennhurst a few years later and was living in the community within two years after *Youngberg* was decided. *Former Pennhurst Patient to Get Settlement*, UPI, July 25, 1984, *available in* LEXIS, Nexis Library, UPI File. The Court also noted that the training and treatment must be reasonable in light of "the circumstances of the case." 457 U.S. at 319 n.25. The emphasis on the particular facts and circumstances of the case before the Court was intended to contrast with the Third Circuit majority's "abandonment of incremental decisionmaking in favor of promulgation of broad standards." *Id.* The Court thus gave broad latitude to lower courts to determine the scope of treatment or training required by the Constitution in individual cases.

7. 457 U.S. at 317.

8. *Id.*

9. *Id.* at 319 n. 25.

10. *Id.* at 323.

11. Planned Parenthood v. Casey, 112 S. Ct. 2791, 2805 (1992).

instead simply ensure that a professional behaves within the bounds of his[12] profession, regardless of the impact his actions might have on the constitutional rights of the plaintiff. The Court has ignored the reality that the exercise of professional judgment by a state actor can itself invade constitutional rights. The Court has thus abdicated its responsibility to provide a barrier between the individual and unwanted professional intrusion by the state.

Since 1982, application of the professional judgment standard has expanded far beyond the gates of the mental institution. Courts have applied the standard to cases involving foster care systems,[13] prisons and jails,[14] academia,[15] state departments of education,[16] police practices,[17] and zoning challenges.[18] The language of professional judgment has been applied in cases involving constitutional claims to effective assistance of counsel,[19] First Amendment claims to freedom of speech and religion,[20] and Equal Protection claims.[21] It is even being introduced into cases presenting claims under statutes long

12. I use the male pronoun throughout this article to refer to professionals, since the majority of professionals whose decisions are granted presumptive validity by this standard are male. For example, most psychiatrists are male. 10 NEWS FOR WOMEN IN PSYCHIATRY 6 (October 1992) (76.2% of all psychiatrists are male; 41% of psychiatric residents are women, but representation at administrative levels is extremely low).

13. Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883, 893-94 (10th Cir. 1992); Winston v. Children and Youth Servs., 948 F.2d 1380, 1390 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 2303 (1992); K.H. *ex rel.* Murphy v. Morgan, 914 F.2d 846, 852-53 (7th Cir. 1990); Del A. v. Roemer, 777 F. Supp. 1297, 1318-19 (E.D. La. 1991); LaShawn A. v. Dixon, 762 F. Supp. 959, 996 (D.D.C. 1991); Rubacha v. Coler, 607 F. Supp. 477, 479 (N.D. Ill. 1985).

14. White v. Napoleon, 897 F.2d 103, 113 (3d Cir. 1990); United States v. Watson, 893 F.2d 970, 979 (8th Cir.), *vacated on other grounds, appeal dismissed sub nom.* United States v. Holmes, 900 F.2d 1322 (8th Cir.), *cert. denied*, 110 S.Ct. 3243 (1990); Danese v. Asman, 875 F.2d 1239, 1243 (6th Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Wells v. Franzen, 777 F.2d 1258, 1261 (7th Cir. 1985); Zwalesky v. Manistee County, 749 F. Supp. 815, 819 (W.D. Mich. 1990); Preston v. Ruggieri, Civ. A. No. 86-4779, 1988 U.S. Dist. LEXIS 12258, at **8-9 (E.D. Pa. Oct. 28, 1988); Newby v. Serviss, 590 F. Supp. 591, 598-99 (W.D. Mich. 1984); Capps v. Atiyeh, 559 F. Supp. 894, 917 (D. Or. 1982).

15. Regents of Univ. of Mich. v. Ewing, 474 U.S. 214, 225 (1985) ("When judges are asked to review the substance of a genuinely academic decision . . . they should show great respect for the Faculty's professional judgment."); Levi v. University of Texas, 840 F.2d 277, 280 (5th Cir. 1988); Gutzwiller v. Fenik, 860 F.2d 1317, 1328 (6th Cir. 1988); Clements v. County of Nassau, 835 F.2d 1000, 1004-05 (2d Cir. 1987); Mauriello v. University of Medicine and Dentistry, 781 F.2d 46, 52 (3d Cir. 1986); Siu v. Johnson, 748 F.2d 238, 245 (4th Cir. 1984); Anderson v. University of Wis., 665 F. Supp. 1372, 1396-98 (W.D. Wis. 1987), *aff'd*, 841 F.2d 737 (7th Cir. 1988).

16. Saint Louis Developmental Disabilities Treatment Ctr. Parents Ass'n v. Mallory, 591 F. Supp. 1416, 1476 (W.D. Mo. 1984) (due process challenge to segregation of handicapped children), *aff'd*, 767 F.2d 518 (8th Cir. 1985).

17. Lavoie v. City of Hudson, 740 F. Supp. 88, 95 (D.N.H. 1990).

18. Pearson v. City of Grand Blanc, 961 F.2d 1211, 1222 (6th Cir. 1992).

19. Strickland v. Washington, 466 U.S. 668, 690 (1984) ("A convicted defendant making a claim of ineffective assistance must identify the acts or omissions of counsel that are alleged not to have been the result of reasonable professional judgment. . . . [C]ounsel is strongly presumed to have rendered adequate assistance and made all significant decisions in the exercise of reasonable professional judgment."), *reh'g denied*, 467 U.S. 1267 (1984).

20. Goldman v. Weinberger, 475 U.S. 503, 507 (1986) ("[W]hen evaluating whether military needs justify a particular restriction on religiously motivated conduct, courts must give great deference to the professional judgment of military authorities . . . .").

21. Levi v. University of Tex., 840 F.2d 277, 280-82 (5th Cir. 1988). *But see* Wilder v. Bernstein, 645 F. Supp. 1292, 1316 (S.D.N.Y. 1986), *aff'd*, 848 F.2d 1338 (2d Cir. 1988).

predating the *Youngberg* decision, such as Title VII[22] and Section 504 of the Rehabilitation Act.[23] Finally, it has been used as a standard for the interpretation and modification of consent decrees.[24]

Unfortunately, courts have broadened the applicability of the *Youngberg* doctrine with little regard for what "professional judgment" and the professional judgment standard might actually mean. Instead, courts use the professional judgment standard as a talismanic invocation, rarely examining the predicate assumptions about professionals upon which the standard relies. Courts, particularly the Supreme Court, regard the professional-client relationship as befitting protection from state interference because they envision it as an intimate partnership dedicated to the client's benefit and furtherance of the client's goals. In this popular construction, the archetype of the "professional" is a neutral individual cloaked in expertise, dedicated to a set of objective values, and governed by a higher code of responsibility in his relationship with his clients. This concept of the professional is a myth, yet the courts appear oblivious to the values deeply embedded in professionalism in general and in the medical and mental health professions in particular. Furthermore, neither the idealized values attributed to medical professionals nor their actual perspectives and priorities have much in common with the ideals of autonomy, self-determination, and individualism embodied in the Constitution.

To make matters worse, the courts idealize the wrong group of professionals, basing the professional judgment standard on a powerful mythology about professionals in the private sphere, but almost always applying it in a public sector context. The Court's image of freely chosen professional-client interaction is thus transplanted to institutional settings where the professionals are state actors, the professional-client relationship is permeated with state concerns and conflicts of interest, and the clients are an indigent and captive population. The professional's power in these situations lies not solely or even primarily in his expertise, but in his ability to control every aspect of his clients' lives, including, ultimately, the decision of whether they will be returned to freedom.

Even if the professional judgment standard were not rooted in false conceptions of the state professional, it also would fail fundamental tests of coherence and clarity as a legal standard. First, the *Youngberg* approach does not clearly delineate the scope of a professional's responsibilities, nor does it clearly indicate who is a professional. Second, it does not distinguish professional decisions that are subject to the professional judgment standard from those that are not. This overbreadth has permitted an expansion of the standard into areas where there is clearly no professional-client relationship, such as the practices

22. Torres v. Wisconsin Dep't of Health and Social Servs., 859 F.2d 1523 (7th Cir. 1988), *cert. denied*, 489 U.S. 1017 (1989), *and* 489 U.S. 1082 (1989).

23. Wynne v. Tufts Univ. Sch. of Medicine, 932 F.2d 19, 26 (1st Cir. 1991) (en banc).

24. United States v. Massachusetts, 890 F.2d 507, 510 (1st Cir. 1989), New York Ass'n for Retarded Children v. Carey, 706 F.2d 956, 971 (2d Cir. 1983).

of universities in denying tenure to professors or dismissing students. The standard has also expanded from cases involving at least a purportedly individualized relationship between a professional and a client to cases involving policy decisions where the concerns of an individual client are no longer relevant, such as budget cutting and government agency program choices.

When a court classifies a state action as a "professional judgment," the standard prevents the courts from considering the rights at stake in many professional decisions. When it collapses an individual rights claim into an issue of professional judgment, a court abandons the task of weighing the constitutional values that may forbid effectuating the professional's decision. Professionals are neither obligated nor competent to consider these values; this must be the court's role. For example, a Jehovah's Witness's refusal of a blood transfusion may squarely conflict with medical judgment, threatening the patient with death.[25] But such a decision is legally protected for reasons independent of professional medical judgment.[26] Rights do not arise because professionals recommend them, nor are they protected by professional judgment. Constitutional rights transcend professional judgment, and in many respects professional judgment is irrelevant or antithetical to the exercise of these rights. Professional judgment is not concerned with idiosyncratic individual choices about speech, association, religious beliefs, marriage, childbearing, life, and death. Yet the professional judgment standard has transferred the focus of decisionmaking about civil rights to professionals whose expertise, values, and orientation make them unsuitable guardians of those rights. The result is that courts abdicate their fact-finding and decisionmaking responsibilities, creating a significant threat to the preservation of civil rights. And because so many constitutional rights cases can be characterized as confrontations between individuals and government "experts" or "professionals," the professional judgment standard threatens constitutional liberties on many fronts.

This Article examines the origins, impact, and implications of the professional judgment standard in a growing variety of civil rights cases. Part I discusses the assumptions and values underlying the concept of professional judgment and examines the reality of professional treatment. The discussion juxtaposes two models. One is the idealized paradigm, assumed in much social and legal discourse (including that of the Supreme Court), of private, individualized interaction with a professional from which the state is excluded. The second, more realistic model of decisionmaking recognizes that

25. Public Health Trust v. Wons, 541 So. 2d 96, 97 (Fla. 1989); Norwood Hosp. v. Munoz, 564 N.E.2d 1017, 1019 (Mass. 1991). In one case, a doctor refused to conduct an operation without prior consent to a blood transfusion. Winthrop Univ. Hosp. v. Hess, 490 N.Y.S.2d 996, 996-97 (Sup. Ct. 1985) (granting order requiring patient to consent to blood transfusion if she has surgery).

26. *See, e.g., Public Health Trust*, 541 So. 2d at 96 (state's interest in having children raised by two parents was insufficient to overcome patient's right to religious beliefs compelling refusal of life-saving transfusion).

professionals' values are often at odds with those of their patients or clients. This conflict is intensified for individuals who, like Nicholas Romeo, reside in understaffed state institutions where the professionals rendering judgments are subject to attendant budgetary and political pressures.

Part II analyzes the professional judgment standard, arguing that it has been applied too broadly. The professional judgment standard should be limited to cases in which the plaintiff claims an affirmative entitlement to professional services, and has received inadequate services or none at all. The professional judgment standard is appropriate to guide courts or juries in determining the level of professional services that the state must provide to individuals in its custody; the standard is inappropriate and harmful in cases where the individual seeks to resist state restrictions on his or her privacy or liberty imposed in the name of professional judgment. Part II also examines the impact of budgetary constraints and the unavailability of services on the professional judgment standard and suggests that the standard can be meaningfully applied only to decisions and recommendations that are insulated from these powerful influences.

Part III considers the expansion of the professional judgment standard to other settings, including higher education, juvenile justice systems, prisons and jails, and foster care programs. It also appraises the expansion to other kinds of claims, including those arising from statutes. Part III discusses the consequences of applying the standard in these settings and examines why it has assumed its present contours in each.

Throughout, I will argue that the professional judgment standard represents a substantial departure from traditional norms of constitutional adjudication. Rather than being simply another deferential standard adopted by an increasingly conservative court, the professional judgment standard is a profound abdication of the judiciary's function in constitutional rights cases, and its proliferation represents a significant danger to the protection of those rights.

## I. THE MEANING OF "PROFESSIONAL" AND "PROFESSIONAL JUDGMENT"

### A. *The Supreme Court's Model of Professional-Patient Interaction*

The Supreme Court emphasized in *Youngberg v. Romeo* that treatment decisions made in institutional settings by qualified professionals are entitled to great deference by the courts.[27] Departing from prevailing constitutional adjudication, the Court held that the defendant professionals' decisions should be regarded as "presumptively valid."[28] To understand why this extreme

27. *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982).

28. *Id.* at 323. A LEXIS search of all Supreme Court cases containing the phrase "presumptively valid" revealed that, until 1982, only statutes, ordinances, regulations, and administrative agency or court proceedings were considered presumptively valid in the face of constitutional challenge. Since *Youngberg*, the kinds of individual decisions considered presumptively valid have proliferated, and include decisions by defense

deference appears so self-evidently logical to the Court that the opinion hardly discusses it,[29] it is necessary to understand the Court's view of professionals and professional decisionmaking. This Section argues that in the last twenty years the Supreme Court has developed and articulated a distinct image of professionals, particularly medical and health care professionals, that has dominated its decisions in a variety of areas.[30] This model, and the assumptions implicit in it, will be illustrated primarily through the Court's decisions involving rights in the area of abortion and mental disability law.

In *Youngberg*, Justice Powell defined a "professional" as "a person competent, whether by education, training or experience, to make the particular decision at issue."[31] But the word "professional" carries far broader connotations than simply competence "to make the particular decision at issue." Justice Powell's definition encompasses plumbers, beauticians, and cat burglars, yet these occupations are not commonly associated with the term "professional." The concept is clearly more complex:

> [A] profession, sociologists have suggested, is an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than a profit orientation, enshrined in its code of ethics.[32]

This service orientation is part of an underlying moral component of the term "professional." It implies a self-regulated responsibility to conform to a set of standards in the use of expertise, competence or knowledge.[33]

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attorneys and officials in institutions of higher education. *See infra* Part III(A).

29. *Youngberg*, 457 U.S. at 322-23. On the most immediate level, of course, deference to state professionals serves the overriding purpose of restricting judicial intervention in state-operated programs and institutions. But, as will be discussed below, the perceived need to restrict judicial intervention arises as much from the Court's vision of the professionals who administer and work in these programs and institutions as from its judicial philosophy about the role of courts.

30. The fact that this image is a value-laden construct, rather than an empirical description, is underscored by an examination of the Court's attitude toward professionals, which used to be considerably more skeptical and less deferential. *See, e.g., In re* Gault, 387 U.S. 1, 27 (1967).

31. *Youngberg*, 457 U.S. at 323 n.30. The Court differentiated between "persons with degrees in medicine or nursing, or with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded," on the one hand, who would be responsible for "[l]ong-term treatment decisions," and "employees without formal training but who are subject to the supervision of qualified persons," on the other hand, who would make "day-to-day decisions regarding care." *Id.*

32. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 15 (1982).

33. *See, e.g.*, Raymond v. Board of Registration in Medicine, 443 N.E.2d 391, 394 (Mass. 1982) ("The ability to practice medicine requires not only technical competence, but also the unswerving dedication to employ it to preserve life, restore health, and alleviate suffering."); GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 674 (1990) ("A core mission of professional education is to inculcate values to encourage self-criticism, single-minded devotion to an individual client, and an ethic of public service."); LUCY YOUNG KELLY, DIMENSIONS OF PROFESSIONAL NURSING 187 (1985) ("A profession is seen as a body of individuals voluntarily subordinating themselves to a standard of social morality more exacting than that of the community in general.").

We also traditionally equate professionalism with neutrality and objectivity. Specifically, a profession is understood to be based on a body of determinate, value-free knowledge.[34] This knowledge, itself objective, is imparted to clients in an objective way, regardless of their race, gender, class, or station in life. To be "professional" is, supposedly, to be nonideological, both as an individual and as a purveyor of an objective body of knowledge.[35] The objectivity and neutrality of a professional is an essential component of our understanding of professional judgment, which is seen as neither idiosyncratic nor ideological, but grounded in "consensually validated knowledge and competence rest[ing] on rational, scientific grounds."[36]

Of all professions, perhaps the medical profession evokes this image most powerfully.[37] Despite a number of recent developments that reflect increased government and third party involvement in health care[38] as well as the deterioration of relations between doctor and patient—epitomized by the patient's rights movement and spiraling litigation[39]—there remains a powerful and, in

34. "The professional offers judgments and advice, not as a personal act based on privately revealed or idiosyncratic criteria, but as a representative of a community of shared standards. The basis of those standards in the modern professions is presumed to be rational inquiry and empirical evidence." STARR, *supra* note 32 at 12.

35. This is hardly an unchallenged assumption. In the legal profession, legal realists and, more recently, critical legal theorists have attacked it full-scale. Nevertheless, it remains the assumption that must be criticized. For a cogent description of this assumption and critiques of it, see Martha Minow, *Partial Justice: Law and Minorities*, *in* THE FATE OF LAW 27-29 (Austin Sarat & Thomas R. Kearns eds., 1991). In the medical profession, such challenges are far less vocal, although not unknown. *See, e.g.*, HAROLD BURSZTAJN ET AL., MEDICAL CHOICES, MEDICAL CHANCES: HOW PATIENTS, FAMILIES, AND PHYSICIANS CAN COPE WITH UNCERTAINTY (1981); WILLIAM F. MAY, THE PATIENT'S ORDEAL (1991). Many of these challenges have originated outside the medical profession. *See, e.g.*, GEORGE J. ANNAS, JUDGING MEDICINE (1988); PAUL RAMSEY, THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS (1970).

36. STARR, *supra* note 32, at 15. *See, e.g.*, Ford v. Wainwright, 477 U.S. 399, 417 (1986) (plurality opinion) (stating that the manner of selecting and using expert examiners must "be conducive to the formation of neutral, sound, and professional judgments . . ."). *See also* David A. Gerber, *Listening to Disabled People: The Problem of Voice and Authority in Robert B. Edgerton's The Cloak of Competence*, 5 DISABILITY, HANDICAP AND SOC'Y 3, 10 (1990) ("[P]sychologists . . . mask their normative assumption with the language and methods of science.").

37. *See* STARR, *supra* note 32, at 4; Jay Alexander Gold, *Wiser than the Laws?: The Legal Accountability of the Medical Profession*, 7 AM. J.L. & MED. 145, 151 n.16 (1981). Entire books are written about the image of the doctor. *See, e.g.*, WILLIAM F. MAY, THE PHYSICIAN'S COVENANT: IMAGES OF THE HEALER IN MEDICAL ETHICS (1983).

38. Government involvement in health care is primarily through Medicaid, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a (1988), and Medicare programs, 42 U.S.C. §§ 426, 1395c (1988), as well as through a host of more specialized programs and requirements, such as the Hill-Burton Act, 42 U.S.C. § 291 (1988). Private third party involvement takes the form of insurance companies, which more and more are becoming directly involved with the provision of health care. *See* Gerald L. Glandon & Michael A. Morrisey, *Redefining the Hospital-Physician Relationship Under Prospective Payment*, 23 INQUIRY 166 (1986); David D. Griner, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861 (1991); Paul E. Kalb, *Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach*, 99 YALE L.J. 1109 (1990); Gilbert S. Omenn & Douglas A. Conrad, *Implications of DRGs for Clinicians*, 311 NEW ENG. J. MED. 1314 (1984).

39. *See* Judith C. Areen, *Bioethics and Law: The Second Stage: Balancing Intelligent Consent and Individual Autonomy*, 31 ARIZ. L. REV. 447, 449 (1989); Paul A. Sommers, *Malpractice Risk and Patient Relations*, LEGAL ASPECTS OF MED. PRAC., Oct. 1985, at 1; Antoinette D. Paglia, Note, *Taking the Tort Out of Court—Administrative Adjudication of Medical Liability Claims: Is It the Next Step?*, 20 SW. U. L. REV. 41 (1991); Note, *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV.

many respects, still dominant set of positive assumptions about doctors and the doctor-patient relationship.[40]

This set of assumptions, which governs many media portrayals of the medical profession and much of our everyday discourse, assumes voluntary, private, individualized interaction between doctor and patient, involving the highest level of intimacy and trust, from which the state is appropriately excluded.[41] Also essential to this image is the assumption that "the physician can be trusted to treat the patient's health needs and interests as central."[42] This is the cornerstone of the medical professional's image and his authority.[43] These assumptions are mirrored in television shows from "Ben Casey," "Dr. Kildare," "The Young Doctors," and "Marcus Welby M.D." to "M*A*S*H*,"

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1519, 1523 (1990); Don G. Campbell, *When the Question of Insurance Arises*, L.A. TIMES, Apr. 26, 1990, at E16; Suzanne Dolezal, *People Sick of Uncaring Doctors*, DET. FREE PRESS, Apr. 23, 1987, at 1B; Nan Silver, *Off the Pedestal: Finding a Good Doctor in the Post-Welby Age*, S.F. CHRON., Nov. 27, 1990, at B3; Bill Stokes, *An Uneasy Alliance: Suspicion, Skepticism and an Army of Outsiders Threaten the Doctor-Patient Relationship—But the Condition is Being Monitored*, CHI. TRIB., Apr. 29, 1990, Good Health Magazine at 14.

40. Images that are empirically disprovable can dominate and shape policy decisions and legal doctrines even when there is a widespread recognition on the part of experts and many policymakers that the images do not reflect reality. *See, e.g.*, Marc A. Fajer, *Can Two Real Men Eat Quiche Together?: Story-Telling, Gender-Role Stereotypes and Legal Protection for Lesbians and Gay Men*, 46 U. MIAMI L. REV. 511 (1992); Sylvia A. Law, *Homosexuality and the Social Meaning of Gender*, 1988 WIS. L. REV. 187, 192-93. This is particularly true when these images are strongly tied to a larger, nostalgic vision of a simpler and better past. Thus, for example, many social practices are still followed as though the traditional nuclear family, with a mother as homemaker, were the norm in this country. In the same manner, the vision of a benevolent, paternalistic doctor having an individualized, trusting relationship with patients of the same race and similar class also continues to dominate even though there is widespread dissatisfaction with the delivery of health care in this country.

41. This vision is key to many of the arguments against national health insurance or so-called "socialized medicine." It is also supported by many books written by physicians portraying the doctor-author as involved in a private, intimate relationship with his patient in which both collaborate for the benefit of the patient. Many of these books have reached the best seller list in recent years, such as OLIVER SACKS, AWAKENINGS (1973), on which a popular movie of the same name was based (Columbia Pictures, 1990); OLIVER SACKS, THE MAN WHO MISTOOK HIS WIFE FOR A HAT (1985); and IRVING YALOM, LOVE'S EXECUTIONER (1989). However, Dr. Sacks also wrote a fascinating book which did *not* make the best seller list, A LEG TO STAND ON (1984) [hereinafter SACKS, A LEG TO STAND ON], in which he writes from a completely different perspective—that of the patient. *See infra* note 86. A recent film about a similar experience, THE DOCTOR (Touchstone Pictures, 1991), ends triumphantly with the doctor reclaiming the patient-centered model of care. Films portraying state-run or government hospitals have been far more ambivalent about the doctor-patient relationship, such as BORN ON THE FOURTH OF JULY (Universal City Studios, Inc., 1989), as have been those portraying psychiatric hospitals, such as ONE FLEW OVER THE CUCKOO'S NEST (Fantasy Films, 1975).

42. Jay Alexander Gold, *The Biosphere and the Circle of Learning*, 5 AM. J.L. & MED. 145, 153 (1979) (book review), *quoting* David Mechanic, *Therapeutic Relationship: Contemporary Sociological Analysis*, *in* ENCYCLOPEDIA OF BIOETHICS 1668 (Warren T. Reich ed., 1978).

43. As Talcott Parsons noted, "[The doctor's] authority rests, fundamentally, on the belief on the part of the patient that the physician has and will employ for his benefit a technical competence adequate to help him in his illness." Talcott Parsons, *Introduction to* MAX WEBER: THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATIONS 59 n.4 (A.M. Henderson & Talcott Parsons trans., 1947).

"St. Elsewhere," and "Trapper John, M.D."[44] and in almost every daytime soap opera, as well as in books at the top of the best-seller list and countless movies.

This image is also at the core of much of the Supreme Court's jurisprudence in cases involving health care professionals, possibly reflecting the Justices' personal experience with the medical profession. The Court sees medical professionals as motivated by concern for the welfare and treatment of their clients,[45] or, at the very least, by the pure and disinterested "professional curiosity a dedicated medical man possesses."[46] Medical professionals are seen as sharing an identity of interest with their clients untainted by other potential conflicts or responsibilities. The relationship is assumed to exist in the private sphere, and to operate best when protected from governmental intrusion.

This vision of doctors and of the doctor-patient relationship, with all its embedded assumptions, received its most explicit articulation in Justice Blackmun's impassioned dissent in *Rust v. Sullivan*:[47]

> In our society, the doctor/patient dialogue embodies a unique relationship of trust. The specialized nature of medical science and the emotional distress often attendant to health-related decisions requires that patients place their complete confidence, and often their very lives, in the hands of medical professionals. One seeks a physician's aid not only for medication or diagnosis, but also for guidance, professional judgment, and vital emotional support. Accordingly, each of us attaches profound importance and authority to the words of advice spoken by the physician. It is for this reason that we have guarded so jealously the doctor/patient dialogue from governmental intrusion.[48]

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44. *Ben Casey* (NBC televison series, 1961-66); *Dr. Kildare* (NBC television series, 1961-66); *Marcus Welby, M.D.* (ABC television series, 1969-76); *M*A*S*H** (CBS television series, 1972-83); *St. Elsewhere* (NBC television series, 1982-88); *Trapper John, M.D.* (CBS television series, 1979-86). Even in television shows where medicine is not the central theme, the image of the doctor remains very powerful: witness Dr. McCoy on *Star Trek* (NBC television series, 1966-69) and Drs. Crusher and Pulaski on *Star Trek: The Next Generation* (Paramount Productions, 1987-present).

45. *See, e.g.*, Washington v. Harper, 494 U.S. 210, 222-23 n.8 (1990); Doe v. Bolton, 410 U.S. 179, 196-97 (1973).

46. Richardson v. Perales, 402 U.S. 389, 403 (1971).

47. 111 S. Ct. 1759 (1991).

48. *Id.* at 1785 (Blackmun, J., dissenting). Because Justice Blackmun, whose affinity for the medical profession is well known, wrote Roe v. Wade, 410 U.S. 113 (1973), and many of the subsequent abortion decisions as well, it might be argued that the image of the professional in these decisions is his rather than the Court's. Nevertheless, his colleagues have adopted Justice Blackmun's language in joining these opinions. Moreover, other justices have written in similar terms. For example, Justice Powell penned similarly striking images of the medical profession in City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 427, 430, 443-50 (1983); images of privacy and the joint doctor-patient venture were invoked by Justice Marshall in H.L. v. Matheson, 450 U.S. 398, 435 (1981) (Marshall, J., dissenting). Other justices have expressed the Court's conception of the medical profession in contexts other than abortion. *See, e.g.*, Parham v. J.R., 442 U.S. 584 (1979) (Burger, C.J.) (discussed *infra* notes 65-67 and accompanying text); Washington v. Harper, 494 U.S. 210 (1990) (Kennedy, J.) (discussed *infra* notes 59-64 and accompanying text). Interestingly, Justice Blackmun has begun to recognize the distinction between the doctor-patient relationship in private and public settings. West v. Atkins, 487 U.S. 42 (1988) (discussed *infra* notes 129-130 and accompanying text).

In fact, the Supreme Court's abortion jurisprudence does much to illuminate the Court's assumptions about the medical profession. It is widely recognized that the abortion decisions are dedicated as much to preserving the privacy and autonomy of the doctor from governmental intrusion as to preserving the rights of the women involved.[49]

But the emphasis in the abortion decisions is not so much on the physician alone as on the special nature of the doctor-patient relationship. Furthermore, the image is of a relationship firmly embedded in the private sphere, with which government interference would be inappropriate and harmful.[50] The decisions clearly assume that the patient's well-being is the sole motivation for the physician's actions and advice.[51] There is also a sense that medical decision-making is a joint venture between doctor and patient: the Court characterizes a personal discussion between physician and patient about the abortion decision, its health risks, and its consequences as a "typical element of the physician-patient relationship."[52] Most of all, the decisions paint a picture of

> the conscientious physician . . . whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human

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49. *See, e.g.*, Andrea Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 59 (1983); Laurence H. Tribe, *The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence*, 99 HARV. L. REV. 330, 335 (1985); *see also* Catherine A. MacKinnon, *Roe v. Wade: A Study in Male Ideology*, *in* ABORTION: MORAL AND LEGAL PERSPECTIVES 45, 53 (Jay Garfield & Patricia Hennessy eds., 1984).

50. The strongest statement the Court made in this regard was in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). Invalidating a statute requiring that certain printed materials be given to a woman seeking an abortion, the Court criticized this condition as

> nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician, [making the physician] in effect an agent of the State in treating the woman and plac[ing] his or her imprimatur upon both the materials and the list. All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures—as it obviously was intended to do—the dialogue between the woman and her physician.

*Id.* at 762-63 (citation omitted). Note the court's dichotomy between "state medicine" and "professional medical guidance."

The fact that the Supreme Court has recently moved in the direction of allowing state regulation to intrude upon the privacy of the doctor-patient relationship, *e.g.*, Planned Parenthood v. Casey, 112 S.Ct. 2791 (1992); Rust v. Sullivan, 111 S.Ct. 1759 (1991); Webster v. Reproductive Health Serv., 492 U.S. 490 (1989), does not mean that the Court has abandoned the image of the doctor-patient relationship as a private one in which the state should not intrude. Rather, the decisions attempt to minimize the effect of the intrusion, *Casey*, 112 S.Ct. at 2823-24; *Rust*, 111 S.Ct. at 1777. The image of the doctor-patient relationship remains the same; it is simply that protecting this relationship is less important to the majority when weighed against competing state interests. In its most recent abortion decision, the Court has moved for the first time to emphasize the woman's right to privacy over the privacy of the physician-patient relationship. *Casey*, 112 S.Ct. at 2807.

51. *See, e.g.*, City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 450 (1983) ("In accordance with the ethical standards of the profession, a physician will advise the patient to defer the abortion when he thinks this will be beneficial to her.") (citation omitted).

52. *Id.* at 447.

> frailty, so-called "error," and needs. The good physician—despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are "good"—will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling.[53]

A number of cases from the past several decades reflect the assumptions discussed above and add another: that professionals in the private and public sectors are more similar due to their shared professional code than dissimilar due to the different contexts and institutions in which they work. This assumption rests on the belief that members of a given profession, with their purported objectivity and neutrality, will apply the same standards and possess the same skills regardless of where they work and who their patients are. For the most part, the Court does not distinguish between the professional competence and commitment of private and public health care providers[54] any more than it distinguishes, in the legal context, between appointed and retained attorneys in cases involving effective assistance of counsel.[55]

This dogged resistance to the possibility that conflicts of interest might influence the opinions and actions of members of the medical profession can be seen in a number of cases. In *Richardson v. Perales*,[56] a case involving the determination of disability for the purpose of Social Security benefits, the Court denied any causal link between the fact that the agency had retained the examining physicians and the unanimous conclusion of the retained physicians that the claimant was not seriously disabled, despite the fact that the claimant's own physician disagreed with this conclusion:

> Although each [of the physicians retained by the agency] received a fee, that fee is recompense for his time and talent otherwise devoted to private practice or other professional assignment. We cannot, and do not, ascribe bias to the work of these independent physicians, or any interest on their part in the outcome of the administrative proceeding beyond the professional curiosity a dedicated medical man possesses.[57]

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53. Doe v. Bolton, 410 U.S. 179, 196-97 (1973).

54. There is one interesting exception to this rule, *West v. Atkins* (also written by Justice Blackmun), discussed *infra* notes 129-130 and accompanying text.

55. *See* Cuyler v. Sullivan, 446 U.S. 335, 344-45 (1980). *But see* Strickland v. Washington, 466 U.S. 668, 708 (1984) (Marshall, J., dissenting).

56. 402 U.S. 389 (1971).

57. *Id.* at 403. While the majority characterized the medical reports as "routine, standard, and unbiased," *id.* at 404, Justice Douglas scathingly dissented. He observed that one of the doctors "was a 'medical adviser' to HEW. . . . Some [of the other doctors] . . . were employed by the workmen's compensation insurance company to defeat respondent's claim." *Id.* at 413 (Douglas, J., dissenting). He continued, "Those defending a claim look to defense-minded experts for their salvation. Those who press for recognition of a claim look to other experts. . . . The use by HEW of its stable of defense doctors without submitting them to cross-examination is the cutting of corners—a practice in which certainly the Government should not indulge." *Id.* at 414. Another case decided the same year as *Richardson* rejected the suggestion that home visits by a social worker could be intended for any purpose other than the benefit of the client. Wyman v. James,

The same attitude pervades the Court's jurisprudence in mental disability cases. While the Court does not necessarily have the highest opinion of the reliability of psychiatric and mental health predictions, diagnosis or treatment,[58] it stubbornly and paradoxically clings to the notion that mental health professionals—whether private or state practitioners—apply a neutral, if murky, body of knowledge for the benefit of their clients.

In *Washington v. Harper*,[59] a recent case involving the right of a mentally ill prisoner to refuse psychotropic medication, the Court rejected the proposition, supported by a number of studies and a leading textbook in the field,[60] that psychiatrists working in the correctional system often use drugs for behavioral control rather than for treatment. According to the Court, "the fact that the medication must first be prescribed by a psychiatrist, and then approved by a reviewing psychiatrist, *ensures* that the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of his institutional confinement."[61] Though Justice Stevens argued that "[u]se of psychotropic drugs . . . serves to ease the institutional and administrative burdens of maintaining prison security and provides a means of managing an unruly prison population and preventing property damage,"[62] the majority flatly rejected Stevens' point with the observation that the Hippocratic Oath would prohibit such misuse. "Unlike Justice Stevens, we will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the

400 U.S. 309, 322-23 (1971). Justice Douglas, more sensitive to the conflicts of interest inherent in being both a health or human-services professional and a paid state agent, again dissented forcefully. *Id.* at 326.

58. *See, e.g.*, Addington v. Texas, 441 U.S. 418, 430 (1979) (requiring a clear and convincing standard of proof in civil commitment proceedings, in part because "[p]sychiatric diagnosis . . . is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician"); *see also* Barefoot v. Estelle, 463 U.S. 880, 927 (1983) (Blackmun, J., dissenting) (arguing that psychiatrists "sometimes attempt to perpetuate" the "illusion" that they have "a special expertise to predict dangerousness"); Jones v. United States, 463 U.S. 354, 379 (1983) (Brennan, J., dissenting) ("[S]trong institutional biases lead [mental health professionals] to err when they attempt to determine an individual's dangerousness, especially when the consequence of a finding of dangerousness is that an obviously mentally ill patient will remain within their control."). *See generally*, Michael L. Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, and Symbolic Values: Random Decisions, Hidden Rationales, or "Doctrinal Abyss?"* 29 ARIZ. L. REV. 1, 7-22 (1987).

59. 494 U.S. 210 (1990).

60. COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1995 (Harold I. Kaplan & Benjamin J. Sadock eds., 4th ed. 1985) ("Observers of the prison system in the United States have been particularly critical of the haphazard ways in which psychopharmacological agents are dispensed."). *Cf.*, Edward Kaufman, *The Violation of Psychiatric Standards of Care in Prison*, 137 AM. J. OF PSYCHIATRY 566, 568 (1980) (noting that chaos resulting from frequent prescription of psychotropic drugs for purposes of control caused prisons to discontinue practice, although overmedication remains widespread); Stanley A. Sitnick, *Major Tranquilizers in Prison: Drug Therapy and the Unconsenting Inmate*, 11 WILLAMETTE L.J. 378, 387-88 (1975) (arguing that prison environment tempts officials to use psychotropic drugs as control agents and citing anecdotal evidence that they do so).

61. *Harper*, 494 U.S. at 222 (emphasis added). It is beyond the scope of this Article to examine the interesting juxtaposition of a "prisoner's medical interests, given the legitimate needs of his institutional confinement."

62. *Id.* at 244-45 (Stevens, J., concurring in part and dissenting in part).

patients; indeed, the ethics of the medical profession are to the contrary."[63] The Court's apparent blindness to the fact that penal psychiatrists have conflicting interests is even more striking in view of its explicit recognition that "[t]he State has undertaken the obligation to provide prisoners with medical treatment consistent not only with their own medical interests, but also with the needs of the institution."[64] Yet these state employed psychiatrists are presumed to act precisely as would a private physician in adhering to the strictures of the Hippocratic Oath.

Like *Harper*, the Court's decision in *Parham v. J.R.*[65] asserts the objectivity and neutrality of state-employed mental health professionals. The Court reversed the opinion of the three-judge district court that the admission of children to state mental hospitals without a judicial-style hearing violated the Due Process Clause of the Fourteenth Amendment. In holding that Georgia's existing admissions process provided sufficient procedural protection, the Supreme Court found that review by an admitting psychiatrist adequately protected the liberty interests of children who were being "voluntarily" committed to state institutions by their parents:

> Georgia's procedures are not "arbitrary" in the sense that a single physician or other professional has the "unbridled discretion" the District Court saw to commit a child to a regional hospital. To so find on this record would require us to assume that the physicians, psychologists, and mental health professionals who participate in the admission decision and who review each other's conclusions as to the continuing validity of the initial decision are either oblivious or indifferent to the child's welfare—or that they are incompetent.[66]

Again, the Court found that the state professionals had "acted in a neutral and detached fashion in making medical judgments in the best interests of the children."[67]

In sum, the Supreme Court's image of the medical professional in general and of mental health professionals in particular seems to be drawn completely from the private sphere. The image—and the *Youngberg* professional judgment standard—rests upon two assumptions. The first assumption is that to act professionally is to act neutrally, objectively, and nonideologically, with the

63. *Id.* at 222-23 n.8. The Court also cited the American Psychiatric Association's own Principles of Medical Ethics. Interestingly, in *Barefoot v. Estelle*, 463 U.S. 880 (1983), the Court approved the admission of psychiatric testimony predicting a specific individual's propensity for violence where the psychiatrist had not personally examined the individual. *Id.* at 903. To give such testimony explicitly violates the American Psychiatric Association's Principles of Medical Ethics. *Id.* at 923-24 n.6 (Blackmun, J., dissenting). Nevertheless, as the Court noted, "as this case and others indicate, there are those doctors who are [quite] willing to testify [in this way] at the sentencing hearing . . . ." *Id.* at 899.

64. *Harper*, 494 U.S. at 225.

65. 442 U.S. 584 (1979).

66. *Id.* at 615.

67. *Id.* at 616.

primary motivation of furthering the patient's best interests. Second, the Court assumes that professionalism transcends the gulf between the public and private spheres for both the professional and the patient, so that no difference exists between the actions and standards of public professionals treating public patients and those of private professionals treating private patients.

### B. *The Reality of Professional-Patient Interaction*

The Supreme Court's image of the mental health professional is inaccurate because the assumptions underlying it are far removed from reality. The assumptions are particularly inaccurate and damaging when applied to cases that, like *Youngberg*, involve indigent patients who must depend for their treatment on professionals employed by the state. This Section will argue that professionals do not in fact act neutrally. Rather, all professionals are shaped by the norms, values, and assumptions of professionalism in general and of their professions in particular. Professional judgment is also inescapably informed by assumptions of class, race, and gender. In addition, professionals who are state actors do not have the same partnership with their clients as do private sector professionals, who are paid by the clients themselves or by private insurance.[68] Duties to the state generate conflicts of interest, and public sector care suffers from severe limitations of resources having few parallels in the private sphere. State institutions often exist primarily for custodial purposes rather than for treatment. Thus, "professional judgment" in state mental health systems takes place under circumstances so far removed from the Court's idealized paradigm of the professional as to make that paradigm unrecognizable and irrelevant.

#### 1. *The Myth of Neutrality*

The image that professionals do not impose their own values on their clients and that they have no goals beyond advancing the client's interest is the source of much of their power and a principal reason that professional pronouncements are taken as persuasive. In fact, professionalism is frequently associated with neutrality in case law.[69] In many different ways, however, professionals embody and impose a complex set of values that are far from neutral. In the private sphere a professional's values may be perceived as benign and welcomed by

68. Even in those circumstances, there is some doubt as to the identity of interests between professionals and patients. *See infra* notes 85-86 and accompanying text. In addition, even this private partnership is being significantly eroded by the growth of HMO's and other forms of managed care programs that put private professionals under conflicting priorities to maximize profits and to provide good medical care. That issue, however, is beyond the scope of this Article.

69. *See supra* notes 56-64 and accompanying text (discussing Richardson v. Perales, 402 U.S. 389 (1971) and Washington v. Harper, 494 U.S. 210 (1990)).

the client; in any event, the client is free to go and select another professional whose values are more consonant with her own. In state institutions, most clients are captive to the values of the professionals who treat them; their only recourse to assert their own values and goals may be a court challenge to the state professional's actions. The courts' failure to grasp the idea that conflict between a professional and a client often involves a clash of value systems leads the courts to apply reflexive presumptions in favor of the professional. Where the clash is evident, as in cases involving religious beliefs and the refusal of blood transfusions, the courts are far less deferential to professionals. The exposure of the value systems underlying professional judgments, then, becomes particularly important.

Members of a given profession often share certain beliefs inculcated as part of their professional training. These beliefs include values common to all professions, such as the notion that the professionals' judgment should be sovereign within their field of expertise. "[T]he ideal of a profession calls for the sovereignty of its members' independent, authoritative judgment."[70] Likewise, all professions share a preference for professional autonomy as against governmental regulation and intervention, whether in the form of legislative requirements or judicial decrees.

Members of a given profession also share values specific to their profession. The legal profession stresses autonomy and individual responsibility, while the medical profession is more paternalistic.[71] In the medical profession, the primary mandate is to cure or restore the health of a patient.[72] When curing or healing a patient conflicts with the patient's own choices, a goal of healing very often supercedes the patient's wishes: patient autonomy is simply not a primary value of the medical profession.[73] Clients in the private sphere, who are relatively

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70. STARR, *supra* note 32, at 23. In fact, "[a] professional who yields too much to the demands of clients violates an essential article of the professional code: Quacks, as Everett Hughes once defined them, are practitioners who continue to please their customers but not their colleagues." *Id.*

71. *See* Martin S. Pernick, *The Patient's Role in Medical Decisionmaking*, *in* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP app. E at 4 (1982) ("[T]raditional codes of medical ethics mention little or nothing about patient consent, and express overt hostility towards providing the patient with much information on which to base a decision."); Alexis M. Nehemkis, *The Eye of the Beholder: Staff Perceptions of Noncompliance*, *in* COMPLIANCE: THE DILEMMA OF THE CHRONICALLY ILL 158, 171-79 (Kenneth E. Gerber & Alexis M. Nehemkis eds., 1986).

72. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 225-26 (1984).

73. The classic example of this situation is when a patient's religious values lead her to refuse blood transfusions. *See* Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989) (state's interest in having children raised by two loving parents was insufficient to overcome patient's right, pursuant to religious beliefs, to refuse life-saving transfusion). But it can also occur simply because a patient prefers a certain level of comfort while a doctor wishes the patient to behave in a less comfortable way that would prolong his life. *See* ANNAS, *supra* note 35, at 27, 30; Nehemkis, *supra* note 71, at 171-72; KATZ, *supra* note 72, at 26 ("[W]hat passes today for disclosure and consent in physician-patient interactions is largely an unwitting attempt by physicians to shape the disclosure process so that patients will comply with their recommendations."). Perhaps the most eloquent statement reflecting this tension and the need for an imperative outside the medical profession to balance the conflicts between healing and autonomy comes from Paul Appelbaum, Charles Lidz, and Alan

more free to consider their doctor's advice in light of their own personal values and to decide the proper course of action for themselves,[74] may expect and appreciate this professional value. The fact that physicians consider treatment and cure to be their first priority should, however, be recognized as a powerful value system that will inevitably skew professional judgment. For example, a physician's doubts about a patient's competence to accept or refuse treatment are typically resolved in the patient's favor if the patient wishes to accept treatment; the patient's competence is challenged only if she refuses treatment.[75] In addition, medical professionals readily sacrifice patient autonomy to protect patients from harm or to reduce risks to their health.

Within the specializations of medicine, each branch also has its own specific set of values, usually (and unsurprisingly) focused on the benefits that the specialists' particular expertise has to offer. For example, physicians at institutions tend to resolve doubts in favor of institutional care.[76]

Members of a given profession also tend to share a professional consensus on many issues—particularly regarding diagnoses and treatments—for which there is actually little or conflicting empirical support.[77] For example, mental health professionals rely heavily on interviews for diagnosis even though studies

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Meisel, who say that situations in which patients refuse treatment

> are among the most difficult situations physicians must handle. They must come to grips with the limits on their authority to order interventions and on their power singlehandedly to combat disease and restore health. Even physicians who are generally supportive of the idea of informed consent may balk at its implications when patients refuse care physicians believe will be highly beneficial. . . . We must all face real limitations on our power to pursue our goals and advance our values. . . . [T]hat is the price we pay as a society for supporting individual freedom of choice.

PAUL APPELBAUM ET AL., INFORMED CONSENT 201-02 (1987). The reality of conflict underlying a perceived identity of interest is also true in other professional contexts, including the attorney-client context. *See* Anthony V. Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 YALE L.J. 2107, 2123 (1991) (Poverty lawyers cannot identify with their clients' struggles and tend to silence them. The silencing is "tied to the denigration of client difference delineated by class, ethnicity, gender, race, sexual preference, and disability."); Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1, 46 (1990) ("The lawyer shared . . . the oppression of gender, but was placed above [her client] in the social hierarchies of race and class. As a result, even though the attorney was sure that her client would follow her instructions, the client did not.").

74. The power imbalance between medical professionals and their private clients is also considerable. Often the patients who have expressed their chagrin most publicly at this discovery are doctors who became patients. *See infra* note 86.

75. *See* Donald Bersoff, *Autonomy for Vulnerable Populations*, 37 VILL. L. REV. (forthcoming Jan. 1993); Bruce J. Winick, *Competency to Consent to Treatment*, 28 HOUS. L. REV. 15, 21 (1991).

76. ANNAS, *supra* note 35, at 158.

77. There is some evidence to suggest that many norms of professional care are not reached through research or evidence, but rather become accepted through some process of professional consensus not based on actual fact. *See, e.g.*, Douglas Bilken, *The Myth of Clinical Judgment*, 44 J. SOC. ISSUES 127, 136 (1988) (suggesting that political and budgetary factors drive so-called "clinical" decisions); Howard Rubenstein et al., *Standards of Medical Care Based on Consensus Rather than Evidence: The Case of Routine Bedrail Use for the Elderly*, 11 LAW MED. & HEALTH CARE 271 (1983) (suggesting that routine use of bedrails, rather than protecting elderly patients, contributes to their injuries). This is particularly true in the field of mental health, where the diagnoses themselves are a result not of empirical research but of professional consensus, *see infra* notes 97-100 and accompanying text. Even when there is dissension within the professional community over a given treatment, it is often not apparent to the public, which may perceive a profession as having a monolithic position on any given treatment issue. This is an entirely reasonable assumption, given the image of professions discussed earlier.

show that interviews are not particularly likely to yield valid results; many standard tests relied upon by mental health professionals are similarly deficient.[78] Worse, studies show that professionals have great confidence in their own judgments and are highly resistant to changing them, even when these judgments are based on invalid tools of diagnosis. Evidence suggests that some professional judgments in the mental health field are made within minutes of meeting the client.[79]

In addition to the unacknowledged value systems incorporated in being a professional and, specifically, being a medical professional, professionals tend to share the values typical of their race, class, and gender. Professionals, particularly those to whom the Supreme Court refers in its decisions applying the professional judgment standard, are overwhelmingly white,[80] male,[81] and, presumably, middle class or affluent. In the private sector most clients are also white and middle class; a slight majority are female.[82] In the private system, in other words, mental health professionals and their clients often have race and class characteristics in common.[83] This is significant, for treatment varies according to how much the professional and his or her client have in common. For example, in the area of informed consent, doctors give more information to white, better educated patients having higher incomes.[84]

Similarities between private sector professionals and clients notwithstanding, the professional's interaction with the client is imbued with power imbalance, detachment, and control.[85] Many doctors in the private sector simply do not

78. Donald Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. REV. 327, 343 (1992).

79. *Id.* at 345.

80. *See infra* text accompanying notes 90-92.

81. *See supra* note 12.

82. Walter R. Gove, *Mental Illness and Psychiatric Treatment Among Women*, in THE PSYCHOLOGY OF WOMEN: ONGOING DEBATES 102, 103 (Mary Roth Walsh ed., 1987).

83. Even when clients of mental health professionals share race and class in common, gender differences sometimes have proven to be extremely problematic in providing treatment. *See, e.g.*, PHYLLIS CHESLER, WOMEN & MADNESS (1972); KATE MILLETT, THE LOONY-BIN TRIP (1990); EDWIN M. SCHUR, LABELING WOMEN DEVIANT: GENDER, STIGMA, AND SOCIAL CONTROL (1983); Jo Anne Morrow, *Women's Health Care and Informed Consent*, 9 GOLDEN GATE U. L. REV. 553 (1978-79).

84. *A Review of Empirical Studies on Informed Consent and Decisionmaking*, *in* 2 MAKING HEALTH CARE DECISIONS: THE LEGAL AND ETHICAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTIONER RELATIONSHIP, PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH 62, 97-98, 121, 124 (finding that "[t]he primary determinant of how much a physician disclosed is the percentage of patients he or she perceived as being capable of understanding their condition or treatment," *id.* at 97-98, and that "[t]here is a relationship between the proportion of patients who are poor and the proportion of patients who [doctors report] can understand treatment," *id.* at 62. Thus, the authors conclude that physicians whose practice consists of mostly poor patients are less likely to think that their patients want the truth. *Id.* at 124); David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 J. AM. MED. ASS'N 2101, 2102 (1992) ("Interestingly, when physicians engage in discussions about treatment with their patients, they are more inclined to talk with patients who are most like them. Patients who seem more intelligent and better educated receive more time and more explanations from their physicians.").

85. *See, e.g.*, Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 480-83 (Cal. 1990) (physician allegedly patented and marketed a cell-line established from patient's blood cells removed during surgery without patient's knowledge), *cert. denied*, 111 S. Ct. 1388 (1991).

give the time or attention to the doctor-patient relationship that the Supreme Court appears to assume. Doctors often treat patients, even patients who pay, as less than equal. It is telling that doctors who have found themselves as patients have articulated with surprise and outrage the powerlessness they experienced in that unfamiliar role.[86]

If wealthy, privileged white doctors sometimes find themselves unheard and depersonalized as patients, it can be assumed that public sector patients, who have less in common with their health professionals, will fare even worse. Treatment for health problems, especially mental health problems, requires an understanding of the patient's culture and personal history.[87] Researchers have observed that "as the sociocultural distance between the clinician and his patient increases, diagnoses become less accurate."[88] This problem is particularly intense in the public sector where the involuntary "clients," unlike their caretakers, are disproportionately members of racial minorities and are indigent. In state and county hospitals, black men are hospitalized at a rate 2.8 times greater than white men, and black women at a rate 2.5 times greater than white women.[89] By contrast, only about 2% of psychiatrists are black.[90] Out of

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86. *See, e.g.*, ED ROSENBAUM, A TASTE OF MY OWN MEDICINE (1988); SACKS, A LEG TO STAND ON, *supra* note 41; ALLEN WIDOME, THE DOCTOR, THE PATIENT (1989). A particularly vivid account is given by Dr. Sacks, a neurologist. He was hospitalized with a leg injury having neurological complications. He wrote of his consternation at being infantilized, ignored, and treated with contempt by his doctor:

> I was stunned . . . I thought: what sort of doctor, what sort of person, is this? He didn't even listen to me. He showed no concern. He doesn't listen to his patients—he doesn't give a damn. Such a man never listens to, never learns from, his patients. He dismisses them, he despises them, he regards them as nothing. And then I thought—I am being terribly unfair. [So Dr. Sacks attempts to see his physician again, and has the following encounter with him:]
>
> "Well, Sacks," he snorted. "What's the matter now? Haven't you been told there is nothing the matter? Are you critical of the surgery or post-operative care?"
>
> "Not at all," I replied. "Both seem exemplary."
>
> "What *is* the matter then?"
>
> "The leg doesn't *feel* right."
>
> "This is very vague and subjective. Not the sort of thing we can be concerned with . . . ." [Sacks describes the sensation in his leg.]
>
> "Sacks, you're unique," the Registrar said. "I've never heard anything like this from a patient before."
>
> "I can't be unique," I said, with anger, and rising panic. "I must be constituted the same way as everyone else! Perhaps (my anger was getting the better of me now), perhaps you don't listen to what patients say; perhaps you're not interested in the experiences they have." "No, indeed, I can't waste time with 'experiences' like this. I'm a practical man, I have work to do."
>
> "Experience aside then, the leg doesn't *work*." "That's not my business."
>
> "Then whose business is it? Specifically, there is something physiologically the matter. What about a neurological opinion, nerve-conduction tests, EMGs, etc.?"
>
> He turned away and gave me no answer.

SACKS, A LEG TO STAND ON, *supra* note 41, at 105, 106-07.

87. Even treatment for physical health problems is complicated when there is a cultural or class gap between doctor and patient. Warren E. Leary, *Uneasy Doctors Add Race-Consciousness to Diagnostic Tools*, N.Y. TIMES, Sept. 25, 1990, at C1. The problem is exacerbated when mental health is at issue. Billy E. Jones & Beverly A. Gray, *Problems in Diagnosing Schizophrenia and Affective Disorders Among Blacks*, 37 HOSP. & COMMUNITY PSYCHIATRY 61 (1986).

88. Herbert S. Gross et al., *The Effect of Race and Sex on the Variation of Diagnosis and Disposition in a Psychiatric Emergency Room*, 148 J. NERVOUS & MENTAL DISEASE 638, 638 (1969).

89. ERIC ROSENTHAL & LEE CARTY, NATIONAL INST. OF MENTAL HEALTH, IMPEDIMENTS TO SERVICES

273,600 licensed psychologists in this country in 1986, only 10,000 were black.[91] Ninety percent of the 3,209 doctorates in psychology in 1989 were awarded to whites.[92]

Studies on diagnosis and treatment confirm what these statistics suggest: members of minorities are misdiagnosed far more often than white patients.[93] The misdiagnosis usually takes the form of overdiagnosing schizophrenia in black patients; blacks are diagnosed with schizophrenia at almost twice the rate of white inpatients.[94] Because schizophrenia is generally considered one of the most serious mental disorders, misdiagnosis may be one explanation for the fact that minorities are involuntarily committed to state institutions at a statistically disproportionate rate. Once there, black men are far more likely to be subject to seclusion than white men.[95]

More subtly, values arising from race, gender, and class may affect not only diagnoses but also the very theories forming the bases for diagnosis and treatment. For example, in 1962 a professional journal attributed the low rate of diagnosed depression among blacks to the black person's lack of self-esteem. A black person was less vulnerable to depression because "he has less to lose and is less apt to lose it."[96]

Diagnostic categories and treatment protocols are established through a highly political process.[97] The American Psychiatric Association's Nomenclature Committee, other decisionmaking councils, and ultimately, the Board of Trustees, must reach a consensus in order to include diagnoses in the Association's Diagnostic and Statistical Manual.[98] This process received public notice when the American Psychiatric Association "declassified" homosexuality as sexual deviation and has again recently been the subject of attention in connection with the listing of diagnoses such as "self-defeating personality disorder" (attributed

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AND ADVOCACY FOR BLACK AND HISPANIC PEOPLE WITH MENTAL ILLNESS 3 (1988).

90. This figure is based on the American Psychiatric Association's Sept. 1992 membership survey. Telephone Interview with Sandy Farris, American Psychiatric Association Membership Office (Oct. 23, 1992). Of the 80% of respondents who listed their race, 2% identified themselves as black. Of course, black psychiatrists may not choose to join the American Psychiatric Association and may be among those who did not list their race.

91. NATIONAL SCIENCE FOUND., PROFILES—PSYCHOLOGY: HUMAN RESOURCES AND FUNDING 94 (1988).

92. U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1991 at Chart 1010 (111th ed. 1990).

93. ROSENTHAL & CARTY, *supra* note 89, at 4-5; Leary, *supra* note 87, at C1.

94. ROSENTHAL & CARTY, *supra* note 89, at 4.

95. *Id.* at 7 (citing W. B. Lawson et al., *Race, Violence and Psychopathology*, 45 J. CLINICAL PSYCHIATRY, 294-97 (1984)).

96. ROSENTHAL & CARTY, *supra* note 86, at 5 (quoting A. J. Prange & M. M. Vitols, *Cultural Aspects of the Relatively Low Incidence of Depression in Southern Negroes*, 8 INT'L J. SOC. PSYCHIATRY 104 (1962)).

97. For an excellent discussion of the value laden nature of many diagnoses, see Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 46-49 (1989).

98. Robert L. Goldstein, *Clinical Judgment and Value Judgment: Moral Foundations of Psychiatric and Legal Determinations of the Status of Homosexuality*, *in* ETHICAL PRACTICE IN PSYCHIATRY AND LAW 293, 297 (Richard Nosner & Robert Weinstock eds., 1990). The Diagnostic and Statistical Manual, now in its third revised edition, classifies mental disorders and lists standardized diagnostic criteria for each.

to persons who continually and knowingly allow themselves to be exploited) and "periluteal dysphoric disorder (commonly known as premenstrual stress syndrome)."[99] Since the profession recognizes diagnoses based on consensus, the race, gender, class, and sexual orientation of those reaching the consensus is relevant to the determination of what behavior constitutes mental illness[100] and what behavior remains within the boundaries of mental health. Although a discussion of the issue is beyond the scope of this Article, numerous accounts have described the power of the mental health profession to enforce gendered behavior norms[101] and the profession's indifference to the effect of minority experiences and culture on behavior. In summary, nonneutral values associated with race, gender, and class shape, however unconsciously, the definition of mental illness as well as its diagnosis and treatment. These values shape, in other words, the very professional judgment that the Supreme Court regards as neutrally applied.

### 2. *The Myth That Professional Judgment Transcends Public/Private Distinctions*

The Supreme Court acknowledged in *Youngberg* that state hospitals are often "overcrowded and understaffed"[102] and explicitly stated that one purpose of the professional judgment standard was to "enable institutions of this type . . . to continue to function."[103] Yet professional judgment, as envisioned by the Supreme Court, is distorted beyond recognition by the limited resources, coercive environment, and unavoidable conflicts of interest inherent in the public sector. Professionals employed by the state are state actors. Those who work in state institutions have conflicting obligations: to the state, whose budgetary demands restrict state employees' behavior; to the institution, which might be more concerned about safety and security than treatment; and to the patients, who did not seek their care and who, for the most part, have no desire to be patients in the first place. The Supreme Court has generally not acknowledged this

99. *See, e.g., DSM-IIIR: Controversial Diagnoses Still not Resolved*, NEWS FOR WOMEN IN PSYCHIATRY, Oct. 1986, at 1-2. This labelling of disease by consensus is not exclusive to the mental health arena. "It comes to this, that *a disease is what the medical profession recognizes as such.*" E.M. JELLINEK, THE DISEASE CONCEPT OF ALCOHOLISM 12 (1960).

100. A well-known example of this phenomenon was the description of slaves' running away as symptomatic of a particular mental disease, "drapetomania." KENNETH M. STAMPP, THE PECULIAR INSTITUTION: SLAVERY IN THE ANTE-BELLUM SOUTH 109 (1956). For an interesting account of racism's effect on psychology, see ROBERT V. GUTHRIE, EVEN THE RAT WAS WHITE (1976).

101. CHESLER, *supra* note 83; SCHUR, *supra* note 83; Richard J. Parker, *Sex Bias in the Administration of California's Mental Health Law*, 8 GOLDEN GATE U. L. REV. 515 (1979).

102. Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

103. *Id.* The Supreme Court stood almost alone in its concern that Pennhurst "continue to function." A district judge found that "there is no question that Pennhurst, as an institution for the retarded, should be regarded as a monumental example of unconstitutionality." Halderman v. Pennhurst State Sch. & Hosp., 446 F. Supp. 1295, 1320 (E.D. Pa. 1977), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979) (en banc). Pennhurst was officially closed on Nov. 2, 1987. *ARC of Pennsylvania Files Petition in Pennhurst Case*, PR NEWSWIRE, Nov. 16, 1987, *available in* LEXIS, Nexis Library, PRNEWS File.

conflict[104] and, when parties have raised the issue, has responded with the assumption that professionalism will serve as a prophylactic against any pressure created by state employment: state actors who are professionals are assumed to act with "professional" intent or motives rather than "state" intent or motives.[105]

The health care professional's values regarding the primacy of treatment[106] become particularly troubling when the professional is a state actor and the state has custody over the patient, for then the professional's already considerable power over the patient is joined with the power of the state. At that point, the professional's orientation to treatment must be recognized as a value system in itself, rather than as a neutral, value-free description of what is required.[107] Somehow, the professional's value system must be balanced against competing values, since the patient's autonomy and ability to weigh the professional's advice against her personal desires and values cannot be taken for granted, as it is in the private sphere.

Furthermore, the exercise of professional judgment under the conditions prevailing in state institutions may often be impossible, as even the Court itself has acknowledged.[108] When the Supreme Court agreed to hear *Youngberg*, it already knew about Pennhurst's abysmal record, having recently decided a case involving that very institution.[109] Justice Rehnquist wrote, "[The District Court's] findings of fact are undisputed: Conditions at Pennhurst are not only dangerous, with the residents often physically abused or drugged by staff members, but also inadequate for the 'habilitation' of the retarded."[110] The record indicated that the institution had "urine and excrement on the ward floors," and "[o]bnoxious odors and excessive noise permeated the institution."[111] The record before the Supreme Court in *Youngberg* showed that little, if anything, had changed in two years: the institution was still

104. *But cf.* West v. Atkins, 487 U.S. 42, 50-58 (1988). *West* is discussed *infra* at notes 129-130 and accompanying text.

105. *See, e.g.*, Washington v. Harper, 494 U.S. 210, 233-35 (1990). For an excellent critique of this assumption, see United States v. Charters, 829 F.2d 479, 498-99 (4th Cir. 1987).

106. *See supra* text accompanying notes 71-75.

107. For an account of the difficulties arising from the failure of physicians and health care professionals to recognize that their orientation to treatment and cure is simply one of a number of competing value systems, see Nehemkis, *supra* note 71.

108. Thus, the Court in *Youngberg* was careful to limit liability in situations when professional judgment could not be exercised because lack of resources precluded the exercise of any such judgment at all. The Court held that a professional could not be held liable for damages in his individual capacity when lack of resources prevented him from "satisfy[ing] his normal professional standards." 457 U.S. at 323.

109. Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981). Romeo was a class member in the *Pennhurst* cases. Just under three years later, the Court decided Pennhurst State Sch. & Hosp. v. Halderman, 465 U.S. 89 (1984). Recently, the Supreme Court declined to grant certiorari on a third Pennhurst case, Halderman v. Pennhurst State Sch. & Hosp., 901 F.2d 311 (3d Cir.), *cert. denied*, 111 S. Ct. 140 (1990), leaving intact the Third Circuit's decision upholding the trial judge's jurisdiction to enforce the settlement concluded by the parties in 1984 and holding that one county's failure to serve 3% of the plaintiff class constituted substantial noncompliance with the settlement.

110. 451 U.S. at 7.

111. Halderman v. Pennhurst State Sch. & Hosp., 612 F.2d 84, 93 (3d Cir. 1979) (en banc).

"unsanitary and understaffed, and many of its residents are subjected to violence and enforced inactivity."[112]

This situation was not unique to Pennhurst, nor to the late seventies. Cases decided in the late eighties and early nineties portray men and women subjected to sexual assault by staff and fellow patients;[113] repeatedly injured and finally beaten to death while institutionalized;[114] kept in full restraints every day for over three years;[115] and given psychotropic and other drugs so casually that they were often delivered to the wrong patient.[116] Cases described institutions where people who could walk were locked in wheelchairs[117] and where patients were "seat-belted to toilets because only one staff member was available to assist six residents."[118] Several days of testimony about the abysmal conditions in state institutions led Congress to pass the Protection and Advocacy for Mentally Ill Individuals Act of 1986.[119]

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112. Romeo v. Youngberg, 644 F.2d 147, 181 (3d Cir. 1980) (en banc) (Seitz, C.J., concurring), *vacated*, 457 U.S. 307 (1982).

113. Higgs v. Latham, No. 91-5237, 1991 U.S. App. Lexis 25549 at *1 (6th Cir. Oct. 24, 1991) (finding sexual assault of female patient by fellow patient) (per curiam); Shaw v. Strackhouse, 920 F.2d 1135, 1140-41 (3d Cir. 1990) (alleging sexual assault by staff member); P.C. v. McLaughlin, 913 F.2d 1033, 1045 (1982) (2d Cir. 1990) (finding institution not liable for sexual abuse of patient by employee); Davis v. Holly, 835 F.2d 1175 (6th Cir. 1987) (alleging sexual assault by staff member); Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1275 (D.N.M. 1990) (citing sexual assault by unknown perpetrator resulting in death), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992); Spare v. Cohen, No. CIV.A.82-3579, 1986 WL 4814 (E.D. Pa. Apr. 22, 1986) (alleging multiple sexual attacks on profoundly retarded man); Butler v. Comm'r of Mental Health, 463 F. Supp. 806 (E.D. Tenn. 1978) (alleging sexual assault by fellow patient). In another case, the court found that the claim of a woman who was sexually molested by being forcibly kissed and groped all over her body was "minor and the injury *de minimus*, [sic] not of sufficient degree to rise to the level of an unconstitutional deprivation of civil rights." Knight v. Colorado, 496 F. Supp. 779, 780 (D. Colo. 1980). The frequency of sexual assault in institutions is not reflected by the relative paucity of these cases, which claim violations of constitutional rights. Examination of civil tort actions and criminal actions gives additional perspective. *See, e.g.*, Commonwealth v. Tavares, 555 A.2d 199 (Pa. Super. Ct. 1989) (affirming conviction of attendant at home for handicapped for forcing residents to have indecent sexual contact). Most sexual assaults in institutions are not reported, and of those that are, few are prosecuted, *see* Susan Stefan, *Whose Egg is it Anyway? Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women*, 13 NOVA L. REV. 405, 428-30 (1989). In addition, cases about the right to abortion of institutionalized people frequently arise from rape and sexual assault. *See, e.g.*, D.R. v. Daughters of Miriam Center for the Aged, 589 A.2d 668 (N.J. Super. Ct. Ch. Div. 1990) (denying application to procure abortion for incompetent ward impregnated by an unknown male); *In re* Jane Doe, 533 A.2d 523 (R.I. 1987) (denying stay of order of abortion to be performed on profoundly retarded ward impregnated in sexual assault by unknown male).

114. Kolpak v. Bell, 619 F. Supp. 359, 366 (N.D. Ill. 1985) (alleging repeated beating by staff members to the extent that autopsy "confirmed . . . that [the plaintiff] sustained multiple fractures with internal injuries and hemorrhage to the left kidney, with blood in the urine").

115. Kirsch v. Thompson, 717 F. Supp. 1077, 1080 (E.D. Pa. 1988).

116. Association for Retarded Citizens v. Olson, 713 F.2d 1384, 1388 (8th Cir. 1983).

117. Society for Good Will to Retarded Children v. Cuomo, 572 F. Supp. 1300, 1346 (E.D.N.Y. 1983) *vacated on other grounds*, 737 F.2d 1239 (2d Cir. 1984).

118. Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1277 (D. N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992).

119. 42 U.S.C.A. §§ 247a, 10,801-10,851 (Supp. 1992). This testimony was underscored by a report prepared by Senate staff who had visited 31 state institutions and interviewed administrators, staff, and patients. The report documented unexplained patient injuries, deaths, abuse, and the indifference of institutional administrators to investigation or prevention of patient abuse. *Care of Institutionalized Mentally Disabled Persons: Joint Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor & Human Resources and the Subcomm. on Labor, Health and Human Services, Education, & Related Agencies of the Senate Comm. on Appropriations*, 99th Cong., 1st Sess. Part II at 17-75 (Appendix: Staff Report on the

And these are only the recorded cases. These lawsuits were brought for the most part by parents[120] or groups of parents.[121] But most residents of institutions have lost all contact with their relatives, and therefore have no one "on the outside" to protect their interests. Other potential sources of scrutiny or protection, such as the media, may be deterred by the remoteness and inaccessibility of state institutions. Many state hospitals, especially in the West, are located in rural areas, so traveling to them requires a substantial investment of time. Institutions, under the guise of protecting the privacy of patients, also tend to obstruct attempts by the press to investigate institutional conditions.

Professionals at state institutions are at best aware of this abuse and neglect, but perceive themselves as helpless to prevent it; at worst, they are indifferent or themselves abusive. State mental hospitals are notoriously unattractive employment options and often are sinkholes for the worst of the psychiatric profession. Practitioners in state hospitals often do not merit the term "professional." Many are unlicensed.[122] Between half and two-thirds of the psychiatrists in state and county mental hospitals and clinics are foreign medical graduates who are of uneven quality and who may face linguistic or cultural barriers to communicating with patients.[123] Moreover, state hospitals have found it so difficult to recruit psychiatrists that some rural states, such as Montana and Wyoming, are forced to rely on temporary staffing agencies that send a different psychiatrist out on rotations as frequently as every two weeks.[124] The notion that the "professional judgment" exercised under these

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Institutionalized Mentally Disabled) (1985).

120. *E.g.*, Feagley v. Waddill, 868 F.2d 1437 (5th Cir. 1989); Kolpak v. Bell, 619 F. Supp 359 (N.D. Ill. 1985).

121. *E.g.*, New York State Ass'n for Retarded Children v. Carey, 706 F.2d 956 (2d Cir.), *cert. denied*, 464 U.S. 915 (1983); Concerned Citizens for Creedmoor v. Cuomo, 570 F. Supp. 575 (E.D.N.Y. 1983); Association for Retarded Citizens v. Olson, 561 F. Supp. 473 (D.N.D. 1982), *aff'd in part and remanded in part*, 713 F.2d 1384 (8th Cir. 1983); *Jackson*, 757 F. Supp. at 1277. The Association for Retarded Citizens is a group composed primarily of parents of mentally retarded citizens, although it includes many members who are not parents. It led the fight to reform in the treatment of individuals who are developmentally disabled.

122. In some states, the fraction of unlicensed psychiatrists practicing in public institutions is as high as 25%. Tamara Henry, *Mental Health Programs get Poor Ratings; Wisconsin Ranks Second*, U.P.I., Sept. 13, 1988, *available in* LEXIS, Nexis Library, UPI File. *See also* Leonard Rubenstein, *Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People*, 20 CLEARINGHOUSE REV. 385, 382 (1986) (citing four states where, in 1978, over 65% of state hospital physicians were unlicensed and 20 states where the number was over a third); *'Rent-a-Shrink' A Rural Success: Temporary Mental Care is Booming*, CHI. TRIB., Nov. 20, 1988, at 27; John Machacek, *State's Care of Mentally Ill Needs Work, Report Says*, GANNETT NEWS SERVICE, Sept. 11, 1990, *available in* LEXIS, Nexis Library, GNS File..

123. An National Institute of Mental Health study in 1980 concluded that over half the psychiatrists in state and county mental hospitals were foreign medical graduates, while a more recent study puts the proportion at two-thirds. Armand Checker & Michael J. Witkin, *A Comparison of U.S. and Foreign Medical Graduates Employed by State and County Mental Hospitals, 1975 and 1980, National Institute of Mental Health Statistical Note 161*, at 3 (Sept. 1982); *see also* E. FULLER TORREY ET AL., CARE OF THE SERIOUSLY MENTALLY ILL: A RATING OF STATE PROGRAMS 9 (3d ed. 1990).

124. TORREY, *supra* note 123, at 9. As the authors note, "the consequences for the continuity and quality of patient care are obvious."

circumstances bears any relationship to the patient's actual needs is problematic at best.

Even if staff are of high quality, other factors may preclude the exercise of professional judgment. Studies have repeatedly shown that working in an institutional setting has marked effects on the professionals employed there.[125] Institutions are closed settings, and, as courts have recognized, there is "a tendency among human service professionals in the institutions to conform their recommendations for treatment or habilitation . . . to the constraints imposed by the state's 'inadequate service delivery system, rather than to exercise true professional judgment.'" [126]

Furthermore, the state mental health professional may be explicitly requested to pursue goals other than the health of his patient, as is illustrated by the case of *Perry v. Louisiana*.[127] In *Perry*, the State of Louisiana sought to medicate forcibly an incompetent mentally ill prisoner in order to render him competent to be executed. The American Psychiatric Association and the American Medical Association forcefully expressed the position of psychiatrists caught between their duties as health professionals and their obligations to their state employer in an *amicus* brief, calling "the directive [by the state] to medicate . . . an excruciating ethical dilemma for treating physicians."[128]

The Supreme Court has only once explicitly acknowledged that state-employed professionals in institutional settings might make different judgments than would professionals in the private sphere. In *West v. Atkins*,[129] the Court observed that professional judgment is profoundly affected by both the state's limited resources and the institutional setting in which the professional works. It is worthwhile to present an extended excerpt from this case, which stands alone in Supreme Court jurisprudence in differentiating private and state practices. When a physician provides services to prison inmates, the Court said, the setting

> inevitably affects the exercise of professional judgment. Unlike the situation confronting free patients, the non-medical functions of prison life inevitably influence the nature, timing, and form of medical care provided to inmates such as West. By regulation, matters of medical

125. *See, e.g.*, ERVING GOFFMAN, ASYLUMS 92 (1961) ("[M]embers of staff. . . are being set to a contradictory task. . . having to coerce inmates into obedience while at the same time giving the impression that humane standards are being maintained and the rational goals of the institution are being realized."); Craig Haney et al., *Interpersonal Dynamics in a Simulated Prison*, 1 INT'L J. CRIMINOLOGY & PENOLOGY 69 (1973).

126. Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1310-11 (D. N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992) (quoting Thomas S. v. Flaherty, 699 F. Supp. 1178, 1196 (W.D.N.C. 1988), *aff'd*, 902 F.2d 250 (4th Cir.), *cert. denied*, 111 S.Ct. 373 (1990)).

127. 498 U.S. 38 (1990); *see also* Brief for the American Psychiatric Ass'n and American Med. Ass'n at 2-5, Perry v. Louisiana, 498 U.S. 38 (1990) (No. 89-5120)

128. Brief for the American Psychiatric Ass'n and American Med. Ass'n at 16 (No. 89-5120), *Perry*, 498 U.S. 38.

129. 487 U.S. 42 (1988).

> health involving clinical judgment are the prison physician's "sole province." These same regulations, however, require respondent to provide medical services "in keeping with the security regulations of the facility." . . . [S]tudies of prison health care, and simple common sense, suggest that his delivery of medical care was not unaffected by the fact that the State controlled the circumstances and sources of a prisoner's medical treatment. For one thing, the State's financial resources are limited. Further, prisoners and jails are inherently coercive institutions that for security reasons must exercise nearly total control over their residents' lives and the activities within their confines; general schedules strictly regulate work, exercise and diet. These factors can, and most often do, have a significant impact on the provision of medical services in prisons.[130]

Virtually all of this applies equally to the state mental institution in *Youngberg* and throws into doubt many of the assumptions of the professional judgment standard.

This Part has attempted to illuminate the proposition that professionals and those in their custody neither speak in one voice nor have the same story to tell. Professional judgment at best defines what a patient needs with reference to a limited conception of what is "good" for people and a highly fallible perception of who the patient is and what the patient values. At worst, professional judgment pursues goals antithetical to the patient's values. Yet professionals wield awesome "cultural authority;" when professionals speak, it is highly likely that their "particular definitions of reality and judgments of meaning and value will prevail as valid and true."[131] The mental health professional has "[t]he authority to interpret signs and symptoms, to diagnose health or illness, to name diseases and offer prognoses. . . . By shaping the patients' understanding of their own experience, physicians create the conditions under which their advice seems appropriate."[132]

Physicians also shape courts' understanding of patients' experiences. The Supreme Court frequently accepts the authority of the professional's story over that of the patient in what it conceives to be medical matters. When the patient's perception clashes with the professionals' interpretation, the Court usually defers to professional "authority." In *Washington v. Harper*,[133] for example, discussing a prisoner who had never been adjudicated incompetent, the Court noted:

> Particularly where the patient is mentally disturbed, his own intentions will be difficult to assess and will be changeable in any event. Respondent's own history of accepting and then refusing drug treatment illustrates the point. *We cannot make the facile assumption that the*

130. *Id.* at 56-57 n.15 (citations omitted).
131. STARR, *supra* note 32, at 13.
132. *Id.* at 14.
133. 494 U.S. 210 (1990).

> *patient's intentions, or a substituted judgment approximating those intentions, can be determined in a single judicial hearing apart from the realities of frequent and ongoing clinical observation by medical professionals.*[134]

In fact, even when the Court concedes that professionals' stories are confusing and contradictory, it does not look elsewhere for meaning but arranges legal rules to accommodate the contradictions. In *Addington v. Texas*,[135] the Court supported a standard of proof lower than "beyond a reasonable doubt" in commitment hearings because "[g]iven the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous."[136]

The particular values, limitations, and conflicts of interest that determine the judgment of the state professional make it critical for courts to distinguish between the descriptions and prescriptions of the professional, on the one hand, and the legal inquiry into the individual rights that state action may threaten, on the other. In applying the professional judgment standard, however, courts transform stories about legal rights into stories about medical needs, whose meaning can then only be interpreted by professionals. The next Part argues that the professional story about violations of the rights to liberty and autonomy is constitutionally inadequate. The professional judgment standard is inapplicable to claims of governmental intrusion on liberty: these stories need to be reclaimed and reframed as accounts of the denial of civil rights.

## II. THE SCOPE OF THE PROFESSIONAL JUDGMENT STANDARD: AFFIRMATIVE AND NEGATIVE RIGHTS UNDER THE CONSTITUTION

As the Supreme Court has recently reiterated,[137] constitutional claims brought by individuals in government custody can be divided into two distinct categories: claims for negative rights and claims for positive rights.[138] Both categories involve the professional judgment standard, but in different ways.

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134. *Id.* at 231-32 (emphasis added) (citation omitted). Yet in other settings we assume that a competent patient is the best source of information about his own intentions, and this information can be and is frequently communicated by him to the judge "in a single judicial hearing."

135. 441 U.S. 418 (1979).

136. *Id.* at 429. Several states have adopted the beyond a reasonable doubt standard in their commitment proceedings. *See, e.g., Commonwealth v. DelVerde*, 517 N.E.2d 159, 161 (Mass. 1988). These states, however, do not appear to have difficulty in committing individuals.

137. DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189 (1989).

138. While commentators have criticized this dichotomy, *see* David P. Currie, *Positive and Negative Constitutional Rights*, 53 U. CHI. L. REV. 864 (1986); Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271 (1990), there is no indication that the Supreme Court or the lower courts will depart from this form of analysis in the foreseeable future. *See, e.g.*, Fialkowski v. Greenwich Home for Children, Inc., 921 F.2d 459, 465 (3d Cir. 1990) (distinguishing between deprivation of rights and affirmative obligations of state).

The first category consists of affirmative claims in which the plaintiff asserts a need for, and a constitutional right to, professional assistance from the state, such as medical care, training or treatment, or legal aid.[139] To prevail in a right-to-treatment claim under the professional judgment standard, the plaintiff must show that the treatment she received constituted "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[140]

The second and broader category encompasses a variety of claims in which the plaintiff challenges the constitutionality of a state action that constrains or limits her rights. Plaintiffs bringing such negative rights claims in an institutional setting must prove that the disputed action, constraint, or limitation is, as above, a substantial departure from professional judgment.[141]

The professional judgment standard comes into play at significantly different stages in these two kinds of decisions, with very different effects. In claims for constitutionally adequate government services, the court applies a constitutional analysis to determine whether the plaintiff is entitled to state services and the general contours of the services to which she is entitled, and only then relies on professional judgment to determine how, specifically, these services should be provided. This approach defers to professionals in decisions they are competent to make. Such deference is appropriate here because the plaintiff is affirmatively seeking to compel state actors to exercise professional judgment on her behalf.[142]

In negative rights claims, however, the plaintiff seeks protection against the exercise of professional judgment by the state. In this context, professional judgment inappropriately displaces the protection of rights from governmental intrusion. If a court applies the professional judgment standard in negative rights cases, professional judgment as to appropriate services or treatment supercedes any judicial analysis regarding the plaintiff's constitutional rights or liberties. The professional effectively exercises his judgment to choose between a patient's rights to family visitation, speech, or freedom from restraint on the one hand, and treatments that may preclude these on the other, without mediation or review by the court.

This approach thus severely curtails constitutional protection of civil rights. As discussed in the preceding Part, values of autonomy, self-determination or

139. Cases claiming ineffective assistance of counsel and many foster care cases fall into this category. *See infra* Part III(A)(4) & (5). As the professional judgment standard has been expanded beyond the mental health system, claims such as those against prisons and jails for not providing adequate treatment or screening for suicidal or mentally disabled prisoners and pretrial detainees also fall into this category. *See infra* Part III(A)(3).

140. Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

141. *Id.*

142. The standard only makes sense, of course, to the extent that professionals can exercise their judgment without distortions due to budgetary concerns or conflicts of interest. *See infra* Part II(B)(4).

freedom from intrusion will probably receive little attention in the medical professional's decision. Indeed, in these cases the very exercise of professional judgment constitutes the alleged abuse of power. This is particularly true in institutional settings, where all aspects of an individual's life are subject to professional oversight: from hygiene[143] to letterwriting[144] to marriage.[145] To assert that constitutional rights in these areas are not violated as long as a professional exercises judgment in limiting or eliminating them substitutes professional values for constitutional values and thereby constitutes an abdication by the courts of their critical obligation to protect individual rights. The Due Process Clause, intended to "prevent government 'from abusing [its] power, or employing it as an instrument of oppression,'"[146] is virtually erased by such an approach.[147]

The professional judgment standard is flawed because it collapses both negative and affirmative claims by institutionalized individuals into one imperative: regardless of the relief the plaintiff actually seeks, he or she is ultimately entitled only to the exercise of professional judgment. By focusing on the institutional context instead of the claims, courts have failed to distinguish between cases in which the plaintiff claims a right to professional judgment and seeks the exercise of such judgment as a remedy, and cases in which the plaintiff challenges the actions of the professional as government interference with constitutional rights. In negative rights cases, the argument that professional judgment was exercised in the challenged action essentially becomes an affirmative defense to the claim. Under the professional judgment standard, courts defer to professionals' decisions rather than inquiring into the legal claims at issue.

This deference is misplaced in negative rights cases because, as described in Part I, professionals base their decisions on a set of values that disregards

143. Green v. Baron, 662 F. Supp. 1378 (S.D. Iowa), *aff'd in part and rev'd in part*, 879 F.2d 305 (8th Cir. 1989).

144. Thornburgh v. Abbott, 490 U.S. 401 (1989).

145. *See, e.g.*, Turner v. Safley, 482 U.S. 78 (1987).

146. DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189, 196 (1989) (quoting Davidson v. Cannon, 474 U.S. 344, 348 (1986)).

147. The breadth of a mental health professional's authority under the professional judgment standard is highlighted by a contrast with the limits on the power of a state-appointed attorney over a client. It would be unimaginable for an attorney to overrule his client's right to proceed pro se because of the attorney's professional assessment that the client would be better served with counsel or to override the defendant's decision to plead not guilty because, in the lawyer's professional judgment, the client stood a better chance with a plea bargain. Denial of a client's unequivocal demand to represent himself would amount to per se reversible error. Meeks v. Craven, 482 F.2d 465, 466 (9th Cir. 1973). Nor may an attorney limit or forbid his client's letter-writing, even if the letters create evidence significantly damaging to the client's case, nor forbid association with friends or family on similar grounds. Yet, as the following Section will show, mental health professionals seek to exercise just such control over their clients' lives in the name of treatment. *See, e.g.*, Walters v. Western State Hosp., 864 F.2d 695 (10th Cir. 1988) (doctors putting patient in seclusion for several days); Doe v. Public Health Trust, 696 F.2d 901 (11th Cir. 1983) (mental hospital precluding communication between patient and her parents) Martyr v. Bachik, 770 F. Supp. 1414 (D. Or. 1991) (mental health facility censoring patients' mail). This is how the professional judgment standard operates in the context of mental health cases.

or de-emphasizes the autonomy and self-determination protected by the Constitution. To make matters worse, as previously noted, although the professionals involved are employed by the state, courts generally fail to inquire as to which elements of a challenged decision are influenced by the state's needs and imperatives, and which represent "pure" professional judgment. In any case, however, the purest professional judgment is no substitute for judicial analysis and protection of constitutional rights.

Section A will discuss the error involved in applying the professional judgment standard to negative rights claims. First, it will examine how the professional judgment standard eliminates consideration of competing constitutional values in claims alleging infringement of privacy rights, unconstitutional punishment, restrictions on freedom of movement, and limitations on family association. It will then discuss the way the professional judgment standard operates to eradicate procedural Due Process rights. Finally, it will evaluate alternatives to the professional judgment standard in negative rights cases. Section B will discuss the application of the professional judgment standard to claims for state-provided professional services, where the professional judgment standard, while still problematic, is more appropriate.

## A. *Challenges to Professional Infringement of Constitutional Rights: The Professional Judgment Defense*

The professional judgment framework reformulates all constitutional questions into a dichotomy between professional judgment and its absence, and thus renders irrelevant those values that transcend the issue of professionalism. An action may be well within the norms of professional judgment and at the same time violate constitutional rights to freedom from physical violence, bodily intrusion, punishment, interference with the parent-child relationship, or limitations of speech or religion. A finding that professional judgment was followed thus has little if any relevance to the protection of civil rights; courts need to look beyond the professional recommendation to the effect of state action on an individual's rights.

### 1. *Negative Rights Claims in the Institutional Setting*

#### a. *Right to Refuse Treatment*

The law is clear that a competent individual outside government custody cannot be treated against her will; the Supreme Court probably raised this rule to the level of a constitutional right in *Cruzan v. Director, Missouri Department*

*of Health.*[148] Most state courts have applied this holding equally to institutionalized persons, requiring a judicial finding of incompetency before an individual can be treated against her will;[149] and many institutionalized individuals in fact remain competent to make treatment decisions.[150] Federal constitutional law, however, follows the professional judgment standard,[151] which requires no showing as to the patient's competence, condition with or without medication, or need for treatment. Nor is it necessary to show that the proposed treatment will be effective, that medication is the least restrictive alternative,[152] or even that any treatment alternatives have been considered or attempted in treating the patient. Certainly, no hearing is required.[153] Rather, the constitutional right of institutionalized patients to refuse antipsychotic medications can be overridden under current law by a showing that the physician has not substantially departed from professional judgment in ordering forced medication.[154]

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148. 110 S. Ct. 2841, 2851 (1990). The Court stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." The four dissenting Justices characterized the right to refuse treatment as "fundamental," 110 S. Ct. at 2865 (Brennan, J., dissenting); 110 S. Ct. at 2885 (Stevens, J., dissenting). Justice O'Connor, a member of the majority, wrote a separate concurring opinion emphasizing the strength of the competent person's right to refuse medical treatment. 110 S. Ct. at 2856-57 (O'Connor, J., concurring).

149. *See* Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986); Rogers v. Commissioner of Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983). *See also* cases cited *infra* note 210. *But see* Commissioner of Correction v. Myers, 399 N.E.2d 452, 458 (Mass. 1979) (requiring competent, unconsenting prisoner to undergo kidney dialysis because state interests in preservation of life and orderly prison administration outweigh individual rights of privacy and bodily integrity).

150. *See* PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 220 (2d ed. 1991).

151. *See* United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016 (1990); Dautremont v. Broadlawns Hosp., 827 F.2d 291, 300 (8th Cir. 1987); Bee v. Greaves, 744 F.2d 1387, 1395-96 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); Project Release v. Prevost, 722 F.2d 960, 977-81 (2d Cir. 1983). While neither the D.C. Circuit nor the Fifth Circuit has addressed the issue, several district court decisions have utilized the professional judgment standard. United States v. Leatherman, 580 F. Supp. 977, 980 (D.D.C. 1983), *appeal dismissed and case remanded*, 729 F.2d 863 (D.C. Cir. 1984). *See also* R.A.J. v. Miller, 590 F. Supp. 1319, 1321 (N.D. Tex. 1984). The application of the professional judgment standard in cases involving the right to refuse treatment arose when federal courts began analogizing the physical restraints used in *Youngberg* to the "chemical restraint" represented by psychotropic medication. The courts also took their cue from the fact that the Supreme Court vacated *Rennie v. Klein*, a Third Circuit right-to-refuse-treatment case pending before it at the time *Youngberg* was decided, and remanded it for reconsideration in light of *Youngberg*. Rennie v. Klein, 458 U.S. 1119 (1982). *See, e.g.*, *Project Release*, 722 F.2d at 979-80; *R.A.J.*, 590 F. Supp. at 1320-21. On remand, the *Rennie* court promptly adopted the professional judgment standard for deciding cases involving the right to refuse medication, although the en banc court could not muster a majority to agree to an exact meaning of the professional judgment standard in the context of the right to refuse treatment. Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (on remand).

152. However, one circuit requires the court to consider the availability of alternative, less restrictive courses of action. *Bee*, 744 F.2d. at 1396. In addition, three members of the en banc court in *Rennie v. Klein* joined in a concurrence that would require such analysis. *Rennie*, 720 F.2d at 274-77 (Weis, J., concurring). Two judges believed the principle should be applicable but found such application foreclosed by *Youngberg*. *Id.* at 271 (Adams, J., concurring); *Id.* at 272 (Becker, J., concurring).

153. In some cases, the state required and the court approved a set of mandatory consultations and additional approvals before medication against the patient's will could commence. All of the consultations were among mental health professionals, usually at the same facility. *See Rennie*, 720 F.2d at 270 & n.9; *R.A.J.*, 590 F. Supp. at 1321-22 (citing *Rennie*).

154. *See Charters*, 863 F.2d at 305-08 & n.4; *Dautremont*, 827 F.2d at 300; Johnson v. Silvers, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release*, 722 F.2d at 977-81.

The professional may well be correct in regarding the treatment as effective and thus may be exercising the best professional judgment in forcibly medicating the patient. But this judicial approach fails to consider—indeed, it does not even articulate—the competing values at stake. These values have been readily recognized in other decisions involving refusals of medical treatment recommended by a treating professional, such as blood transfusions violating the religious beliefs of the patient.[155]

Individuals refusing treatment do not seek services or challenge the quality of treatment. Their claim is to be protected from state intrusions in the name of treatment. The professional judgment standard is meaningless in this context. It may be appropriate to use the professional judgment standard to decide whether an institutionalized or imprisoned patient is constitutionally *entitled* to a particular treatment program or to a certain medication or drug, such as AZT.[156] But to apply the identical standard to determine the constitutionality of *forcing* AZT or some other medication on an unwilling patient misses the enormous distinction between the two scenarios.[157] The professional judgment standard does not distinguish between treatment requested and treatment refused. Furthermore, because the focus is on the professional's judgment rather than on the legal claim, no distinction is made between "treatments" such as restraints that implicate traditional liberty interests in freedom of movement and more benign treatments such as basket weaving and pottery classes.

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155. These competing values were well stated in a dissenting opinion by Justice Burger when he was a judge on the D.C. Circuit. Reviewing a case in which Georgetown College had petitioned the court for permission to administer blood to an unwilling Jehovah's Witness at the university's hospital, Burger quoted from Justice Brandeis's famous declaration that "'[t]he makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.'" *In re* President of Georgetown College, 331 F.2d 1010, 1016-17 (D.C. Cir. 1964) (Burger, J., dissenting) (quoting Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)). Judge Burger then noted that:

> Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.

*Id.* at 1017 (Burger, J., dissenting) (emphasis omitted).

156. *See* Hanson v. Clarke County, 867 F.2d 1115 (8th Cir. 1989) (noting mentally retarded person has constitutional right to adequate treatment and placement, but not to an optimal placement); Commonwealth v. Davis, 551 N.E.2d 39, 41 (Mass. 1990) (explaining involuntarily committed patient entitled to "treatment which is suitable for him to the best of the staff's collective judgment," but not to optimal treatment) (citations omitted); Wilson v. Franceschi, 735 F. Supp. 395, 397 (M.D. Fla. 1990) (indicating prisoner claiming that denial of AZT constitutes unconstitutional cruel and unusual punishment must show that "an official's conduct consists of 'acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.'") (quoting Estelle v. Gamble, 429 U.S. 97 (1976)).

157. The crucial distinction between the state's "duty to treat" and the patient's obligation to accept that treatment, or his "duty to be treated," was made long ago by Professor Jay Katz, who worried that the "right" to treatment would be forced on unwilling patients. Jay Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 761-63 (1969). *See also supra* note 148, discussing Cruzan v. Director, Mo. Dep't of Health. 110 S. Ct. 2841, 2851 (1990).

### b. *Behavior Modification: Punishment, Liberty and Professional Judgment*

Behavior modification is a central goal of many mental disability professionals, especially those dealing with mental retardation.[158] It is also used with juveniles, particularly in the area of juvenile justice. Cases involving behavior modification programs represent a particularly good example of the importance of distinguishing between negative and affirmative constitutional claims. In some of these cases, plaintiffs assert a constitutional right to behavior modification programs as treatment. In others, plaintiffs seek judicial protection from behavior modification programs that they claim infringe their liberty; these negative rights cases call for a different analysis than the affirmative rights cases. Yet the professional judgment standard as presently applied does not admit this distinction.[159]

Where plaintiffs have asserted an affirmative right to behavior modification programs, courts have appropriately looked to the professional judgment standard and found such programs constitutionally required.[160] The professional judgment standard has not yet been applied to behavior modification programs in negative rights cases because plaintiffs are not bringing federal constitutional challenges to behavior modification programs in state institutions.[161] In this author's experience, mental health lawyers do not litigate such claims because they assume they would fail under the professional judgment standard. This is probably correct, because behavior modification is a widely accepted professional practice. Yet looking simply to professional judgment would miss the crux of such negative rights claims.

In constitutional challenges to behavior modification programs, plaintiffs do not challenge the programs' professional adequacy; rather, they demand

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158. COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 60, at 1481-82 ("Comparative studies indicate that behavioral therapies involving straightforward applications of shaping and contingency management are the treatment of choice for developing appropriate social behaviors . . . .").

159. There are many reasons for the apparent paradox that there have been both cases claiming the right to behavior modification and cases objecting to such programs. Objections to behavior modification tend to be filed on behalf of prisoners, children in the juvenile justice system, and people in psychiatric hospitals; claims asserting a right to behavior modification programs are more often made on behalf of mentally retarded people. Additionally, "behavior modification" covers a wide variety of programs, including electric shock and cattle prods, *see infra* notes 162-170 and accompanying text, and programs that involve only positive reinforcement. The complexity of this issue is illustrated by *Youngberg* itself: the Pennhurst staff had devised a behavior modification program to eliminate Romeo's aggressive behavior, but his mother refused permission to implement it. Youngberg v. Romeo, 457 U.S. 307, 311-12 (1982).

160. *See, e.g.*, Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1309 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1186, (W.D.N.C. 1988), *aff'd*, 902 F.2d 250 (4th Cir. 1990), *cert. denied*, 111 S. Ct. 373 (1990); Lelsz v. Kavanagh, 673 F. Supp. 828, 864, 866 (N.D. Tex. 1987).

161. Such claims are reported in cases involving other contexts, such as juvenile justice, prison, and jail settings, *e.g.*, S.D. v. Faulkner, 705 F. Supp. 1361, 1366 (S.D. Ind. 1989); Goodwin v. Shapiro, 545 F. Supp. 826, 826-27, 840 (N.J. 1982); Clonce v. Richardson, 379 F. Supp. 338, 352 (W.D. Mo. 1974), where, until recently, the professional judgment standard had not been applied, *see infra* Part III(A)(2)-(3).

freedom from punishment, bodily restraint, or even assert the right to adequate food, clothing and shelter. In the name of behavior modification, clients have been denied access to food,[162] religious services,[163] and visitation with their families.[164] They have been slapped, grabbed and pulled by the hair,[165] and jabbed between their fingers by the point of a pencil with sufficient force to leave welts and scratches.[166] Less than twenty-five years ago, the use of cattle prods was acceptable as behavior modification.[167] By 1971, over 26 studies had employed electric shock or emetics to suppress homosexual or other so-called deviant sexual behavior.[168]

Programs of aversive therapy and behavior modification are certainly within the realm of professional judgment.[169] Professionals rely on the effectiveness of these programs to extinguish target behaviors.[170] However, by evaluating a program solely on the basis of whether its use departs from professional judgment, a court ignores the individual rights at stake.

For example, patients at the Iowa Security Medical Facility challenged the use of apomorphine, a drug that causes vomiting for fifteen minutes to an hour, to punish an individual who "violated the behavior protocol established for him by the staff."[171] These "violations" included refusing to get up, giving cigarettes against orders, talking, swearing, and lying.[172] The defendants' response to

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162. Goodwin v. Shapiro, 545 F. Supp. at 844 (explaining stipulation of settlement providing that "nutritionally adequate diet shall not be . . . withheld in any way as part of a behavior modification program").

163. *See* David B. Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CAL. L. REV. 81, 85-86 (1973), for a discussion of a "token economy" system at an institution where attendance at religious services was made contingent on patients' completion of work assignments or self-care activities. The program was tremendously successful in increasing "target behaviors." Presumably, a patient could agree to participate in such a treatment program voluntarily; by the same token, to force a patient into such a treatment program would raise serious First Amendment questions. Under current analysis, however, the question would be whether such a program was a departure from professional standards or practice.

164. Doe v. Public Health Trust, 696 F.2d 901, 905 (11th Cir. 1983). *See infra* notes 181-183 and accompanying text.

165. Milonas v. Williams, 691 F.2d 931, 942 (10th Cir. 1982), *cert. denied*, 460 U.S. 1069 (1983).

166. Kate' Sch. v. Dep't of Health, 94 Cal. App. 3d 606, 623 (1979).

167. As late as 1969, a top journal in the field of psychiatry reported successful use of cattle prods on mental patients to reduce aggressive behavior. Katz, *supra* note 157, at 776-77 n.64 (citing Arnold M. Ludwig et al., *The Control of Violent Behavior through Faradic Shock*, 148 J. NERVOUS & MENTAL DISEASE, 624, 624-26, 635-36 (1969)).

168. RALPH SCHWITZGEBEL, DEVELOPMENT AND LEGAL REGULATION OF COERCIVE BEHAVIOR MODIFICATION TECHNIQUES WITH OFFENDERS, *in* LEONARD ORLAND, JUSTICE, PUNISHMENT, TREATMENT 205, 207 (1973).

169. There is, however, some doubt about the long-term effectiveness of aversive therapy. *See, e.g.*, Morgan v. Sproat, 432 F. Supp. 1130, 1147-48 (S.D. Miss. 1977).

170. For example, one study of the treatment of transvestism noted that "the patient received painful electric shocks on his feet from a grid on which he was standing while dressing in women's clothes. Over a period of 8 days, the patient received a total of 200 shocks during the frequent treatment sessions. A follow-up study 14 months later indicated only one subsequent relapse of cross-dressing by this patient." SCHWITZGEBEL, *supra* note 168, at 207.

171. Knecht v. Gillman, 488 F.2d 1136, 1137 (8th Cir. 1973); *see also* Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973) (challenging administration of succinycholine, described as a "breath-stopping" drug, as aversive treatment).

172. *Knecht*, 488 F.2d at 1137.

the plaintiffs' constitutional challenge was that "there had been a 50% to 60% effect in modifying behavior by the use of apomorphine at ISMF."[173] For a professional, the central issue regarding aversive behavior therapy such as apomorphine is its effectiveness in changing behavior, and professional norms are based largely on the effectiveness of treatment. Constitutional norms, on the other hand, are based on different values, and the "successful" outcome of the apomorphine injections may be irrelevant to a legal inquiry into whether such injections violate constitutional rights.

In a recent case, a pretrial detainee was sent to a correctional medical facility for "examination and treatment." The treatment team described the patient, Mr. Green, as having

> constantly tested limits, been uncaring of expectations, and ... alienated his peers. He would belch and pass gas in public, neglect his hygiene if allowed, be profane,—in short, he would almost defy both staff and patients. Not only would he not accept, but argue against constructive criticism.[174]

The treatment team formulated the following therapy:

> We therefore propose that he be placed on a special treatment program whereby he earn himself out of the B unit [seclusion unit] in two weeks. This goes as follows: On his first 24 hours, he is granted nothing. On day 1 he gets his blanket at night; on day 2, he earns his mattress at night; on day 3 he earns the privilege to work; day 4 he earns his breakfast; on day 5 he earns the privilege of attending 9 a.m. class; on day 6 he earns the privilege of attending group, but if that is not a group day, he can earn an hour's free time; on day 7 he earns lunch; on day 8 he earns 1 p.m. class; on day 9 he earns supper[;] on day 10, he earns an hour of free time; on day 11 he earns evening class, but in the absence of that, he is given one-half hour on the unit; on day 12 he is allowed to earn commissary; on day 13, he is finally liberated. Any violations would set him back one day.[175]

Because Green was a pretrial detainee, his claims were considered under the standard set forth in *Bell v. Wolfish*.[176] However, had Green been a patient

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173. *Id.* at 1138.

174. Green v. Baron, 662 F. Supp. 1378, 1380 (S.D. Iowa 1987), *aff'd in part and rev'd in part*, 879 F.2d 305 (8th Cir. 1989).

175. *Id.* at 1381.

176. This standard permits constitutional deprivations if they are reasonably related to a legitimate purpose and not excessive in relation to that purpose. Bell v. Wolfish, 441 U.S. 520, 538-39 (1979). The jury in *Green* found for the defendants. However, the district court judge decided that the jury instructions had been flawed, and granted plaintiffs' motion for judgment n.o.v.. The court of appeals agreed that the jury instructions were flawed, but concluded after reviewing the evidence in the light most favorable to defendants that a jury could have found that the deprivations Green experienced were rationally related to a legitimate government objective. Therefore, the court remanded for a new trial. *Green*, 879 F.2d at 310.

in a state mental institution, the professional judgment standard would probably have upheld the program. In closing statements to the jury, the defendants' attorney made the following argument: "I think the crux of this case is really this question—were the things that happened to Mr. Green at the Oakdale facility—were they punishment or were they treatment? It's our position that they were treatment."[177] If the answer to this question was that "the things that happened to Mr. Green" were professionally acceptable treatment, then the professional judgment standard would have been met, ending the inquiry.

However, because constitutional rights include autonomy, bodily integrity, and the right to be left alone, a finding that the challenged actions are professionally acceptable treatment is insufficient. As the district court stated,

> the dichotomy between an intent to punish and an intent to treat is . . . false. When a mental patient is intentionally subjected to harsh conditions in order to deter him from maintaining a course of conduct, the fact that it is done in the name of psychiatric treatment does not keep it from being intentional punishment.[178]

The importance of the court's role in protecting individuals from state intrusion—and the inability of the professional judgment standard to accomplish this end—can be seen by considering the consequences if the professional judgment standard were to be adopted in cases alleging illegal search and seizure, psychologically coerced confessions, or police entrapment. Many such actions could be considered professionally acceptable police practices, but citizens' rights against police intrusion would be greatly diminished if professional acceptability from the standpoint of the police were all that the Constitution required.[179] Courts are often blind to this argument in cases involving behavior modification and other treatment practices of professionals primarily because of the images, discussed in Part I, that judges associate with professionalism. Courts are unaccustomed to connecting the word "treatment" with an unwilling patient compelled to submit to professional ministrations. To the courts, "treatment" does not connote an adversarial relationship. But in negative rights cases, the professional and patient are adversaries, and the court must rely upon constitutional doctrines and values, rather than on professional values, to resolve the dispute.

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177. *Green*, 662 F. Supp. at 1386.

178. *Id.* The court of appeals disagreed, finding that Green could not prevail under the Fourteenth Amendment unless the defendants had intended to punish him or the deprivation was excessive in relation to the defendant's goals. *Green*, 879 F.2d 305. The key is whether the courts follow their own conception of excessive deprivation or defer to professional judgment.

179. *See also supra* note 147, discussing a defendant's constitutionally protected right to proceed pro se at trial, despite the opinion of a state professional, her court-appointed attorney, that it would not be in her best interest.

c. *Family Rights*

The Constitution protects from government intrusion decisions regarding marriage, family association, and procreation.[180] Such decisions play a major role in shaping an individual's identity. The idea that the state could dictate an individual's family decisions is antithetical to constitutional values. However, to a mental health professional, dictating these choices may seem a useful aspect of treatment. Once again, because professional goals threaten constitutional values, family rights would be severely curtailed if the professional judgment standard were applied to this kind of decision.

In institutional settings, romantic attachments and family interactions are often viewed as central to an individual's illness and treatment. In one case, parents who had hospitalized their minor child were forbidden from visiting her because her therapy regimen "required Jane to earn all privileges, including the privilege to communicate with her parents in person or in writing."[181] This practice is common at institutions and treatment facilities.[182] It is an exercise of professional judgment aimed at behavior modification or protection of the patient.

Yet denying parents and children the right to see each other raises issues of individual rights unrelated to whether the treatment decision departed from professional judgment. The First and Fourteenth Amendment rights of familial association are not limited to situations in which professionals deem exercise of those rights appropriate or wise. To determine the constitutionality of restrictions on family visitation solely according to the professional judgment standard ignores the salience of these rights and precludes them from consideration by courts hearing challenges to such restrictions.[183]

A visitation case decided before *Youngberg* illustrates this point. The court applied a rational basis test to the defendant's visitation policies, which prohibited patients from receiving visits from the same person more than twice a week. The court found that these policies bore no relation to asserted concerns about security and treatment.[184] The court did not consider whether the policies

180. Moore v. City of East Cleveland, 431 U.S. 494, 499 (1977).

181. Doe v. Public Health Trust, 696 F.2d 901, 905 (11th Cir. 1983).

182. *See, e.g.*, Gary H. v. Hegstrom, 831 F.2d 1430, 1436 (9th Cir. 1987) (Ferguson, J., concurring) ("Visitation for those students in D-1 is limited to thirty minutes on Sunday afternoons.").

183. The court in *Doe v. Public Health Trust* avoided the more difficult questions in this case by finding that if the child was a voluntary patient, her rights could be waived in exchange for the benefit of treatment, as long as the no-communication rule was "medically legitimate and therapeutic." 696 F.2d at 904. The case was remanded for consideration of whether these conditions had been met. The court declined to articulate a standard for determining whether the rule was "medically legitimate and therapeutic," but suggested that the *Youngberg* standard might be appropriate. *Id.* The court thus finessed the issue of whether Doe's parents, who committed her "voluntarily," could waive *her* right to refuse treatment or to visitation with her family. While a parent can "voluntarily" commit a minor, Parham v. J.R., 442 U.S. 584 (1979), it does not necessarily follow that the parent can waive all of the minor's rights.

184. Schmidt v. Schubert, 422 F. Supp. 57 (E.D. Wis. 1976) (granting plaintiffs' motion for summary judgment on challenge to hospital visitation policies).

conformed to professional judgment; rather, it based its decision on the lack of a sufficient relationship between the policy and its stated purpose. Although it is not apparent that a rational relationship between treatment goals and institutional policy forbidding family association is a sufficiently strict standard, the rational relationship requirement is clearly an improvement over the professional judgment standard.

Romantic and sexual attachments between patients are also the focus of professional judgment. These are often

> either prohibited outright or subjected to intense staff scrutiny. The guidelines published by one hospital provide: "If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you and whether it would be to your advantage to continue or discontinue the relationship." Several authors have suggested that "sexual activity between psychiatric inpatients should be strictly prohibited, and when it occurs patients should be isolated . . . and tranquilized if necessary."[185]

Institutionalization—indeed, any government custody—involves a necessary limitation of privacy rights. Yet these rights survive incarceration[186] and institutionalization in some form.[187] Institutional restraints on intimate relationships and marriage have implications far beyond their therapeutic function, implications that the professional judgment standard does not address. The values of autonomy and the right to make personal decisions about intimate matters such as sex and marriage are not likely to weigh heavily on the minds of professionals. One ex-patient reports the reaction to a single kiss between two patients in an institutional setting:

> [I]n the lobby of our ward, where both men and women are allowed to mingle platonically, a woman whom I had met began to scooch over next to me on the couch where we were both sitting. She teasingly leaned over toward me, flirting mischievously with the idea of kissing me in public (as what, at any time, wasn't public?). Finally, as I had decided to be as brave or stupid as she was being, our lips touched. I was, in fact, very much attracted to her. This simple act of kissing,

185. Stefan, *supra* note 113, at 431.

186. *Turner v. Safley*, 482 U.S. 78, 95-96 (1987).

187. In *Youngberg v. Romeo*, the Supreme Court noted: "Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." 457 U.S. 307, 321-22 (1982). The standards set out in *Wyatt v. Stickney* include the right to "suitable opportunities for the patient's interaction with members of the opposite sex," subject to "adequate" or "appropriate" supervision. Wyatt v. Stickney, 344 F. Supp. 373, 381 (M.D. Ala. 1972); Wyatt v. Stickney, 344 F. Supp. 387, 399 (M.D. Ala. 1972). Interestingly, institutionalized mentally ill people enjoy greater rights than institutionalized mentally retarded people, whose rights may be abrogated by order of a qualified mental retardation professional. *Compare* 344 F. Supp. at 381 *with* 344 F. Supp. at 399.

> which was the extent of any physical contact I received during that three months . . . took much courage on the part of both of us. Shock treatments were rampant in [our institution] and we knew we would be reported. Sure enough, the attendants came pouring out from behind the glass window to separate us.[188]

In fact, there are consistent reports of women being institutionalized *because* of sexual behavior.[189] Although, for a variety of reasons, litigation in this area is sparse,[190] it is evident that applying the professional judgment standard to these kinds of claims will exclude some of the core values protected by the Constitution.

### 2. *Professional Judgment and the Denial of Procedural Due Process*

Procedural due process is a crucial component in defending against government infringement of substantive rights. One of the crucial flaws of the professional judgment standard is that it precludes a meaningful opportunity for notice and a hearing. Under the professional judgment standard, a claim that a substantive right has been violated is refocused from the issue of the loss of the right itself to the question of whether the right was deprived pursuant to professional judgment. Such judgments are perceived by courts to arise from a decisionmaking process opaque to judicial inquiry, "one much more subjective and less susceptible, therefore, to fine-tuned judicial review,"[191] and therefore a process too subtle for procedural formalities. Thus, courts conclude that they can grant no meaningful procedural protections to plaintiffs.

Under the professional judgment standard, the finding that professional judgment was exercised satisfies the patient's rights to procedure as well as her substantive rights. As one court held in a case involving academic professionals,

> Indeed, the process due one subject to this highly subjective evaluative decision can only be the exercise of professional judgment by those empowered to make the final decision in a way not so manifestly arbitrary and capricious that a reviewing court could

188. DOUG CAMERON, HOW TO SURVIVE BEING COMMITTED TO A MENTAL HOSPITAL 44 (1980).

189. *E.g., In the Matter of Lynette H.*, 368 S.E.2d 452 (N.C. Ct. App.), *vacated*, 374 S.E.2d 272 (N.C. 1988); JUDI CHAMBERLIN, ON OUR OWN 119-20 (1978); CHESLER, *supra* note 83, at 162.

190. Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?* 3 J. FORENSIC PSYCHIATRY (forthcoming June 1992) ("lawyers are quick to abandon any allegiance to advocacy roles in" cases involving right to voluntary sexual activity in institutional settings).

191. Siu v. Johnson, 748 F.2d 238, 244-45 (4th Cir. 1984) (holding that in state university tenure decision, due process requires only professional academic evaluation, not adversarial legal proceedings). As discussed in Part I, the perceived objectivity of professionalism is one of the assumptions supporting the Supreme Court's presumption of the validity of professional decisions. Nevertheless, courts can and do refer without apparent contradiction to the unreviewable *subjectivity* of professional judgment as a reason to deny procedural—and ultimately, substantive—due process protections. *Id.* at 244.

> confidently say of it that it did not in the end involve the exercise of professional judgment.[192]

This collapsing of substantive and procedural rights under the professional judgment standard was explicated by another court reviewing a challenge to the use of physical restraints. That court observed:

> [A] medical determination by the appropriate professional provides all of the process that is due in such a case; thus, if plaintiff's substantive due process rights were not violated (because professional judgment was exercised), any procedural due process requirements (*which require essentially the same exercise of professional judgment*) would undoubtedly have been fulfilled as well.[193]

In other words, a court's determination that professional judgment was exercised ends both the procedural and the substantive inquiry simultaneously.

Because there is no recognition of competing values—because the patient's voice is so completely silenced—no balancing is required of the judge. The professional takes over the judicial function entirely, assessing conflicting interests and authorizing limitations on substantive constitutional rights if professional judgment so requires. This is precisely the procedure endorsed by the Fourth Circuit in its en banc decision in *United States v. Charters*:[194]

> It is therefore settled that in appropriate circumstances government may properly commit base-line decisions to "deprive" persons of certain liberty (or property) interests to appropriate professionals exercising their specialized professional judgments rather than to traditional judicial or administrative-type adjudicative processes. This occurs when the conflicting interests—individual and governmental—can only be assessed in those terms, and even when, as is usual, the exercise of professional judgment necessarily involves some interpretation of the disputable "meaning" of clinical "facts."[195]

Yet the courts act disingenuously when they raise a white flag in the face of subjective, interpretive decisions by state officials. Many subjective decisions are governed by procedural due process protections, thus requiring at least some

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192. *Id.* at 245. *See also* United States v. Charters, 863 F.2d 302, 308 n.4 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016 (1990) (collapsing the substantive and procedural due process analysis; for both analyses, the professional judgment standard is adequate, if properly administered, to safeguard constitutionally protected liberty interests).

193. Wells v. Franzen, 777 F.2d 1258, 1261 n.2 (7th Cir. 1985) (citation omitted) (emphasis added). *See also* McCartney v. Barg, 643 F. Supp. 1181, 1184 (N.D. Ohio 1986) (reading *Youngberg* as holding that "the analytical approach in determining the extent of both substantive and procedural due process rights is similar.").

194. 863 F.2d 302.

195. *Id.* at 308.

accountability and openness from the decisionmakers.[196] Perhaps it is the Supreme Court's idealized image of certain professions that has led it to defer absolutely to professional expertise in this particular area. Whether one calls this deference an abdication of the court's function of the development of procedural standards or the "commit[ment of] base-line decisions to 'deprive' persons of certain liberty . . . interests to appropriate professionals,"[197] the result is to eliminate procedural due process protections for the victims of such decisions. As will be discussed in the following Subsection, however, courts can, and in other contexts do, develop procedural protections to weigh substantive claims of individuals who challenge the decisions of government experts.

### 3. *Adjudicating Negative Rights: Alternatives to the Professional Judgment Standard*

Courts can be extremely deferential without abdicating their responsibility to create meaningful standards for reviewing constitutional challenges to state action. Standards can give discretion to state defendants while still permitting traditional due process review of challenged state actions. The best examples are the standards developed to review allegations of constitutional deprivation in prisons and jails. When considering constitutional claims in these settings, courts balance individual rights against state interests as they do in noncustodial settings. However, the Court views state interests as heightened in custodial settings, and thus employs a more deferential standard of review.[198]

The standard of review used to assess whether a restriction or regulation by prison officials violates constitutional standards was established by the

196. For example, the decision to terminate parental rights could be characterized as a subjective decision best left to the "professional judgment" of foster care workers, yet the Constitution requires notice, hearing, and, in certain circumstances, representation before such a deprivation occurs. *See, e.g.*, Lassiter v. Department of Social Servs., 452 U.S. 18, 32-33 (1981) (holding that trial judges should decide in particular cases whether due process requires the appointment of counsel for indigent parents in termination proceedings).

197. *Charters*, 863 F.2d at 308.

198. Ideally, courts should review claims of constitutional violations in institutional settings according to the same varied standards used in noncustodial settings, though the fact of government custody will increase the state interests to be considered. For example, claims of violations of First Amendment rights would be judged according to First Amendment and case law standards, while claims of violations of bodily security would be judged according to Fourteenth Amendment standards and case law in that area. *See infra* text accompanying note 217. Given the current composition of the Supreme Court, the use of a single standard is unlikely to change in the near future. Less than five years ago, the Supreme Court rejected the argument that prison regulations totally foreclosing the exercise of fundamental rights should be scrutinized under a more rigorous standard than those merely limiting the exercise of those rights. O'Lone v. Estate of Shabazz, 482 U.S. 342, 349 n.2 (1987). Earlier, the Court failed to draw a distinction between claims that implicated fundamental rights and those that did not. Block v. Rutherford, 468 U.S. 576, 597-98 (1984) (Marshall, J., dissenting) (stating that the Court applies rational relation review to prison regulations without considering respondents' claim that these regulations abridge fundamental rights). The Court has also rejected the argument that more rigorous scrutiny is appropriate unless a court concludes that the activity for which prisoners seek protection is "presumptively dangerous." Turner v. Safley, 482 U.S. 78, 88-89 (1987), *cited with approval in O'Lone*, 482 U.S. at 349 n.2.

Supreme Court in *Turner v. Safley*.[199] A "regulation is valid if it is reasonably related to legitimate penological interests."[200] The Court listed four factors for courts to consider in determining whether a regulation is reasonably related to valid penological objectives: (1) whether the prison regulation is rationally related to the legitimate governmental interest put forward to justify it; (2) the availability of other avenues for the exercise of the asserted right; (3) the impact that accommodating the right would have on guards and other inmates and on the allocation of the prison's resources generally; (4) the existence of alternatives to the challenged regulation that would satisfy the prison's concerns.[201] This standard is extremely deferential to state needs, yet it preserves the judicial function of evaluating constitutional rights in the face of invasive state actions. Unlike the professional judgment standard, the *Turner* standard requires the state specifically to identify the state interests served by the policy or regulation; it requires a relationship between those interests and the challenged action; and it requires the court to determine whether the relationship is constitutionally sufficient according to four fairly specific considerations. Even if only a rational relationship is required, it is the court that determines whether this relationship exists, while weighing the governmental interest against identified constitutional rights of the plaintiff. The court must articulate the reasoning behind its determination in terms of such tangible criteria as the existence of alternatives to the challenged policy and the cost of accommodating the prisoner's rights.

This adjudicatory path is significantly different from the professional judgment standard. Because the only sources of information about professional judgment are professionals themselves, "the due process standard is based on norms set by the mental health professionals."[202] The definition of actions that comport with constitutional standards is, in effect, left to the professional community. While the Supreme Court characterized the professional judgment standard as a "balancing" of state interests against the plaintiff's liberty interests,[203] it is really nothing of the kind. As traditionally understood, balancing in constitutional cases requires the court to weigh the challenged action's impact on the plaintiff's rights against the state interests served by the deprivation. The professional judgment standard simply inquires whether the deprivation of the plaintiff's rights would be acceptable to professionals. The deprivation need not be related to state interests; indeed, state interests may never be articulated. Thus, balancing does not take place under the professional judgment standard—neither professionals nor courts compare the degree of harm to the individual with the necessity of the government action.

199. 482 U.S. 78 (1987).
200. *Id.* at 89.
201. *Id.* at 89-91.
202. Wells v. Franzen, 777 F.2d 1258, 1262 (7th Cir. 1985).
203. Youngberg v. Romeo, 457 U.S. 307, 321 (1982).

The proof of this constitutional pudding is in the outcomes of the cases, which show that the standard articulated in *Turner v. Safley*[204] and its progeny give prisoners more substantive and procedural protection against state abuse than would the professional judgment standard. Under this standard, appellate courts have rejected involuntary medication that trial courts had permitted under the professional judgment standard.[205] Courts have also imposed procedural due process requirements for involuntary medication of prisoners that would not be required under the professional judgment standard. Finally, *Turner* itself vindicated the family and association rights of a prisoner in a way that a ruling under the professional judgment standard would not have.

In *Washington v. Harper*,[206] the Supreme Court considered the right of a prisoner to refuse antipsychotic medication under the *Turner* standard, and articulated a specific substantive standard that the state must meet before overriding a prisoner's refusal of medication: the state must show that the prisoner was mentally ill; that, as a result of this mental illness, the prisoner was a danger to himself or others; and that the medication would benefit the prisoner.[207] The Court further held that the prisoner was entitled to procedural protections to guard against erroneous conclusions with regard to his mental illness, his dangerousness, or the benefit the drugs might provide. The state's procedures, which provided for "notice, the right to be present at an adversary hearing [with lay assistance], and the right to present and cross-examine witnesses," were found sufficient.[208]

The protections established in *Harper* are far less extensive than those that the court below had found to be constitutionally mandated,[209] and far less extensive than those granted by almost every state court considering the right to refuse treatment.[210] Nevertheless, both the substantive and procedural[211]

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204. 482 U.S. 78 (1987).

205. This is reflected in the number of cases involving involuntary medication of prisoners that were reversed on appeal because the lower court had incorrectly applied the professional judgment standard and had permitted medication without any showing as to dangerousness or the benefit of the medication. *See, e.g.*, Brower v. Smith, No. 89-6700, 923 F.2d 848 (Table, text in Westlaw) (4th Cir. Jan. 18, 1991); Peacock v. Adams, No. 89-7695, 1990 U.S. App. LEXIS 17398 (4th Cir. Mar. 26, 1990).

206. 494 U.S. 210 (1990).

207. The Court held that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Id.* at 227. However, the Court created some confusion about what the constitutional standard requires by specifically upholding the Washington State Special Offender Center's policy. *Id.* at 236. This policy allows involuntary medication only if the prisoner "(1) suffers from a 'mental disorder' and (2) is 'gravely disabled' or poses a 'likelihood of serious harm' to himself, others, *or their property*." *Id.* at 215 (quoting the policy) (emphasis added).

208. *Id.* at 235.

209. Harper v. Washington, 759 P.2d 358, 363-65 (Wash. 1988), *rev'd*, 494 U.S. 210 (1990).

210. *See, e.g.*, Riese v. St. Mary's Hosp., 271 Cal. Rptr. 199 (Cal. Ct. App. 1988), *app. dismissed*, 774 P.2d 698 (Cal. 1989); People v. Medina, 705 P.2d 961 (Colo. 1985); *In re* Orr, 531 N.E.2d 64 (Ill. App. 1988); *In re* M.P., 510 N.E.2d 645 (Ind. 1987); Rogers v. Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986); *In re* K.K.B., 609 P.2d 747 (Okla. 1980); State *ex. rel.* Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987).

211. In at least two cases, courts have invalidated institutional policies permitting forcible medication

requirements for giving involuntary medication to a prisoner under *Harper* are more rigorous than those mandated by the professional judgment standard.

The same is true in the area of family rights and freedom of association. In *Turner* itself, the Court invalidated a prison regulation forbidding inmate marriage unless the prison superintendent found compelling reasons to approve it.[212] The Court stated that the regulation was an "exaggerated response to . . . security objectives"[213] with "obvious, easy alternatives."[214] The Court found that the rule "sweeps much more broadly than can be explained by petitioners' penological objectives."[215] Most interestingly, the Court noted that "although not necessary to the disposition of this case . . . the rehabilitative objective asserted to support the regulation itself is suspect," since marriage of male prisoners was routinely permitted and marriage of female prisoners routinely denied.[216] If the regulation at issue in *Turner* had been subject to the professional judgment standard, the inquiry and outcome would have been substantially different. Since many institutions and professionals discourage their patients from marrying and engaging in intimate relations, the regulation probably would not have constituted a departure from the standards of the profession; therefore, it would very likely have been upheld.

Thus, by applying a *Turner*-type standard instead of the professional judgment standard to state mental institution cases, the courts would reclaim their role as the guardian of constitutional limits on state power. Judges are confident and experienced in balancing various interests and in drawing conclusions about whether a policy rationally accomplishes a particular purpose. Courts could inquire into the relation between the challenged restriction and the state's interest, be it therapeutic or otherwise. They could consider the availability of other avenues for the exercise of the plaintiff's right, the effect of accommodating the right on other patients and staff, and the availability of less restrictive alternatives to the current rule or decision. Unlike the professional judgment standard, this approach would require state professionals to articulate reasons for their judgments and leave to the court the job of explicitly considering the impact of these judgments on the patient's rights.

Although it is preferable to the professional judgment standard, however, a *Turner*-type standard is far from ideal because it too provides individuals diminished constitutional protections once they enter institutions. Individuals in institutions merit no punishment, and should, as the Supreme Court acknowledged in *Youngberg*, be treated with greater consideration than

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of patients pursuant to professional judgment because these policies lacked the procedural protections mandated by *Harper*. Williams v. Wilzack, 573 A.2d 809 (Md. 1990); Cliff v. Warden, No. 88-0000455, 1990 WL 279544 (Conn. Super. Ct. Sept. 7, 1990).

212. Turner, 482 U.S. at 96.

213. *Id.* at 98.

214. *Id.*

215. *Id.*

216. *Id.* at 99.

individuals in jail.[217] Negative rights claims of mental patients should be evaluated according to the standards used to protect such rights in noninstitutional settings, with the fact of government custody simply increasing the state's legitimate interests. Short of this, however, the *Turner*-type standard would at least preserve the basic framework of our constitutional system by requiring courts to conduct meaningful judicial review of state infringements of civil liberties.

### B. *Affirmative Claims for Adequate Government Services: The Appropriate Use of Professional Judgment*

In resolving affirmative claims for government services, courts follow an adjudicatory path that appropriately involves the professional judgment standard. First, the court determines if the individual has a constitutional right to services from the state. Such a right arises from the specific nature of an individual's custody. For example, individuals institutionalized for mental disabilities are entitled to "minimally adequate training,"[218] and every circuit but one that has ruled on the question has held that children in foster care are entitled to safe placement.[219] Once the court has determined that the plaintiff has such a right, *Youngberg* rightly requires that the service delivered accord with professional standards.

The following hypothetical case study is intended to clarify the basis for these rights, the standard by which violations of these rights should be judged, and the distinction between standards to adjudicate affirmative claims under the Due Process Clause and standards applicable to negative rights claims. Sandoz Pharmaceuticals, Inc. recently developed a new drug called Clozaril[220] to treat persons diagnosed with schizophrenia.[221] However, because its risks require a rigorous monitoring program, it is quite expensive.[222] Let us imagine that

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217. *Youngberg*, 457 U.S. at 321-22.

218. Youngberg v. Romeo, 457 U.S. 307, 319, n.25 (1982).

219. Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883 (10th Cir. 1992); Winston v. Children and Youth Servs., 948 F.2d 1380 (3rd Cir. 1991), *cert. denied*, 112 S. Ct. 2303 (1992); K.H. *ex rel.* Murphy v. Morgan, 914 F.2d 846 (7th Cir. 1990); Taylor v. Ledbetter, 818 F.2d 791 (11th Cir. 1987), *cert. denied*, 489 U.S. 1065 (1989); Gibson v. Merced County Dep't of Human Resources, 799 F.2d 582 (9th Cir. 1986); Doe v. New York City Dep't of Social Servs., 709 F.2d 782 (2d Cir. 1983), *cert. denied*, 464 U.S. 864 (1983); LaShawn A. v. Dixon, 762 F. Supp. 959 (D.D.C. 1991); Del A. v. Roemer, 777 F. Supp. 1297 (E.D. La. 1991); Rubacha v. Coler, 607 F. Supp. 477 (N.D. Ill. 1985). The single exception is the Sixth Circuit, which in Eugene D. v. Karman, 889 F.2d 701, 710 (6th Cir. 1989), cast doubt on whether the Constitution permits such claims to be brought by children in foster care.

220. Clorazil is the brand name of the drug Clozapine.

221. For examples of Clozapine's use and effectiveness, *see infra* notes 244-247 and accompanying text.

222. Treatment with Clozaril used to cost $9,000 a year. Daniel Ward et. al, *Letter to the Editor: Injunction to Cover Cost of Clozapine*, 148 AM. J. OF PSYCHIATRY 271 (1991). The high cost of the drug treatment resulted from Sandoz's requirement that patients pay for weekly blood monitoring by Caremark, Inc., as part of the purchase price of the drug. This practice ceased in May 1991, and Sandoz recently settled a lawsuit for 20 million dollars charging that the arrangement violated antitrust laws. *Sandoz Agrees to Pay $20 Million to Settle Clozaril Lawsuit*, 10 MENTAL HEALTH L. RPTR. 82 (Sept. 1992). A prisoner with AIDS

a patient who has been hospitalized for years at a state institution, for whom no other treatment has worked, claims that the failure to treat her with Clozaril constitutes a denial of her due process right to minimally adequate treatment.

This hypothetical presents a question clearly distinct from that which a court would face if the patient refused Clozaril, and the state wished to medicate her forcibly.[223] It also differs from the question presented by an allegation that the state denied the patient Clozaril because of her race in violation of the Equal Protection Clause. Rather, this scenario involves the claim that an individual in government custody has a substantive due process right to treatment, and that this right includes the affirmative right to receive a specific drug that may constitute the only effective treatment for the condition causing her loss of liberty.

Determining the existence of this right is clearly a matter for the courts. The courts must examine its basis in law and craft a standard for the application of this right. Yet, unlike negative rights claims, this affirmative claim asserts that professional judgment mandates treatment with Clozaril. This Section will first describe the theoretical foundations of the right to treatment and then discuss how courts use the professional judgment standard to implement the right. I will argue that the professional judgment standard is appropriate in cases involving affirmative claims to government services to the extent that state professionals apply their judgment untainted by state resource limitations, but that the standard is problematic where this is not the case. I will also argue that *Youngberg*'s command that state professionals' judgments be presumed valid seriously undercuts the protection provided by the professional judgment standard.

### 1. *Legal Foundation of the Right to Treatment*

Although courts have recognized a right to treatment for over twenty years,[224] both the basis for the right to treatment and its meaning in specific cases have been the subject of substantial commentary.[225] Early district court

requesting treatment with AZT presents a similar question to that of the patient in the Clozaril scenario. Yet, of course, the two issues are not identical because presumably the prisoner having AIDS has not lost his liberty on account of this condition, while the schizophrenic patient was hospitalized specifically to treat her schizophrenia.

223. *See* discussion *supra* Part II(A)(1)(a).

224. Covington v. Harris, 419 F.2d 617, 625 (D.C. Cir. 1969) (for mentally ill in hospital); Johnson v. Solomon, 484 F. Supp. 278, 297-300 (D. Md. 1979) (for juveniles in mental institution); Gary W. v. Louisiana, 437 F. Supp. 1209, 1216-20 (E.D. La. 1976) (for mentally retarded, physically handicapped and delinquent children); Davis v. Watkins, 384 F. Supp. 1196, 1197 (N.D. Ohio 1974) (for patients in state mental hospital); Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (same); *accord* Welsch v. Likins, 373 F. Supp. 487, 491-500 (D. Minn. 1974) (for persons in state mental institutions).

225. Scholarly work on the right to treatment was abundant prior to 1982, and came to a virtual halt in the years after *Youngberg* was decided. *Compare* Morton Birnbaum, *Some Remarks on "The Right to Tretament,"* 23 ALA. L. REV. 623 (1971); Bruce G. Mason & Frank J. Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface*, 10 CREIGHTON L. REV. 124 (1976); Ralph K. Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. C.R.-C.L. L. REV. 513 (1973); Roy G. Spece, Jr., *Preserving*

cases employed different standards than the *Youngberg* Court and based the right to treatment on a different foundation. These cases are commonly assumed to grant rights much broader than the right to treatment established in *Youngberg*.[226] This belief is unfounded, for many of the early cases are as hesitant about invading professional prerogatives as was the *Youngberg* Court.[227] Rather, *Youngberg* establishes a foundation for a right to treatment more expansive and more true to constitutional values than the early cases.

In the first of the early cases, *Wyatt v. Stickney*, the court based the right to treatment on the so-called "quid pro quo" theory.[228] Under this theory, in the absence of conviction after a procedurally sound criminal trial, the state cannot totally deprive a person of his or her liberty without offering some affirmative benefit—such as treatment or habilitation—in return.[229] Thus, habilitation is the constitutionally required quid pro quo for civil confinement. Another version of the quid pro quo theory requires that when the state deprives an individual of liberty in order to provide treatment, it must in fact provide that treatment.[230]

The problem with the quid pro quo theory for institutionalized individuals is that, although it provides a foundation for the right to treatment, it also allows the provision of treatment to serve as sufficient justification for deprivations

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*the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 ARIZ. L. REV. 1 (1978); Symposium, *The Mentally Ill and the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969); Symposium, *The Right to Treatment*, 57 GEO. L.J. 673 (1969); Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1973); John C. Roberts, Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87 (1967); Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973); *with* Note, *Beyond* Youngberg*: Protecting the Fundamental Rights of the Mentally Retarded*, 51 FORDHAM L. REV. 1064 (1983); Note, *The Constitutional Right to Treatment in Light of Youngberg v. Romeo*, 72 GEO. L.J. 1785 (1984).

226. *See, e.g.*, New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

227. *See* Bowring v. Godwin, 551 F.2d 44, 48, n.3 (4th Cir. 1977) ("[C]ourts are ill-equipped to prescribe the techniques of treatment . . . . The exact contours of relief should be left to the sound discretion of experts in the field."); *Johnson*, 484 F. Supp. at 301 n.28 ("[T]oo detailed a foray into the unresolved clinical and treatment issues . . . could stifle new developments."); Davis v. Balson, 461 F. Supp. 842, 853 (N.D. Ohio 1978) (professional standards "must be accorded great weight" though they will not always "be constitutional minimums"); *Gary W.*, 437 F. Supp. at 1219 (cautioning against the imposition of "inexorable bonds").

228. *Wyatt*, 325 F. Supp. at 784. Earlier cases, notably Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), strongly intimated that such a right to treatment existed constitutionally, but rested their holdings on a statutory guarantee. Following *Wyatt*, many courts found that institutionalized individuals had a right to treatment, usually based on some form of the quid pro quo theory. *See Johnson*, 484 F. Supp. 278; *Gary W.*, 437 F. Supp. 1209; *Davis*, 384 F. Supp. 1196; *Welsch*, 373 F. Supp. 487.

229. A form of the quid pro quo theory, though not under that name, was first articulated by Morton Birnbaum, a doctor and lawyer, in *The Right to Treatment*, 46 A.B.A. J. 499, 503 (1960). The quid pro quo theory and other early theories supporting the right to treatment are explained and analyzed in Clark v. Cohen, 794 F.2d 79, 93-94 (3d Cir. 1986) (Becker, J., concurring), *cert. denied*, 479 U.S. 962 (1986).

230. *See* Youngberg v. Romeo, 457 U.S. 307, 325-26 (1982) (Blackmun, J., concurring). *See also* Clark v. Cohen, 794 F.2d at 93-94. Thus, if the patient claiming a right to Clozapine had been committed under a state statute entitling him to treatment, then the fact of his commitment automatically created a entitlement to treatment.

of liberty.[231] This approach would severely undermine negative rights claims challenging "treatment" decisions as deprivations of liberty. The treatment challenged by the plaintiff as a deprivation of liberty becomes, under the quid pro quo theory, a justification for the individual's confinement. Treatment rights become a substitute for liberty rights.

The *Youngberg* Court defused the potential for forced exchanges under the quid pro quo theory by finding that the right to treatment arises directly from a plaintiff's liberty interests. In determining the scope of the right to treatment, the Court explained that courts

> may start with the generalization that there is a right to minimally adequate training. The basic requirement of adequacy, in terms more familiar to courts, may be stated as that training which is reasonable in light of identifiable liberty interests and the circumstances of the case.[232]

This language could imply a very broad right to treatment. The Supreme Court has repeatedly emphasized both that institutionalization itself is a massive curtailment of liberty[233] and that there is a separate identifiable liberty interest in avoiding the stigmatization of inappropriate hospitalization.[234] If an individual is unnecessarily or inappropriately hospitalized,[235] both of these liberty interests may oblige the state to provide the treatment necessary to end the deprivation of liberty.

The *Youngberg* rationale thus leaves open, where the quid pro quo theory does not, the possibility of a right to the treatment necessary to be free of institutional confinement.[236] Under the quid pro quo theory, treatment is the price paid by the state to purchase the individual's liberty. Under *Youngberg*'s

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231. This justification is clearly recognized by most proponents of these theories, *see, e.g.*, Donaldson v. O'Connor, 493 F.2d. 507, 520 (5th Cir. 1974) (noting that the need for treatment is grounds for commitment under state statutes), *vacated*, 422 U.S. 563 (1975); *Spece*, *supra* note 225, at 6 (providing needed treatment is a "legitimate, if not compelling, purpose for involuntary civil commitment"), and was considered one of the dangers of the right to treatment, Katz, *supra* note 157, at 755. The Supreme Court appears to have foreclosed this possibility in Foucha v. Louisiana, 60 U.S.L.W. 4359 (U.S. May 18, 1992), which construed *O'Connor v. Donaldson* to hold that "it [is] unconstitutional for a State to continue to confine a harmless, mentally ill person." *Id.* at 4361 (citing O'Connor v. Donaldson, 422 U.S. 563 (1975)). The Court concluded that "keeping Foucha against his will in a mental institution is improper absent a determination in civil commitment proceedings of current mental illness and dangerousness." *Id.*

232. *Youngberg*, 457 U.S. at 319 n.25.

233. The Court most recently reiterated its prior holdings to this effect in Foucha v. Louisiana, 112 S.Ct. 1780, 1785 (1992) ("'[T]he loss of liberty produced by an involuntary commitment is more than a loss of freedom from confinement.'") (quoting Vitek v. Jones, 445 U.S. 480, 492 (1980)).

234. Parham v. J.R., 442 U.S. 584, 600-01 (1979); Addington v. Texas, 441 U.S. 418, 426 (1979).

235. For example, many developmentally disabled individuals are confined inappropriately in mental hospitals, *see, e.g.*, McCartney v. Barg, 643 F. Supp. 1181, 1182-83 (N.D. Ohio 1986); Armstead v. Pingree, 629 F. Supp. 273, 275 (M.D. Fla. 1986).

236. Judge Becker contends that the right that logically follows from the quid pro quo theory is one to "habilitation to enable [the involuntarily civilly committed] to leave their commitment." Clark v. Cohen, 794 F.2d 79, 94 (3d Cir. 1986) (Becker, J. concurring), *cert. denied*, 479 U.S. 962 (1986). His is the only argument that can be made for this interpretation of the quid pro quo theory.

rationale, the constitutional predicate for the right to treatment is to protect or increase liberty, including liberty from the total restraint of institutionalization. A number of courts have adopted this approach, finding that "the involuntarily committed have the constitutional right 'to minimally adequate habilitation . . . which will tend to render unnecessary . . . prolonged isolation from one's normal community.'"[237]

*Youngberg* also links treatment within the institutional setting to liberty interests, stating that "when training could significantly reduce the need for restraints or the likelihood of violence," the state might well be constitutionally required to provide that treatment.[238] Both professional literature and case law link insufficient staffing and insufficient treatment programs with the increased use of restraints and seclusion[239] and increased danger to the mentally handicapped.[240] Thus, involuntarily committed individuals also have the right to treatment "which will tend to render unnecessary the use of chemical restraint, shackles, solitary confinement, locked wards . . . and [to] conditions of life which are normal enough to promote rather than detract from one's chance of living with fewer restrictions on one's movement."[241]

The treatment or habilitation required under *Youngberg* is not the kind that works toward an elusive and perhaps undefinable "cure"; such a requirement could conceivably keep many people institutionalized for life and would lead judges to even greater deference to professionals. Instead, the *Youngberg* standard's link to liberty interests makes the right to treatment understandable to and definable by a court. *Youngberg*'s right to treatment focuses on reducing the obstacles to liberty, both those within the institution and the fact of

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237. Cameron v. Tomes, 783 F. Supp. 1511, 1515 (D. Mass. 1992) (quoting Mihalcik v. Lensink, 732 F. Supp. 299, 302 (D. Conn. 1990) (first alteration in original) (emphasis omitted); *see also* Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1312, 1313 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200-01 (W.D.N.C. 1988), *aff'd*, 902 F.2d 250 (4th Cir. 1990), *cert. denied*, 111 S. Ct. 373 (1990)).

238. *Youngberg*, 457 U.S. at 324.

239. Paul J. Schwab & Connie B. Lahmeyer, *The Uses of Seclusion on a General Hospital Psychiatric Ward*, 40 J. CLINICAL PSYCHIATRY 228, 231 (1979) (increased use of seclusion is associated with staff-patient ratios and staff availability); Wyatt v. Aderholt, 503 F.2d 1305, 1310-11 (5th Cir. 1974) (aides in understaffed hospital frequently put patients in seclusion and restraint without physicians' orders); *Thomas S.* 699 F. Supp. at 1189 (seclusion and restraint routinely relied on in lieu of a systematic treatment program); Lelsz v. Kavanagh, 673 F. Supp. 828, 851 (N.D. Tex. 1987) (mechanical restraints used in lieu of programs); Halderman v. Pennhurst State Sch. & Hosp., 446 F. Supp. 1295, 1307 (E.D. Pa. 1977), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979) (en banc) (physical restraints used for as long as 720 continuous hours due to staff shortages).

240. Harold Carmel et al., *Physician Staffing and Patient Violence*, 19 BULL. AM. ACAD. PSYCHIATRY L. 49, 50 (1991)(physical aggression increases as the patient-physician ratio increases); Myra G. Eisenberg & Diana O. Tierney, *Profiling Disruptive Patient Incidents*, 11 QUALITY REV. BULL. 245, 247 (1985) (disruptive behavior increased during periods of reduced staff-patient ratios and few therapeutic activities); Pearl Katz & Faris R. Kirkland, 53 PSYCHIATRY 262, 274 (1990); *Wyatt*, 503 F.2d at 1311 (patients suffered brutality and four residents died due to understaffing); *Thomas S.*, 699 F. Supp. at 1186-89 (due to inadequate treatment programs, patients are injured by self-abuse); *Lelsz*, 673 F. Supp. at 863 (unacceptable therapy programs put clients at increased risk of harm); *Halderman*, 446 F. Supp. at 1308 (understaffing resulted in injuries to residents by other residents and self-abuse).

241. *Cameron*, 783 F. Supp at 1515 (citation omitted).

institutionalization itself. Such an approach resolves the constitutional question of the right to treatment with reference to constitutional rights. Professional judgment is employed only to serve those rights by determining the particular treatment the patient should receive, as discussed below.

### 2. *Standards for the Right to Treatment*

After finding that a right to treatment exists and articulating the basis for it, the *Youngberg* Court formulated a standard to determine the particular treatment to which an individual plaintiff is entitled, a standard that appropriately involves professional judgment. The patient demanding a certain treatment is not necessarily entitled to receive it simply because she has a right to treatment of some kind.[242] Rather, the right to a particular treatment turns on whether that treatment is "reasonable in light of [her] identifiable liberty interests and the circumstances of the case,"[243] an issue that courts must determine with the aid of mental health professionals.

For example, some patients may have a right to receive Clozaril while others may not, depending on the efficacy of that treatment to their conditions. An article describing various forensic patients treated with Clozaril mentions one patient with a longstanding diagnosis of schizophrenia who was forced to wear a helmet to prevent him from injuring himself.[244] This "treatment," like most uses of restraints, simply prevented further injury without ameliorating his underlying psychiatric problem; and in so doing, it substantially restricted his liberty and offered no hope of release. However, he responded extremely well to Clozaril, and was transferred to a less secure unit and then to a group home.[245] Another individual in the study, on the other hand, "still complained of auditory hallucinations" after treatment with Clorazil.[246] When his dosage was increased, he suffered two grand mal seizures.[247]

The complexity of prescribing treatment for different individuals shows the role professional judgment should play in a court's determination of what treatment is constitutionally required. Because the court cannot know the potential benefits and drawbacks of various treatments in achieving a patient's

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242. The right to treatment has never been understood as a right to optimal treatment or to treatment of the patient's choice. Society for Good Will to Retarded Children v. Cuomo, 902 F.2d 1085, 1089 (2d Cir. 1990) ("[T]he issue is not whether the optimal course of treatment as determined by some experts was being followed, but whether 'professional judgment in fact was exercised.'"); Hanson v. Clarke County Iowa, 867 F.2d 1115, 1120 (8th Cir. 1989) ("[L]iberty interests explicated in Youngberg [do not] create a substantive due process right to optimal care and treatment."); Lelsz v. Kavanagh, 807 F.2d 1243, 1251 (5th Cir.), *cert. denied*, 483 U.S. 1057 (1987) (state has no obligation to grant "a benefit of optimal treatment").

243. *Youngberg*, 457 U.S. at 319 n.25.

244. Gary J. Maier, *The Impact of Clozapine on 25 Forensic Patients*, 20 BULL. AM. ACAD. OF PSYCHIATRY & L. 297, 300-01 (1992).

245. *Id.* at 301.

246. *Id.* at 303.

247. *Id.* at 303.

liberty interests—either through release from confinement or greater liberty in the institution—it must rely on professional judgment as to whether it is reasonable to require a given treatment to secure a patient's liberty.

The problem with the professional judgment standard in right-to-treatment cases is not, therefore, the judicial reliance on professional judgment per se; the problem is that *Youngberg* commands courts to presume the validity of the judgments of state professionals, who are often defendants in the litigation. The professionals whose decisions are challenged in these cases are plagued by the conflicts of interest discussed in Part I(B)(2), and even the best-intentioned are subject to enormous pressure to adjust or dilute their professional standards to conform to inadequate resources and substandard supplies and facilities.[248] The patient's treatment may not represent the result of a decision or judgment at all, but simply a default in the absence of alternatives.[249]

As discussed in Part I, the model of the private professional-patient relationship, with the professional using his expertise to advance the patient's interests, excludes these realities. The judgment of state professionals may well be handicapped and distorted by contradictory imperatives. For example, a private psychiatrist with a schizophrenic patient who had not responded to any other form of medication over time would almost certainly exercise his professional judgment by recommending Clozaril.[250] Whether the hope of relief was worth the expense involved would be the patient's choice to make, on an individual basis. A professional in a state institution may be faced with the state's refusal to fund Clozaril for any patient because of its cost.[251] Therefore, the "decision" not to use Clozaril may not represent a judgment by the professional at all, but a decision by agency administrators who are not mental health professionals.[252] Many "professional judgments" granted presumptive validity by *Youngberg* are in effect default judgments, not the result of a decision among options but the consequence of an absence of options. Deference is inappropriate under these circumstances. By the same token, state professionals whose judgment dictates that their clients should receive treatment in the community may be deterred

248. *See supra* Part I(B)(2).

249. *See id.* The question of the extent to which budgetary considerations and lack of resources are permissible factors in a professional's judgment is one of the most important questions raised by the professional judgment standard, and is discussed in Part II(B)(4), *infra*.

250. Michael Winerip, *To Some, Hope is Just a Drug Too Far Away*, N.Y. TIMES, August 9, 1992, at A41 (noting that a single psychiatrist in private practice in New York had more patients on Clozaril than all the patients in two New York State Hospitals combined, despite the fact that 554 patients in the hospitals would potentially benefit from the drug).

251. The Texas legislature appropriated $4.2 million for Clozaril use, yet only 430 patients are receiving it out of a potential 20,000-40,000 people who could benefit from it. Oklahoma does not allocate any money for Clozaril treatment. *Wider Access Has Doubled Number of Patients on Clozaril*, PHARMACEUTICAL BUS. NEWS, May 29, 1992, Finance/Business Section.

252. For example, only one-fifth of eligible patients receive Clozaril in Massachusetts, although the state mental health commissioner who announced the program denied that cost was a factor, citing instead "the state's limited medical and nursing expertise." Judy Foreman, *Clozapine Access will be Limited*, BOSTON GLOBE, July 27, 1990, at 13.

from recommending this treatment because of the social, political and legal consequences involved. Attempts to exercise professional judgment in these cases might entail considerable career costs for the professional.[253] In other cases, the lack of staff or physical plant problems may make it impossible for a professional to exercise professional judgment. Private professionals may share some of these extraneous pressures, but not to the same degree.

The significant obstacle plaintiffs face due to the presumptive validity of state professional action is well illustrated by translating Justice Blackmun's persuasive argument against special deference to prison administrators into the institutional setting.[254] When an institutionalized person attempts to demonstrate that the treatment she receives is a departure from professional standards or practice, she is necessarily calling into question the professional judgment of the defendants. Under these circumstances, it is perverse to insist that a court grant presumptive validity to the very decisions being challenged. Such a requirement boils down to a command that when a court is confronted by a claim of departure from professional standards, it must assume that professional standards were met.

The question before the judge, therefore, should simply be what approach professionals in general would take to treat a person in the plaintiff's situation so that her release from confinement could be expedited. If the court is convinced that several different approaches are acceptable to accomplish this goal, and that the defendants chose one of them for valid professional reasons, then the plaintiff has received treatment that is reasonable in light of her liberty interests.[255]

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253. Many mental health professionals have claimed that they were fired or disciplined because they expressed concern over the adequacy of the treatment or safety of their patients. *See, e.g.*, Schwartzman v. Valenzuela, 846 F.2d 1209, 1211 (9th Cir. 1988) (psychologist discharged after publicly criticizing hospital for unnecessary administration of psychotropic drugs, failure to provide safe work environment, and failure to supervise patient who raped and killed another patient at institution); Downing v. Williams, 624 F.2d 612, 615 (5th Cir. 1980) (patient suffered cardiac arrest and had to wait 45 minutes for ambulance; a psychiatrist was fired for making the following entries in patient's chart: "No suction; No resusc. equipment; No emergency ambulance available; Gross neglect; Would have to suction *by mouth*."), *vacated*, 645 F.2d 1226 (5th Cir. 1981).

254. Justice Blackmun stated:

> When a detainee attempts to demonstrate . . . that the challenged conditions are not "reasonably related to a legitimate government objective," he necessarily is calling into question the good faith of prison administrators. Under those circumstances, it seems to me somewhat perverse to insist that a court assessing the rationality of a particular administrative practice must accord prison administrators "wide-ranging deference . . . ." . . . Such a requirement boils down to a command that when a court is confronted with a charge of administrative bad faith, it must evaluate the charge by assuming administrative *good* faith. . . . I regard it as improper to make the plaintiff prove his case twice by requiring a court to defer to administrators' putative professional judgment.

Block v. Rutherford, 468 U.S. 576, 592-93 (1984) (Blackmun, J., concurring in the judgment) (citations omitted) However, the *Rutherford* majority found that prison administrators *are* entitled to "wide-ranging deference." *Id.* at 585.

255. Of course, if the defendants' course of action was preventive rather than ameliorative when ameliorative treatment was available, as in the helmet example, *supra* text accompanying note 244, or if

### 3. *Right to Treatment Recommended by a State Professional*

Another advantage of the professional judgment standard in affirmative claims is its potential to enforce a professional's recommendation of treatment that increases the plaintiff's liberty. This is particularly clear in cases in which plaintiffs assert a right to be treated in the community rather than in an institution. The presumptive validity accorded to professional judgments combined with the plaintiff's right to liberty-increasing treatment under *Youngberg* allows plaintiffs to make a strong case for forcing a state to comply with the recommendations of its professionals for community placement that had been ignored due to inertia or lack of funds.[256] After all, as one court noted, "[n]othing in *Youngberg* authorizes state officials to ignore the judgment of their own professionals or precludes a court from enforcing it once the judgment is made."[257]

Recently, courts have granted class recovery and class remedies in such claims.[258] These courts hold that freedom from bodily restraint under *Youngberg* "includes the right to be free from confinement in an institution where such confinement is shown on a factual basis to be unnecessary."[259] Although in *Youngberg* itself, the parties agreed that no amount of treatment would enable Romeo to live outside an institutional setting,[260] the liberty interests at stake in right-to-treatment cases clearly include freedom from unnecessary

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the treatment had been used for months or years without effect, it might not be professionally acceptable in the particular individual's case.

256. Clark v. Cohen, 794 F.2d 79 (3d Cir.), *cert. denied*, 479 U.S. 962 (1986); Thomas S. v. Morrow, 601 F. Supp. 1055 (W.D.N.C. 1984), *aff'd in part and modified in part*, 781 F.2d 367 (4th Cir.), *cert. denied*, 476 U.S. 1124 (1986), *and cert. denied*, 479 U.S. 869 (1986); Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992).

Only a few courts have held that the right to treatment in *Youngberg* was inapplicable to decisions involving placement, that is the location of treatment. *See, e.g.*, Sabo v. O'Bannon, 586 F. Supp. 1132, 1141 n.7 (E.D. Pa. 1984). The environment in which treatment is delivered is undoubtedly considered by professionals to be a part of treatment, and has been ever since there have been mental health professionals. *See* David J. Rothman, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC (1990); Herbert A. Eastman, *Metaphor and Madness, Law and Liberty*, 40 DEPAUL L. REV. 281 (1991).

257. Lelsz v. Kavanagh, 629 F. Supp. 1487, 1494 (N.D. Tex. 1986).

258. Thomas S. v. Flaherty, 902 F.2d 250 (4th Cir. 1990), *cert. denied*, 111 S. Ct. 373 (1990); *Jackson* 757 F. Supp. 1243 (D.N.M. 1990).

259. Homeward Bound, Inc. v. Hissom Memorial Ctr., No. 85-C-437-E, 1987 WL 27104, at *20 (N.D. Okla. July 24, 1987) (citing *Youngberg*).

260. 457 U.S. at 317. As noted previously, Romeo moved out of Pennhurst after the Supreme Court's decision and was living in the community within two years of the decision. *Former Pennhurst Patient to Get Settlement*, UPI, July 25, 1984 *available in* LEXIS, Nexis Library, UPI File.

confinement[261] and the stigma associated with institutionalization.[262] As one court emphasized:

> An individual confined to an institution against his best interests is unduly restrained to the same extent that an individual shackled to his wheelchair is unduly restrained. If professional judgment dictates that community placement is necessary in the best interest of the individual, then the individual has a constitutional right to such placement, and continued confinement in the institution constitutes undue restraint.[263]

Indeed, this issue is ideal for illustrating the dichotomy between claims for treatment based on professional judgment and claims against state infringement of liberty. If a plaintiff's claim simply challenges the fact of institutionalization as an unconstitutional restraint on liberty,[264] the claim should be judged not according to the professional judgment standard but rather according to the constitutional standards set out in *Foucha v. Louisiana*[265] and *O'Connor v. Donaldson*.[266] These cases forbid keeping an individual "against his will in a mental institution . . . absent a determination in civil commitment proceedings of current mental illness and dangerousness."[267] On the other hand, if the claim is that professional judgment requires services and treatment to be provided in a community setting, then the claim is one for affirmative services and may be appropriately adjudicated under the professional judgment standard.[268] Finally,

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261. Vitek v. Jones, 445 U.S. 480 (1980); Addington v. Texas, 441 U.S. 418 (1979); O'Connor v. Donaldson, 422 U.S. 563 (1975).

262. The liberty interest in avoiding the undoubtedly crippling stereotypes associated with institutionalization has been recognized in a series of Supreme Court decisions. Parham v. J.R., 442 U.S. 584 (1979); *Addington*, 441 U.S. at 425-26. The Court recognized the level of stigmatization associated with hospitalization when it noted that even convicted felons had a liberty interest in avoiding being so categorized. Vitek v. Jones, 445 U.S. at 492-93. *See also* Doe v. Austin, 848 F.2d 1386, 1391 (6th Cir. 1988), *cert. denied*, 488 U.S. 967 (1988); Donahue v. Rhode Island Dept. of Mental Health, 632 F. Supp. 1456, 1462 (D.R.I. 1986).

263. Lelsz v. Kavanagh, 629 F. Supp. 1487, 1494-95 (N.D. Tex. 1986).

264. Some cases have also successfully challenged institutionalization as segregation under the Equal Protection Clause of the Fourteenth Amendment. *See* Homeward Bound Inc. v. Hissom Memorial Ctr., No. 85-C-437-E, 1987 WL 27104 (N.D. Okla. July 24, 1987).

265. 112 S. Ct. 1780 (1992) (insanity acquittee may not be held in mental institution unless he is both mentally ill and dangerous).

266. 422 U.S. 563 (1975) (nondangerous person capable of surviving alone or with willing help of others may not be involuntarily confined).

267. *Foucha*, 112 S. Ct. at 1784. "Even if the initial commitment was permissible, 'it could not constitutionally be continued after [mental illness and dangerousness] no longer existed.'" *Id.* (quoting O'Connor v. Donaldson, 422 U.S. at 575).

268. These community setting claims may be seen as raising concerns under *DeShaney* about the obligation of the state to provide services outside of institutional settings. DeShaney v. Winnebago County Dep't Social Servs., 489 U.S. 189 (1988). However, these affirmative rights have been found to arise only when individuals are "wholly dependent on the state." *See* Jackson v. Fort Stanton State Hosp. & Training Sch., 964 F.2d 980, 991 (10th Cir. 1992). *DeShaney* is properly read, and has been interpreted by the courts, to create a dichotomy based on government custody. Cases since *Deshaney* support this distinction in finding that children in foster care in the community, as opposed to those not in state custody, have rights under the Fourteenth Amendment. *See infra* Part III(A)(4). Logic and common sense also support this reading. Some so-called "community settings" are actually cottages on the grounds of an institutional facility; some are locked facilities; some house as many as 50 or 60 residents. To differentiate effectively between

professional judgment should have no relevance if the plaintiff in a community setting is *resisting* treatment that the state seeks to impose.[269]

The right to treatment under *Youngberg* springs from the liberty interests of institutionalized individuals. Unlike the quid pro quo theory, which sees treatment as compensation for a deprivation of liberty, *Youngberg* links treatment to the enhancement of liberty and the prevention of restraint. The Supreme Court explicitly stated that "[i]t may well be unreasonable not to provide training when training could significantly reduce the need for restraints . . . ."[270] The logic of *Youngberg* supports an exchange between the state and an individual that is more favorable to the individual than that which the quid pro quo theory justifies: treatment cannot simply justify massive state restraints on liberty but must serve to *restore* liberty lost due to state-imposed restraint.

### 4. *The Effect of Budget Constraints on Application of the Professional Judgment Standard*

A fundamental question in defining professional judgment is whether it must focus solely on an individual's needs and circumstances, as a professional would in a private relationship with a client, or whether professional judgment may include consideration of state budgetary constraints or the availability of treatments.[271] The *Youngberg* Court emphasized that it is the factfinder—a jury or court—that is to perform the balancing of state and plaintiff interests, using professional judgment as the standard to guide that balancing.[272] However, the circuits dispute whether and to what extent fiscal constraints and the unavailability of resources for treatment can inform professional judgment. It is a crucial issue because the treatment recommended by professional judgment defines the limit of the patient's entitlement under *Youngberg*. A proper understanding of the professional judgment standard rejects judgment driven by budgetary concerns or the unavailability of treatment alternatives while allowing the same attention to costs that private sector professionals give. Thus,

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institutional and community care is difficult, if not impossible. To distinguish further between being in custody "voluntarily" and "involuntarily" is more problematic and has caused division among and even within the circuits. *Compare* Doe v. Austin, 848 F.2d 1386, 1392 (6th Cir. 1988), *cert. denied*, 488 U.S. 967 (1988) *with* Higgs v. Latham, No. 91-5273, 1991 U.S. App. LEXIS 25549 (6th Cir. Oct. 24, 1991) *and* Jordan v. Tennessee, 738 F. Supp. 258 (M.D. Tenn. 1990). This issue is, however, beyond the scope of this Article.

269. Several states have passed laws authorizing "outpatient commitment" which would permit forcible medication in community settings. *See* Susan Stefan, *Preventive Commitment: Misconceptions and Pitfalls in Creating a Coercive Community*, 11 J. HEALTH & HUM. RESOURCES ADMIN. 459 (1989). To date, no constitutional challenges to these statutes have been brought.

270. Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

271. By "budgetary constraints" I mean simple lack of funds allotted, in contrast to the "availability of treatments," which is limited not by funding levels but by governmental inertia in developing or funding alternative forms of treatment that may be less expensive than those currently provided.

272. *Youngberg*, 457 U.S. at 321.

institutionalized individuals' constitutional rights will not ebb and flow at the mercy of state appropriations.[273]

The majority of courts have affirmed that professional judgment may not be controlled by availability of resources or budgetary considerations,[274] holding, for example, that "what is appropriate care, treatment and placement must be determined by a qualified professional based upon medical and psychological criteria, not upon what resources are available."[275] In fact, "[e]vidence that the professional judgment was made to conform to what was available may indicate that the judgment was 'a substantial departure from accepted professional judgment, practice or standards.'"[276] This interpretation makes sense—accepted professional standards are based on expertise in diagnosis and treatment, not developed on the basis of state budgetary or resource considerations.[277] As one court has said:

> The obligation of the defendants to eliminate existing unconstitutionalities cannot depend upon what the Governor or the Legislature may do . . . . Neither should lack of funding be available as an excuse for the defendants' failure to provide the plaintiff class, who through no fault of their own are clients of the state hospital system, with minimally adequate care, treatment and placement.[278]

If courts permit the professional judgment calculus to include resource availability or budgetary considerations, the ultimate result will be varying

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273. Almost every state's mental health budget is underfunded, and fiscal constraints no doubt take their toll on institutional professionals. Courts have recognized and condemned "a tendency among human service professionals in the state psychiatric institutions to conform their recommendations for treatment or habilitation . . . to the constraints imposed by the state's inadequate service delivery system, rather than to exercise true professional judgment." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1196 (W.D.N.C. 1988), *aff'd in part and modified in part*, 781 F.2d 367 (4th Cir.), *cert. denied*, 476 U.S. 1124 (1986), *and cert. denied*, 479 U.S. 869 (1986).

274. *See* Kirsch v. Thompson, 717 F. Supp. 1077, 1080 (E.D. Pa. 1988); Baldridge v. Clinton, 674 F. Supp. 665, 670 (E.D. Ark. 1987); Lelsz v. Kavanagh, 629 F. Supp. 1487, 1495 (N.D. Tex. 1986); Clark v. Cohen 613 F. Supp. 684, 704 (E.D. Pa. 1985), *aff'd*, 794 F.2d 79 (3d Cir. 1986) (endorsing the concept that professional judgment "must be based on medical or psychological criteria and not an exigency, administrative convenience, or other non-medical criteria"), *cert. denied*, 479 U.S. 962 (1986); Thomas S. v. Morrow, 601 F. Supp. 1055, 1060 (W.D.N.C. 1984), *aff'd in part and modified in part*, 781 F.2d 367 (4th Cir. 1986), *cert. denied*, 476 U.S. 1124 (1986), *and cert. denied*, 479 U.S. 869 (1986). *See also* Ohlinger v. Watson, 652 F.2d 775, 779 (9th Cir. 1981) (a pre-*Youngberg* case holding that, "[l]ack of funds, staff or facilities cannot justify the States' failure to provide . . . treatment necessary for rehabilitation").

275. *Baldridge*, 674 F. Supp. at 670 (citations omitted).

276. *Lelsz*, 629 F. Supp. at 1495 (citations omitted).

277. *See, e.g.*, AMERICAN PSYCHOLOGICAL ASSOCIATION, SPECIALTY GUIDELINES FOR THE DELIVERY OF SERVICES (1989); American Psychiatric Association, *Ethical Principles of Psychologists* 45 AM. PSYCHOLOGIST 390-95 (1989). By exempting state professionals from individual liability for failure to exercise professional judgment because of budget limitations, the *Youngberg* Court indicated that professional judgment is an absolute standard from which budgetary constraints might force a departure. *Id.* at 323. The holding indicates that it is not appropriate to consider budgetary constraints in professional decisionmaking. The Court could easily have declared instead that professional judgment only required consideration of those alternatives made feasible by available resources.

278. *Baldridge*, 674 F. Supp. at 670.

standards of constitutionality across the fifty states, depending on how well each state funded mental health services. This kind of varying outcome, where constitutional rights erode in lock-step with reductions in state funding for the mental health system, was precisely what the Supreme Court tried to avoid when creating the professional judgment standard,[279] which permits an assessment of challenged actions at a given institution against professional standards developed nationwide.

This is not to say that state professionals must act as if they had unlimited insurance policies for each of their clients. Courts must oversee some kind of balancing between the state's fiscal interests and the plaintiff's right to treatment. However, the professional judgment standard, arising as it does from the model of the private sphere professional relationship, both allows and controls such considerations. A professional in the private sector can reasonably recommend several treatment alternatives at various costs, which all adequately meet the patient's needs though they may not be equally beneficial, and can let the patient choose among them. Thus, the question is whether the treatment being labeled inadequate would be among the options offered this patient in a private setting. It may not be the treatment that a private patient with wealth or insurance would choose. But would a professional recommend it to a private patient? If so, then the professional judgment standard is met.

Where courts have allowed professional judgment to be based on the availability of resources, an examination of the treatment approved reveals an obliteration of the already scant protection of patients' constitutional rights. In *P.C. v. McLaughlin*,[280] a mildly retarded young man was inappropriately held at Brandon, an institution for severely retarded people, for over two years because no other placement could be found for him. While there, P.C. was sexually assaulted by a staff member. P.C. argued "that he was not sent to Brandon based on an exercise of professional judgment because—as appellants admit—his admission did not hinge on a decision that his level of functioning necessitated it."[281] The court agreed, finding that the "decision was prompted by the total lack of any viable alternative" but went on to hold that "[b]ecause P.C.'s placement decision was made by qualified professionals in light of the circumstances then facing them, their judgment is entitled to deference in the courts reviewing that decision."[282]

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279. Youngberg v. Romeo, 457 U.S. 307, 321 (1982) (referring to the requirement of "uniformity in protecting these [liberty] interests").

280. 913 F.2d 1033 (2d Cir. 1990).

281. *Id.* at 1043.

282. *Id.* This comes close to adopting the standard proposed by Chief Justice Burger in his concurring opinion in Youngberg v. Romeo, 457 U.S. 307, 331 (1982), that a court's inquiry ceases after it determines that professionals made the decision. Courts have uniformly refused to interpret *Youngberg* this way. *See, e.g.*, Griffith v. Ledbetter, 711 F. Supp. 1108, 1111 n.1 (N.D. Ga. 1989).

*P.C.* is an example of the case the Supreme Court had in mind when it carved out an exemption from damages actions for professionals who can not exercise their judgment because of financial constraints. *See supra* note 277. P.C. asked for both injunctive relief and damages against individual defendants. The

Yet the defendants did not make a professional judgment to place P.C. at Brandon; P.C. was placed and kept at the institution because the "defendants did not have a residential placement available."[283] Brandon was not selected because it was cheaper; in a professional sense, Brandon was not "selected" at all. P.C.'s placement was not the result of decision, but of default.

The Second Circuit's analysis left P.C. with no right to appropriate treatment. Rather, he was merely entitled to have a professional perform the triage that left him confined in an institution where he clearly did not belong. The Second Circuit ignored *Youngberg*'s insistence that the right to treatment be linked to liberty interests; surely no liberty interest is vindicated when an individual is confined in a completely restrictive facility that cannot provide him with useful services.[284]

The only other case finding that professionals may consider budgetary constraints or availability of services did not, as *P.C.* did, legitimize decisions made wholly for resource-limitation reasons. In *Jackson v. Fort Stanton State Hospital & Training School*,[285] the Tenth Circuit reversed a District Court's order enjoining treatment teams from considering the unavailability of community placements in making recommendations for placement of institutionalized people. The court held that "[a] professional determination that includes an analysis of cost is reasonable and does not constitute '. . . a substantial departure from accepted professional judgment.'"[286] However, the court also recognized the risk that:

> [B]y imposing overly extensive cost restrictions in individual cases, the state could so limit the range of recommendations available to professionals that *their judgment would be rendered inadequate to meet*

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defendants admitted that the only reason P.C. went to the institution for severely retarded people was that the state could not find a placement that would meet minimal professional standards. *P.C.*, 913 F.2d at 1038. According to the court, P.C.'s social worker engaged in significant efforts to find him such a placement and should not have been held individually liable for his failure to provide the placement he knew P.C. needed. *Id.* at 1037. But equally clearly, P.C. stated a claim for equitable relief to require the state to provide him with a placement consistent with the professional judgment of those charged with his care.

283. 913 F.2d at 1038.

284. *P.C.* stands in stark contrast to *Thomas S. v. Morrow*, 601 F. Supp. 1055 (W.D.N.C. 1984). Like P.C., Thomas S. suffered from mild mental retardation and behavioral problems. Like P.C., after he turned 18, Thomas was bounced among inappropriate placements, including a nursing home and a detoxification facility, "because there [was] no place else for him to go." *Id.* at 1057. The *Thomas S.* court, however, saw professional judgment as addressed exclusively to the needs of the client: "[J]udgment . . . modified to fit what is available . . . likely has become 'a substantial departure from accepted professional judgment, practice, or standards.'" *Id.* at 1060. The defendant's budgetary constraints cannot limit the equitable power of the court to remedy continuing conditions that depart from the standard of professional judgment. Otherwise, the state could provide its own defense to unconstitutional conduct simply by lowering legislative appropriations. Thus, Thomas S. was "entitled to treatment recommended by qualified professionals whose judgment is unsullied by consideration of the fact that the state does not now provide appropriate treatment or the funding for appropriate treatment." *Id.* at 1060.

285. 964 F.2d 980 (10th Cir. 1992).

286. *Id.* at 992 (citation omitted).

*constitutional standards*. In such a case, the court might have to enter an order that would implicate appropriations decisions.[287]

Despite its partial recognition that budgetary constraints could prevent the exercise of professional judgment, the circuit court crucially misunderstood the findings and holding of the district court. The lower court had held that the *unavailability* of community services could not be taken into consideration in a decision not to recommend them; it had not said that a professional could not consider cost.

The distinction between the two considerations is significant: services, though quite affordable, may be unavailable due to bureaucratic indecision or legislative inaction. In *P.C.*, for example, the state may well have paid more for P.C's inappropriate confinement than for treatment in a professionally appropriate setting. On the other hand, in the Clozaril scenario, the drug is readily available, and the right to treatment question turns on whether the state must pay high costs to provide the drug to every patient who might benefit from it. As discussed above, the state need not do so if there are other more economical treatments that are sufficiently effective that professionals in the private sector would also prescribe them.

In sum, professional judgment may comprehend more than one acceptable treatment for a given condition, allowing patients some flexibility to choose according to their economic means. Courts should allow state professionals this same range of treatments as they attempt to care for multiple needs with limited funds. However, when funds become so depleted as to prevent any professionally acceptable treatment, the constitutionally required professional judgment standard is no longer being met. Likewise, the state violates the patient's right to treatment when it gives her inadequate treatment simply because it has failed to develop programs to meet her needs.

## III. THE EXPANSION OF THE PROFESSIONAL JUDGMENT STANDARD

The professional judgment standard does not by its terms refer to the institutional setting for which it was developed. In fact, the standard articulated in *Youngberg* is worded so broadly that it lends itself to application in a growing number of areas whose resemblance to the professional-client relationship in state institutions is increasingly remote. For example, the Supreme Court has held the professional judgment standard applicable to most constitutional challenges to decisions of academic defendants on tenure, the denial of degrees, and the dismissal of students for academic reasons.[288] The standard has also been applied in cases challenging agency and systemic decisions in social service

287. *Id.* at 992 (emphasis added).
288. *See infra* Part III(A)(1).

systems including budget cuts, agency policies, and reallocation of resources.[289] Finally, the professional judgment standard has been used in cases involving claims of ineffective assistance of counsel[290] and statutory discrimination claims.[291] Indeed, use of the standard is expanding so rapidly that it could conceivably be applied to any constitutional claim for professional services or challenge to professional decisionmaking.

These new applications are not necessarily harmful in cases involving an individual professional-client relationship and an affirmative claim for the sorts of services the professional is expected to provide. But for claims alleging state intrusion on negative rights, the professional judgment standard presents problems similar to those arising in the negative rights claims of patients in state mental institutions: the standard precludes striking a balance between plaintiff and state interests and instead casts the claim as a question of whether professionals would ratify the intrusion into the plaintiff's rights. Cases involving the juvenile justice system and academia fit this category.

Many of the cases now considered under the professional judgment standard also lack the characteristics that originally justified, at least in theory, the deference to the expert's voice. Originally, the standard applied to individual professional-client relationships where the professional at least was presumed to share an identity of interest with his client and to be answerable to a higher canon of professional responsibility. Application of the professional judgment standard is now spreading to situations significantly different from this original scenario. The focus of the standard has changed from the nature of the professional-client relationship to the nature of the decisionmaking: most of the recent cases involve subjective decisions by alleged experts, often affecting powerless and isolated groups of people. These are the sorts of decisions most susceptible to abuse, affecting classes of people whose rights the courts should be most alert to protect.

### A. *Expansion to Systems Not Involving Mental Disabilities*

#### 1. *Higher Education*

Cases challenging decisionmaking in higher education illustrate how quickly and thoughtlessly the use of the professional judgment standard has spread to situations very different from the one originally contemplated in *Youngberg*. These cases also show the great power the standard places in the hands of state experts: universities have yet to lose a single case decided under the professional judgment standard.

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289. *See infra* Part III(B).
290. *See infra* Part III(A)(5).
291. *See infra* Part III(C).

Three years after *Youngberg* was decided, the Supreme Court adopted the professional judgment standard in *Regents of University of Michigan v. Ewing*,[292] a case involving a student's due process challenge to his expulsion from an undergraduate/medical school program after failing a required examination. The student argued that the university had acted arbitrarily by refusing to allow him to retake the exam, depriving him of a property interest in continuing his course of studies. The Supreme Court assumed, without deciding, that such an interest did exist,[293] but held that

> [w]hen judges are asked to review the substance of a genuinely academic decision, such as this one, they should show great respect for the faculty's professional judgment. Plainly, they may not override it unless it is such a substantial departure from accepted academic norms as to demonstrate that the person or committee responsible did not actually exercise professional judgment.[294]

The Court made no attempt to analyze its extension of the professional judgment standard to a new variety of constitutional challenge; nor did it discuss the suitability to an academic setting of a standard developed in response to constitutional litigation in overcrowded, underfunded state institutions. Rather, the Court discussed the university's procedures for deciding Ewing's case,[295] finding that "the faculty's decision was made conscientiously and with careful deliberation, based on an evaluation of the entirety of Ewing's academic career."[296] The decision thus seems to transform a substantive due process challenge into a procedural case, endorsing the substantive decision to expel Ewing because of the procedural safeguards that had been followed in his case.[297]

The Court presumed without question that these decisions are "necessarily subjective."[298] In support of its conclusion that Ewing's dismissal did not deviate from academic norms, the Court noted that nineteen other students, some

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292. 474 U.S. 214 (1985).

293. Justice Powell wrote separately to indicate his strong doubt that any protectable interest was at stake. *Id.* at 228 (Powell, J., concurring).

294. *Id.* at 225.

295. *Id.* at 216-17, 217 n.4, 219.

296. *Id.* at 225.

297. *Id.* at 225-28. This review of the procedure followed by professionals contrasts with the lack of procedural review of the judgments of state mental health professionals, *see supra* Part II(A)(2), and suggests that courts can require expert decisionmaking to conform to certain procedures. One reason for the Court's procedural approach in *Ewing* may be that "accepted academic norms," *Ewing*, 474 U.S. at 227, tend to emphasize procedures that mask an ultimately subjective decision whose basis is completely unarticulated. The fact that these procedures tend to be customary does not mean that they are required by the Constitution. As the Court held earlier in *Board of Curators v. Horowitz*, 435 U.S. 78, 90 (1978), the very fact that academic dismissals are subjective means that hearings are *not* required. As noted in the discussion on procedural due process, *supra* Part II(A)(2), and forced medication, *supra* Part II(A)(1)(a), the perceived subjectivity of these decisions may result from the framing of the standard rather than from an inability to articulate standards and to provide procedural protection.

298. *Ewing*, 474 U.S. at 228.

with "better" records than Ewing's, were dismissed from the program without being permitted to take the examination at all.[299] On the other hand, Ewing was the only student in seven years who was not permitted to retake the examination in question; some students, in fact, took it three times or more.[300] The Court took the contradictions of this history as evidence that the decisionmaking was subjective, which it clearly was, and that it necessarily was subjective, which is far less clear.[301]

Indeed, the expulsion decision was only subjective because the university chose to make it so, and because the Court did not require anything more. The school easily could have set clear rules regarding the examination and expulsion from the program: all students could have been permitted to retake the examination once, or any student with a grade point average under a certain number could have been precluded from taking the examination. This approach would have made the Court's elaborate inquiry into the procedures surrounding Ewing's expulsion unnecessary, while allowing it to review the rationality of the substantive policy. The *Ewing* Court, however, did not review the substantive standard applied to dismiss Ewing, even though that was the basis of his claim, because no substantive standard was even articulated by the University. What might have been called arbitrariness and standardless subjectivity in other settings was insulated from inquiry by its transformation into "professional judgment."

Both before and after *Ewing*, courts have applied the professional judgment standard to cases involving the expulsion of students, the refusal to readmit students,[302] and the failure to grant a professor tenure.[303] In most of these cases, the courts have followed *Ewing* in sifting the procedural record rather carefully while ignoring the question of the substantive standard used by the institution in making the decision.[304]

In academic cases, the expert decision accorded deference does not even make a pretense of arising from a professional-client relationship. The rationale underlying the professional judgment standard, at least in part, was that there was an identity of interest between the decisionmaking professional and his client.[305] Little remains of such a fiduciary relationship in the higher education

299. *Id.* at 228 n.14.

300. *Id.* at 219.

301. *Id.* at 228 n.14.

302. Mauriello v. Univ. of Medicine and Dentistry of N.J., 781 F.2d 46, 52 (3d Cir.) (upholding dismissal of student from Ph.D. program), *cert. denied*, 479 U.S. 818 (1986); Anderson v. Univ. of Wis., 665 F. Supp. 1372, 1396-97 (W.D. Wis. 1987) (upholding refusal to readmit student to law school), *aff'd*, 841 F.2d 737 (7th Cir. 1988).

303. Siu v. Johnson, 748 F.2d 238, 245 (4th Cir. 1984). Although *Ewing* had not been decided at the time, *Siu* adopted the *Youngberg* standard in analyzing a due process challenge to the refusal to grant tenure to a professor.

304. After announcing a very deferential standard, the Court reviewed the University of Michigan's actions regarding Ewing's dismissal with a level of attention to detail in the record not seen in professional judgment decisions regarding challenges to institutional treatment. Other courts have treated education cases similarly. *See, e.g.*, *Anderson*, 665 F. Supp. 1372 (W.D. Wis. 1987) (exhaustively examining the record).

305. *See supra* Part I(A).

context: while there is individualized interaction between professors denied tenure and the faculty tenure committee, and between students dismissed from academic programs and the committees that make those decisions, these relationships are adversarial, not fiduciary. Certainly neither the professor nor the students are, in any sense, "clients" of the decisionmaking committee.

The decision to apply the professional judgment standard based on the nature of the decisionmaking at issue rather than on the existence of a professional-client relationship carries the seeds of a massive expansion of deference to government experts. Courts apply the professional judgment standard in academia because they see decisionmaking in that context as inherently subjective, discretionary, and native to the specialized domain of professionals, a domain courts should invade with great hesitation, if at all. The decisionmaking of many state actors, however, can also be so characterized, and thus be similarly shielded from constitutional scrutiny.

### 2. *Juvenile Justice*

The professional judgment standard has been used to defend intrusive practices designed to control children in the juvenile justice system. Such negative rights cases are singularly inappropriate for the application of the professional judgment standard. Juvenile institutions can characterize almost every restriction and restraint as treatment, a particularly insidious possibility in a justice system whose mandate to rehabilitate coexists with an explicit or implicit responsibility to confine, and even to punish, individuals regarded as young criminals.

Most juvenile justice cases involve the use of isolation and restraint.[306] One case challenged the practice of placing juveniles in extended isolation for "several days" or "weeks" for "'mouthing off' to staff, refusing to obey an order or directive, yelling or swearing, [and] getting out of bed at night without permission . . . ."[307] Other policies and practices defended as exercises of professional judgment include isolation for hours at a time in a room measuring four by eight by nine feet and "grab[bing] one of the student's arms and grabbing and pulling of the hair. . . ."[308]

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306. *See, e.g.*, Gary H. v. Hegstrom, 831 F.2d 1430, 1431 (9th Cir. 1987); Santana v. Collazo, 793 F.2d 41, 42-43 (1st Cir. 1986); Santana v. Collazo, 714 F.2d 1172, 1178 (1st Cir. 1983); Milonas v. Williams, 691 F.2d 931, 935-36 (10th Cir. 1982).

307. *Gary H.*, 831 F.2d at 1434 (Ferguson, J., concurring).

308. *Milonas*, 691 F.2d at 941-42. The court noted that by the time the suit was commenced, a child's time in the isolation room had been limited to 24 hours at a time. *Id.* The district courts in *Milonas* and *Gary H.* found for the plaintiffs. The different outcome of each case on appeal turned on the remedies devised by the district courts: *Milonas*, where the judge enjoined four specific practices of defendants (e.g., polygraph examinations, isolation except when a boy was physically violent, censorship of mail) was upheld, while *Gary H.*, which had ordered defendants to follow very specific guidelines drawn from professional standards, was vacated and remanded.

The use of such harsh methods in juvenile justice facilities should not be surprising, but it is not acceptable. While mental health authorities have at least formally embraced the goal of providing treatment, no unifying institutional goal governs policy and practices in the juvenile justice field.[309] Confusion reigns in juvenile justice systems as to whether the primary goal should be controlling potentially dangerous individuals or treating children who can still be saved. Such confusion leads to youths being shackled and hogtied in isolation cells called "adjustment unit[s]."[310] The confusion also makes it impossible to define and assess any meaningful legal standard of professional judgment.

Moreover, in the juvenile justice field, the medical professional's conflict of interest between serving the institutional needs of his employer and the needs of his patients is exacerbated by the overtly punitive characteristics of much of the "treatment" dispensed to juveniles in state custody. Thus, only the most attenuated "professional-client" relationship may exist between a facility professional and a juvenile, and commonality of interests is often lacking. Cases involving juvenile justice issues are, for the most part, classic negative rights cases for which the older, rights-focused approach[311] is most appropriate.

### 3. *Prisons and Jails*

It is difficult to imagine a relationship farther from the voluntary, private professional-client model than the relationship between a prisoner or pretrial detainee and prison or jail officials. Such officials are not professionals in the sense described in Part I, the inmates are not their clients, and the relationship between the two groups is essentially adversarial. In addition, preexisting standards created by the Supreme Court determine the constitutionality of actions by prison and jail officials.[312] Despite these facts, the professional judgment standard is being applied to cases in this area.

Courts have applied the professional judgment standard to prisoners' claims of undue bodily restraint,[313] unsafe conditions,[314] and excessive force in shooting escaping prisoners.[315] Not only has the *Youngberg* standard been

309. *See* Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment and the Difference It Makes*, 68 B.U. L. REV. 821, 833, 846-47 (1988); Jodi Siegel, *Reforming Florida's Juvenile Justice System: A Case Example of* Bobby M. v. Chiles, 19 FLA. ST. U. L. REV. 693, 701 (1992).

310. Siegel, *supra* note 309, at 698 n.39.

311. *In re* Gault, 387 U.S. 1 (1967); Nelson v. Heyne, 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974).

312. Turner v. Safley, 482 U.S. 78 (1987); Bell v. Wolfish, 441 U.S. 520, 540 (1979) (holding that deprivation of liberty of pretrial detainee must bear reasonable relationship to rational government objective); Estelle v. Gamble, 429 U.S. 97 (1976) (holding deliberate indifference to medical needs of prisoners to be cruel and unusual punishment in contravention of Eight Amendment).

313. Preston v. Ruggieri, Civ. A No. 86-4779, 1988 U.S. Dist. LEXIS 12258, at **8-9 (E.D. Pa. Oct. 28, 1988); Wells v. Franzen, 777 F.2d 1258, 1261-62 (7th Cir. 1985).

314. Zwalesky v. Manistee County, 749 F. Supp. 815, 819 (W.D. Mich. 1990); Danese v. Asman, 875 F.2d 1239, 1243 (6th Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990).

315. Newby v. Serviss, 590 F. Supp. 591, 598-99 (W.D. Mich. 1984) (applying professional judgment

imported into challenges to the adequacy of psychiatric care in prisons and jails,[316] but it has also been applied to cases challenging medical care without a mental health component.[317] Some courts have applied *Youngberg*'s professional judgment standard to wrongful death actions arising from inmate suicides.[318] Some courts apply a combination of standards.[319] As in the higher education cases, courts rarely undertake to explain the logic behind their extension of the professional judgment standard to this very different scenario.[320]

The application of the professional judgment standard to cases involving prisoners and pretrial detainees is even more incongruous than its use in the academic arena. The relationship between a prison or jail employee and a prisoner or pre-trial detainee bears no resemblance to a professional-client relationship. The individuals making the challenged decisions are often guards, who cannot be categorized as "professionals" under any ordinary understanding of the term.[321] To the extent that prison administrators can be considered professionals, their primary mission is prison security and efficiency rather than the welfare of prisoners. While in the juvenile justice arena at least some tension exists between the model of juveniles as clients deserving treatment and the model of juveniles as security risks, prisons and jails lack even the pretense of a professional-client alliance. The professional judgment standard, which seeks to balance plaintiff interests and state interests,[322] becomes in the prison and jail context a mere proxy for the latter. Conflict of interest problems lurking

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standard to claim that prison supervisory personnel had duty to provide reasonably safe conditions of confinement).

316. Langley v. Coughlin, 715 F. Supp. 522, 535 (S.D.N.Y. 1989); Capps v. Atiyeh, 559 F. Supp. 894, 916-17 (D. Or. 1983).

317. McCloud v. Delaney, 677 F. Supp. 230, 232 (S.D.N.Y. 1988) (applying combination of Eighth Amendment and professional judgment standards to claim of inadequate medical treatment); Willis v. Barksdale, 625 F. Supp. 411 (W.D. Tenn. 1985) (death from heat stroke).

318. See cases cited *supra* note 314.

319. *McCloud*, 677 F. Supp. at 232. *See also* Lewis v. New York City Dep't of Correction, No. 87 Civ. 3640, 1988 U.S. Dist. LEXIS 8845 (S.D.N.Y. Aug. 12, 1988). After holding that the *Estelle* standard was the appropriate standard, the court found that the plaintiff "has not shown that this decision was 'such a substantial departure from an accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment,'" *Id.* at *7 (quoting Youngberg v. Romeo, 457 U.S. 307, 323 (1982)).

320. The sole case to examine the doctrinal confusion with any care, *Langley v. Coughlin*, 715 F. Supp. 522, 539 (S.D.N.Y. 1989), considered the application of *Youngberg* to pretrial detainees' claims as the logical result of the Supreme Court's decision in *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 989 (1989). The court in *Langley* noted that since affirmative entitlements to government services were based on "the obligation of the state to provide appropriate care for people involuntarily in its custody, we may fairly infer that the standards by which to judge an alleged failure to provide such care should be comparable regardless of the circumstances under which the individual is involuntarily confined." 715 F. Supp. at 539.

321. *See* Preston v. Ruggieri, Civ. A No. 86-4779, 1988 U.S. Dist. LEXIS 12258 (E.D. Pa. Oct. 28, 1988). For a description of the typical background of guards in the Texas correctional system, which can hardly be called professional training, see Ruiz v. Estelle, 503 F. Supp. 1265, 1288-89 (S.D. Tex. 1980). In fact, in one case, the plaintiff prevailed precisely because he was placed in restraints by guards rather than by a professional. Wells v. Franzen, 777 F.2d 1258 (7th Cir. 1985). Most other cases applying the professional judgment standard to actions by guards do not comment on this issue.

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

in the public mental health context and exacerbated in the juvenile justice system disappear in prison and jail cases, because no pretense of identity of interest between prison professionals and inmates ever existed. Rather, use of the professional judgment standard simply masks the adversarial relationship that earlier courts understood so well.[323]

Given the dissimilarities between prisons and jails and the original treatment-oriented context of the professional judgment standard, why do courts employ the standard in cases involving prisoners? First, in other contexts courts have emphasized the contextuality and subjectivity of the decisions prison officials must make:

> [R]umor, reputation, and even more imponderable factors may suffice to spark potentially disastrous incidents. The judgment of the prison officials in this context, like that of those making parole decisions, turns largely on "purely subjective evaluations and on predictions of future behavior," indeed, the administrators must predict not just one inmate's future actions, as in parole, but those of an entire institution.[324]

Second, courts characterize prisons and jails as unfamiliar, self-contained arenas where administrators are confronted with complex and nearly incomprehensible burdens on a daily basis.[325] In the professional judgment cases, also, it would appear that courts have concluded that prison decisionmaking is too subtle for meaningful judicial inquiry.

The dangerous potential for unreflective expansion of the professional judgment standard is evident here. Almost any decision by a state actor can be characterized as subjective, and manifold activities can be seen as beyond judicial expertise. Subjectivity of decisionmaking in an arena professed to be unfamiliar to the courts has apparently sufficed to transform decisions made there into a "professional judgment." The careless application of the professional judgment standard to decisions by clientless nonprofessionals suggests an almost unlimited future scope for the standard.

This expansion of judicial deference is wholly unnecessary. Even if all these decisions were products of professional judgment, courts should still assess them not for their professional effectiveness, but for their impact on constitutional rights. Courts have reviewed such "professional" decisions as the assignment of inmates to cell blocks, and have invalidated decisions that segregated inmates

323. *See, e.g.*, Spain v. Procunier, 600 F.2d 189, 199 (9th Cir. 1979); Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980); Jones v. Wittenberg, 323 F. Supp. 93, 99 (N.D. Ohio 1971).

324. Hewitt v. Helms, 459 U.S. 460, 474 (1983) (upholding informal, nonadversarial review of administrative confinement decisions) (quoting Connecticut Bd. of Pardons v. Dumschat, 452 U.S. 458, 464 (1981)).

325. O'Lone v. Shabazz, 482 U.S. 342, 349-50 (1987); Procunier v. Martinez, 416 U.S. 346, 404-05 (1974).

by race in violation of the Equal Protection Clause.[326] Unnecessarily, the professional judgment standard has simply become a shorthand for decision-making by defendants in an area in which courts have little desire to intervene.

### 4. *Foster Care*

Foster care cases usually involve affirmative claims for services and thus resemble right to treatment cases. As discussed above, the professional judgment standard can serve as a useful guide to the level of services required.[327]

Unlike the application of the professional judgment standard to higher education and prisons and jails, the expansion of the professional judgment standard to cases involving children in the foster care system has been accompanied by substantial analysis and discussion about whether such an application is appropriate. The circuits are presently in conflict, with older decisions applying *Estelle v. Gamble*'s deliberate indifference standard[328] to assess the rights of children in foster care,[329] and more recent decisions, particularly since *DeShaney v. Winnebago County Department of Social Services*,[330] applying the professional judgment standard.[331] A few foster care cases mix the two standards.[332]

Foster care cases typically challenge the state's failure to provide adequate services to those in its custody. The application of the professional judgment standard is particularly appropriate in this context if decisionmakers are true professionals making choices independent of financial or staffing considerations.[333] The relationship between a child and his or her caseworker is or should be the individualized relationship discussed in Part I of this Article, specifically geared toward assisting and benefiting the client and facilitated by the professional's appropriate training. Foster care cases almost always involve

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326. Lee v. Washington, 390 U.S. 333 (1968); Battle v. Anderson, 376 F. Supp. 402, 410-11 (E.D. Okla. 1974).

327. *See supra* Part II(B).

328. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) ("deliberate indifference to serious medical needs of prisoners" violates Eight Amendment's ban on cruel and unusual punishment).

329. Taylor v. Ledbetter, 818 F.2d 791 (11th Cir. 1987), *cert. denied*, 489 U.S. 1065 (1989); Doe v. New York City Dep't of Social Servs., 709 F.2d 782, 791-92 (2d Cir. 1983), *cert. denied*, 464 U.S. 864 (1983).

330. 489 U.S. 989 (1989).

331. Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883 (10th Cir. 1992); K.H. v. Morgan, 914 F.2d 846 (7th Cir. 1990); LaShawn A. v. Dixon, 762 F. Supp. 959 (D.D.C. 1991); Del A. v. Roemer, 777 F. Supp 1297 (E.D. La. 1991). One circuit has questioned whether foster care amounts to sufficient state custody to create any enforceable rights under *Youngberg*. *See* Eugene D. v. Karman, 889 F.2d 701, 710 (6th Cir. 1989), *cert. denied*, 496 U.S. 931 (1990).

332. *See, e.g.*, Gibson v. Merced County Dep't of Human Resources, 799 F.2d 582, 589-90 (9th Cir. 1986) (finding that defendants did not act with deliberate indifference but citing *Youngberg* analysis at length).

333. This assumption is probably inaccurate for most, if not all, of the state foster care systems. *See, e.g.*, NATIONAL COMM'N ON CHILDREN, BEYOND RHETORIC: A NEW AMERICAN AGENDA FOR CHILDREN AND FAMILIES 288 (1991); RICHARD WEXLER, WOUNDED INNOCENTS: THE REAL VICTIMS OF THE WAR AGAINST CHILD ABUSE 230-37 (1990); *LaShawn A.* 762 F. Supp. at 977.

a claim of entitlement to this professional paradigm and the quality of services it represents.

Unfortunately, the difficulties that hinder the implementation of the professional judgment standard in right-to-treatment cases are rampant in the foster care cases as well. These problems include budget constraints, lack of appropriate alternative placements, and lack of training or expertise of the so-called "professionals," who are often social workers with little or no actual education in the field. In addition, the courts' understanding of the professional judgment standard in foster care cases has been almost uniformly deficient. For example, one court indicated that use of the professional judgment standard is appropriate in actions for injunctive relief but suggested that a deliberate indifference standard might be more appropriate in actions to recover monetary damages.[334] This court also apparently misinterpreted the Supreme Court's grant of immunity to professionals sued for damages in their individual capacities when the failure to exercise professional judgment stemmed from budgetary constraints; the court took this rule to mean that budgetary constraints might provide relief from liability in a suit for injunctive relief.[335]

Another case purporting to follow the professional judgment standard held that plaintiffs must show knowledge on the part of the state in order to meet the standard.[336] The confusion of the court regarding the mental state required by *Youngberg* is obvious; the statement that a showing of knowledge is required is followed scarcely a page later by an analysis in which the court equates the professional judgment standard with the standard imposed for judging claims of ineffective assistance of counsel.[337] This standard—conformity to minimal professional standards—probably does not require the showing of any particular mental state.[338]

The professional judgment standard is generally appropriate for use in foster care cases, provided that courts ensure that the judgments in question have been made by true professionals and have not been distorted by gross underfunding or other budgetary constraints. However, no cases have yet been decided in

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334. *LaShawn A.*, 762 F. Supp. at 996 n.29. *Youngberg* was, of course, an action seeking damages.

335. *Id.* at 997. In an incomprehensible twist of logic, however, the court refused to accept the argument in the case before it because it found that the defendants had not exercised professional judgment: "[T]he Court has determined that defendants have failed to exercise professional judgment almost as egregiously as they have failed to carry out their constitutional duties. *Because of this*, defendants' arguments about fiscal constraints are unavailing." *Id.* (emphasis added).

336. K.H. v. Morgan, 914 F.2d 846, 852 (7th Cir. 1990). However, the court also held that "[t]he only right in question in this case is the right of a child in state custody not to be handed over by state officers to a foster parent or other custodian, private or public, *whom the state knows or suspects to be a child abuser*." *Id.* Thus, the placement of a child with a foster parent *suspected* by the state of being a child abuser raises the possibility that a standard of recklessness (or even gross negligence) may be sufficient, despite the court's earlier statement to the contrary.

337. *Id.* at 853.

338. *See* Strickland v. Washington, 466 U.S. 668, 689, 699 (1984). There has been some suggestion that "sheer negligence" by counsel creates a claim of ineffective assistance of counsel, Lankford v. Idaho, 111 S. Ct. 1723, 1737 (1991). To the extent that negligence describes a state of mind, it is a far cry from the knowledge or recklessness envisioned by Judge Posner in *K.H.*, 914 F.2d 846.

which the meaning and appropriate application of the professional judgment standard in the context of foster care have been addressed with the attention and vigor found in the more persuasive mental health cases.[339] Thus, it is impossible to know what services it will guarantee to children.

### 5. *Effective Assistance of Counsel in Criminal Cases*

Two years after the Supreme Court decided *Youngberg v. Romeo*, it confronted for the first time the challenge of setting standards for judging whether a defendant had received effective assistance of counsel.[340] As in other rights-to-services cases, the standards of the profession here provide a useful determinant of the quality of aid to which the claimant is entitled.

Although the Court stopped short of adopting the professional judgment standard, the analysis and rhetoric of these cases are almost identical to those articulated in *Youngberg*. The Court admonished that:

> Because of the difficulties inherent in making the evaluation, a court must indulge a strong presumption that counsel's conduct falls within the wide range of reasonable professional assistance. . . . A convicted defendant making a claim of ineffective assistance must identify the acts or omissions of counsel that are alleged not to have been the result of reasonable professional judgment. The court must then determine whether, in light of all the circumstances, the identified acts or omissions were outside the wide range of professionally competent assistance. . . . [T]he court should recognize that counsel is strongly presumed to have rendered adequate assistance and made all significant decisions in the exercise of reasonable professional judgment.[341]

The Court has also stated explicitly that the standard for ineffective assistance of counsel remains constant, regardless of whether counsel is retained by the accused or appointed by the State.[342]

The professional judgment standard is appropriate in ineffective assistance of counsel cases according to the analysis of Part II, since it applies only when the plaintiff makes an affirmative constitutional claim for services.[343] Where a client claims that the lawyer failed to render legal services of adequate quality,

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339. Among these mental health cases are Shaw v. Strackhouse, 920 F.2d 1135 (3d Cir. 1990); Jackson v. Fort Stanton State Hosp. & Training Sch., 757 F. Supp. 1243 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992); Thomas S. v. Morrow, 601 F. Supp. 1055 (W.D.N.C. 1984), *aff'd in part and modified in part*, 781 F.2d 367 (4th Cir.), *cert. denied*, 476 U.S. 1124 (1986), *and cert. denied*, 479 U.S. 869 (1986).

340. *Strickland*, 466 U.S. 668; United States v. Cronic, 466 U.S. 648 (1984).

341. *Strickland*, 466 U.S. at 689-90.

342. Cuyler v. Sullivan, 446 U.S. 335, 344 (1980). The Court stated, "We may assume with confidence that most counsel, whether retained or appointed, will protect the rights of an accused." If anything, the Court here was concerned about the inadequacy of *retained* counsel. *Id.*

343. *See supra* text accompanying notes 137-147.

the professional judgment standard is a useful tool for setting the required quality level.

### B. *Expansion to Systemic and Policy Decisions*

The professional judgment standard began by diverting judicial attention from the plaintiff's claim and reframing it as an inquiry into the professional's decisionmaking process. As described above, as use of the standard expanded, it lost its grounding in the professional's relationship with and obligation to the client, and came to be applied generally to decisions marked by subjectivity and discretion. Simultaneously, courts grew lax in their requirement that the decisionmaker be a true professional, and that decisionmaking be individualized. These developments culminated in the standard's recent application to cases involving policy decisions that affect large groups of people and have no individualized basis. These cases involve challenges to state budget-cutting practices and to the operation of entire social service programs such as foster care systems.[344]

The attack on budget cuts has drawn life from a variety of legal arguments: that such cuts preclude the exercise of professional judgment on behalf of those entitled to it; that they lead to deterioration of the plaintiff's abilities or condition;[345] that cuts affecting only specific groups receiving government services violate the Equal Protection Clause;[346] and that professional judgment was not exercised in making the cuts themselves.

Litigation challenging budget cuts arises in large part from a misreading of *Youngberg* to suggest that those responsible for the inadequacy of resources and the resulting inability to exercise professional judgment should be liable

344. *See, e.g.*, LaShawn A. v. Dixon, 762 F. Supp. 959 (D.D.C. 1991).

345. Many clients deteriorate in institutional settings. They lose the ability to perform simple everyday tasks. Justices Blackmun, Brennan, and O'Connor suggested in a concurring opinion in *Youngberg* that there may exist a due process right to receive the training necessary to prevent the loss of self-care skills a client possessed upon entering an institution, 457 U.S. 307, 327 (1982) (Blackmun, J., concurring). Several courts that have considered the question have adopted Justice Blackmun's analysis by holding that such a right exists, or have suggested at least that they would adopt such a standard were the issue properly raised. *See* P.C. v. McLaughlin, 913 F.2d 1033, 1042 (2d Cir. 1990); Clark v. Cohen, 794 F.2d 79, 95-96 (3d Cir.), *cert. denied*, 479 U.S. 962 (1986); Society for Good Will to Retarded Children Inc. v. Cuomo, 737 F.2d 1239, 1250 (2d Cir. 1984); McNamara v. Dukakis, No. 90-12611-Z, 1990 WL 235439, at *3 (D. Mass. Dec. 27, 1990); Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1309 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992); K.H. v. Morgan, No. 87-C-9833, 1989 U.S. Dist LEXIS 10516, at *25 (N.D. Ill. Sept. 6, 1989), *aff'd in part*, 914 F.2d 846 (7th Cir. 1990); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1201 (W.D.N.C. 1988), *aff'd*, 902 F.2d 250 (4th Cir.), *cert. denied*, 111 S. Ct. 373 (1990); Doe v. New York City Dep't of Social Servs., 670 F. Supp. 1145, 1172-73 (S.D.N.Y. 1987) (applying standard to foster care); Association for Retarded Citizens v. Olson, 561 F. Supp. 473, 487 (D.N.D. 1982), *aff'd in part*, 713 F.2d 1384 (8th Cir. 1983).

346. Philadelphia Police & Fire Ass'n for Handicapped Children v. City of Phila., 699 F. Supp. 1106, 1111 (E.D. Pa. 1988) (holding that cuts only in programs for clients who live at home unconstitutionally discriminate between those clients and others who live in community residence facilities).

either for damages or injunctive relief.[347] In fact, the Supreme Court merely held that treating professionals were immune from damage judgments if their failure to exercise professional responsibility was based on budgetary constraints.[348]

In *Philadelphia Police & Fire Ass'n for Handicapped Children v. City of Philadelphia*,[349] the first case challenging budget cuts, the district court found that *Youngberg* protected the interests of mentally retarded individuals living at home in continuing to receive services from the defendants because the loss of such services would cause them to regress, thereby jeopardizing their health and safety. The court found that the budget cuts did not constitute an exercise of the defendant's professional judgment since the cuts were based on "administrative" or "fiscal" considerations rather than on consideration of the class members' individual needs.[350]

The Third Circuit reversed,[351] finding itself constrained by the "broad, harsh decision"[352] in *DeShaney v. Winnebago County Department of Social Services*,[353] which had been decided while the case was on appeal. The appellate court held that mentally retarded people living at home had no affirmative constitutional right to services, and since no liberty interest was implicated, no remedy was available. Therefore, the court neither rejected nor accepted the district court's application of the professional judgment standard to budget cutting.

Since *Philadelphia Police*, a federal court in financially beleaguered Massachusetts has considered constitutional challenges to budget cuts affecting institutionalized individuals.[354] The court held state administrators to the professional judgment standard in cutting the budget for mental health services[355] and cited the "interaction between the top levels of [the Department

347. This theory was suggested by Judge Posner in K.H. v. Morgan, 914 F.2d 846, 854 (7th Cir. 1990) (citations omitted) ("The officials responsible for the inadequacy of those resources might be liable in damages, provided they were sued in their personal rather than official capacities, . . . and there might of course be broader liability in an injunctive suit against those officials."). *See also* McNamara v. Dukakis, Civ. A. No. 90-12611-Z, 1990 WL 235439, at *6 (D. Mass. Dec. 27, 1990). Judge Posner's statement in *K.H.* regarding monetary relief against officials responsible for inadequate resources appears to be based on a misreading of *Youngberg*. While limiting the circumstances under which *damages* can be collected for departure from professional judgment, *Youngberg* appears to indicate that injunctive relief will always be available if the departure from professional judgment is proven. In the case of individual plaintiffs, there should be no need to sue the individuals responsible for the lack of funding, since plaintiffs will obtain injunctive relief simply from the liability of the treating professional. *See* Greason v. Kemp, 891 F.2d 829, 836-37 (11th Cir. 1990).

348. Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

349. 699 F. Supp. 1106 (1988), *rev'd*, 874 F.2d 156 (3d Cir. 1989).

350. *Id.* at 1117-18.

351. Philadelphia Police and Fire Ass'n v. City of Phila. 874 F.2d 156 (3d Cir. 1989).

352. *Id.* at 166.

353. 489 U.S. 189 (1989).

354. McNamara v. Dukakis, Civ. A. No. 90-12611-Z, 1990 WL 235439 (D. Mass. Dec. 27, 1990).

355. *Id.* at *6 ("Youngberg suggests that the professional to which the court should look in determining the adequacy of treatment depends on the 'particular decision at issue.'. . . Accordingly, decisions about distribution of scarce resources in the mental health context should also be made by 'person[s] competent, whether by education, training or experience,' such as 'administrators,' with the appropriate background."

of Mental Health] and local program administrators and staff, including individuals with clinical background at every level" as evidence that an agency exercised professional judgment in implementing budget cuts.[356]

It is becoming increasingly common for the professional judgment standard to be applied to decisions made not by an individual professional, but rather by a collective body charged with policymaking, such as a state agency. In *LaShawn A. v. Dixon*, for example, the court held that "the Constitution places a duty upon state agencies to exercise professional judgment when carrying out their responsibilities."[357] In *Winston v. Children & Youth Services*, the court upheld a county foster care agency's visitation policy in part because "the agency exercised discretion in establishing a visitation policy comporting with professional standards."[358]

The processes of systemic policymaking and of running a county or state agency are the antithesis of the model of professional judgment, in which individualized and contextualized decisionmaking advances the interest or health of a specific client. As in the prison and jail cases, the professional judgment standard has, in the claims against social service systems, lost all vestiges of a professional-client relationship. Furthermore, most social and foster services cases do not even consist of discernible relationships between identifiable individuals. Instead, they involve two amorphous groups: the service agency and the community of its clients.

### C. *Expansion to Interpretation of Statutory Claims and Consent Decrees*

Not only is the professional judgment standard, due to its vagueness, now being applied to areas where legal rules have not been clearly set, but it is also being applied in areas previously the domain of settled legal doctrine. Having evolved into a doctrine applicable wherever challenged state action involves complex decisionmaking, regardless of whether a professional-client relationship exists, the professional judgment standard is now used to resolve even statutory claims for which extensive precedent using other modes of analysis exists, such as claims under Title VII of the Civil Rights Act of 1964[359] and the Rehabilitation Act of 1973.[360]

For example, courts have begun to incorporate the professional judgment standard in cases charging discrimination on the basis of handicap under Section 504 of the Rehabilitation Act.[361] This provision was designed to extend to

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(citations omitted) (quoting Youngberg v. Romeo, 457 U.S. 307, 323-25 (1982))).

356. *Id.*

357. 762 F. Supp. 959, 994-95 (D.D.C. 1991).

358. 948 F.2d 1380, 1390 (3d Cir. 1991), *cert. denied*, 112 S. Ct. 2303 (1992).

359. Pub. L. No. 88-352, 78 Stat. 241, 253-266 (1964) (codified at 42 U.S.C. 2000e-2000e17 (1988)).

360. Pub. L. No. 93-112, 87 Stat. 355 (1973) (codified as amended in scattered sections of 29 U.S.C.).

361. *Id.* at § 504, 87 Stat. at 394 (current version at 29 U.S.C. § 794 (1988)).

handicapped persons[362] the protection against discrimination on the basis of race, sex or national origin provided by Title VII.[363] Section 504 requires that a federally funded educational program provide "reasonable accommodation" to a person's disabilities in order for handicapped people to have equal access to its benefits.[364] Recently, the First Circuit announced that in handicap discrimination actions brought against universities under Section 504 of the Rehabilitation Act, the determination of whether the university reasonably accommodated the plaintiff's handicap should be made by "evaluat[ing] whether [the] facts add up to a professional, academic judgment that reasonable accommodation is simply not available."[365] The question of what constitutes reasonable accommodation does not fall within the particular expertise or professional background of academics but is, in fact a legal question; nevertheless, the use of the professional judgment standard grants deference to university decisions in matters pertaining to reasonable accommodation of their handicapped students so long as the school documents that its officials have weighed the alternatives.

The professional judgment standard has similarly been used to defend policy decisions challenged under Section 504 of the Rehabilitation Act. In *St. Louis Developmental Disabilities Treatment Center Parents Ass'n v. Mallory*,[366] the court applied the standard where severely handicapped children claimed they were automatically segregated from the public school system and sent to separate schools for the handicapped in violation of the Education for All Handicapped Children Act,[367] Section 504 of the Rehabilitation Act of 1973,[368] and the Equal Protection and Due Process Clauses of the Constitution. The plaintiffs argued that school assignments were based simply on the label "severely

362. The provision prohibits any program receiving federal funds from discriminating against a person otherwise qualified to participate in the program on the basis of that person's handicap. In deciding whether the individual is otherwise qualified to participate in the program, the court must determine whether reasonable accommodations to the handicap would enable the plaintiff to participate in the program. *Id.*

363. Pub. L. No. 88-352, 78 Stat. 241, 253-266 (1964) (codified at 42 U.S.C. 2000e-2000e17 (1988)).

364. 29 U.S.C. § 794a (1988). *See* Southeastern Community College v. Davis, 442 U.S. 397 (1979) (finding that reasonable accommodation did not require substantial change in programs to accommodate hearing-impaired applicant).

365. Wynne v. Tufts Univ. Sch. of Medicine, 932 F.2d 19, 27-28 (1st Cir. 1991) (en banc). While the court did not adopt wholesale the "substantial departure from accepted academic norms" language of *Ewing*, rightly recognizing that accommodation "may involve new approaches or devices quite beyond 'accepted academic norms,'" *id.* at 26 (quoting *Southeastern Community College*, 442 U.S. at 412), it did retain the professional judgment language, as quoted above. The court established a somewhat more fact-based standard:

> If . . . relevant officials within the institution considered alternative means, their feasibility, cost and effect on the academic program, and came to a rationally justifiable conclusion that the available alternatives would result either in lowering academic standards or requiring substantial program alteration, the court could rule as a matter of law that the institution had met its duty of seeking reasonable accommodation.

*Id.*

366. 591 F. Supp. 1416 (W.D. Mo. 1984), *aff'd*, 767 F.2d 518 (8th Cir. 1985).

367. 20 U.S.C. § 1401 (Supp. 1990).

368. Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (1973) (current version at 29 U.S.C. § 794 (1988)).

handicapped" rather than on any individualized assessment of the benefits of integrating the child into a regular public school.[369]

The district court applied the professional judgment standard to resolve the Due Process and Section 504 claims, noting that "there is an ongoing debate on the proper educational placement for the profoundly handicapped. The Court's function, however, is not to decide the debate nor interfere with the decision of Missouri's educators unless they have substantially departed from 'acceptable professional judgment, practice or standards.'"[370]

Claims of segregation, however, transcend "professional judgment" about educational matters. In the 1950's and 1960's, there was an ongoing debate about whether racial integration in the schools was educationally appropriate,[371] and indeed that debate continues to this day.[372] Had decisions regarding racial integration been framed as decisions involving the professional judgment of educators, our schools would look very different today. An expert's judgment according to the standards of his profession (whatever they might be) does not justify discrimination, whether on the basis of race or handicap.

Other cases, while not explicitly adopting the professional judgment standard, have used its language and logic in troubling ways. Citing professional judgment language, courts have accepted defendants' interpretations of consent decrees.[373] Similarly, the Seventh Circuit has deferred to the professional judgment of the director of a prison in a Title VII case to determine whether the exclusion of men from certain jobs in a prison setting was justified.[374]

In several recent foster care cases,[375] courts have applied the professional judgment standard in interpreting the requirements of the Adoption Assistance and Child Welfare Act.[376] In one case, the court held that the "[p]laintiffs ha[d]

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369. *St. Louis Developmental Disabilities*, 591 F. Supp. at 1440.

370. *Id.* at 1466 (quoting Monahan v. Nebraska, 687 F.2d 1164, 1171 (8th Cir. 1982), *cert. denied*, 460 U.S. 1012 (1983)).

371. *See* William F. Anderson, Jr., *Instructional Problems of Integration*, 37 PHI DELTA KAPPAN 353 (1956); Nick A. Ford, *A Teacher Looks at Integration*, 15 PHYLON 261 (1954); Gerald S. Lesser et al., *Some Effects of Segregation and Desegregation in the Schools*, *in* INTEGRATED EDUCATION 267 (Meyer Weinberg ed., 1968); Clyde V. Martin et al., *Segregation vs. Desegregation*, 41 PHI DELTA KAPPAN 319 (1960).

372. *See, e.g.*, Derrick A. Bell, Jr., *Serving Two Masters: Integration Ideals and Client Interests in School Desegregation Litigation*, *in* THE STRUCTURE OF PROCEDURE 271 (Robert M. Cover & Owen M. Fiss eds., 1979).

373. *See* United States v. Massachusetts, 890 F.2d 507, 510 (1st Cir. 1989) (upholding plan to improve conditions at state hospital for mentally ill despite its variance with original decrees); New York Ass'n for Retarded Children v. Carey, 706 F.2d 956, 971-72 (2d Cir. 1983) (upholding modification of consent decree subject to professional judgment standard), *cert. denied*, 464 U.S. 915 (1983).

374. Torres v. Wisconsin Dep't of Health and Social Servs., 859 F.2d 1523, 1531-32 (7th Cir. 1988), *cert. denied*, 489 U.S. 1017 (1989), *and cert. denied*, 489 U.S. 1082 (1989).

375. *See, e.g.*, Del A. v. Roemer, 777 F. Supp. 1297, 1311 (E.D. La. 1991) (holding that the Adoption Assistance and Child Welfare Act, 42 U.S.C. § 671 (1988), did not create private right of action, and that even if it did, defendants' actions would not violate Act); Winston v. Children and Youth Servs., 948 F.2d 1380, 1390 (3d Cir. 1991) (deferring to professional judgment of government agency employees in establishing visitation policy), *cert. denied*, 112 S. Ct. 2303 (1992).

376. 42 U.S.C. § 671 (1988). It should be noted that the Supreme Court recently held that the Act does not create certain private rights of action, Suter v. Artist M., 112 S. Ct. 1360 (1992), raising the possibility that the type of case represented by *Del A.* and *Winston*, *see supra* note 375, will no longer be brought.

not proved by a preponderance of the evidence that the decision to allow [a child] to remain in [an abusive] foster home . . . did not involve an exercise of minimally acceptable professional judgment."[377] In another case, the court upheld a visitation policy allowing one hour of biweekly visitation between children in foster care and their parents against a challenge that such decisions should be made on an individualized basis, because the policy had been developed on an individualized basis.[378]

Whether or not the requirements of these statutes were violated, the application of professional judgment analysis in these cases is disturbing for a variety of reasons. Although the standard may be appropriate for constitutional challenges to the treatment of children in foster care, it is not relevant to claimed violations of rights created by federal statute. The professional judgment standard was created by Chief Judge Seitz and adopted by the Supreme Court as a constitutional framework for balancing an individual's rights and the state's interests. Rights created by federal statutes, such as the Rehabilitation Act, Title VII, and the Adoption Assistance and Child Welfare Act, should not be subject to the same balancing. Statutes explicitly define rights that are not subject to intervening professional interpretation and redefinition prior to judicial enforcement. When Congress intends courts to defer to professional judgment, it has not hesitated to say so.[379] The courts' importation of a constitutional standard originally intended as a guide to adjudicating substantive Due Process rights into statutory determinations shows the threat that this amorphous standard poses not only to individual constitutional rights but to statutory rights as well.

## IV. CONCLUSION

The problem with defining a professional as "a person competent, whether by education, training or experience, to make the particular decision at issue"[380] is that this definition transforms the court's understanding of both "the decision at issue" and who should properly be making it. Thus courts recast questions of law as questions of fact, which, in turn, will necessarily be regarded as the province of "professionals" to whom the court should defer. The decision properly at issue in *Youngberg v. Romeo*, for example, was *not* the clinical one of whether Romeo should have been restrained, but the constitutional one of whether the imposed physical restraints, *regardless of clinical efficacy or indication*, violated his constitutional rights. The clinical decision is one that

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However, the cases still exemplify courts' readiness to defer to professionals on statutory questions.

377. *Del A.*, 777 F. Supp. at 1313.

378. *Winston*, 948 F.2d at 1391-92.

379. *See, e.g.*, S. REP. NO. 404, 89th Cong., 1st Sess., pt. 1, at 46-47 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986 (on role of physician in determining appropriate treatment under certain federal health insurance programs).

380. Youngberg v. Romeo, 457 U.S. 307, 323 n.30 (1982).

professionals, unconstrained by budgetary problems and conflicts of interest, would presumably be qualified to make. The legal decision is one that judges are not only qualified but also required to make in order to preserve liberties guaranteed by the Constitution. While judges may need to inquire into the clinical or professional rationale underlying the decision to restrain in order to make a decision regarding constitutionality, that rationale should not form the substance of the constitutional standard.

An evaluation of the restraints' propriety in terms of clinical standards may be relevant to the relationship between government purposes and the means used to achieve those purposes. Clinical standards cannot and should not, however, be transmuted into constitutional values, and satisfying them cannot be equated with fulfilling constitutional norms. As Justice Blackmun noted in a case challenging prison regulations, "I am concerned about the Court's apparent willingness to substitute the rhetoric of judicial deference for meaningful scrutiny of constitutional claims . . . . The fact that particular measures advance prison security . . . does not make them *ipso facto* constitutional."[381] Freedom from bodily restraint, like freedom from governmental intervention in general, may not be in the best interests of the individual, especially in the judgment of others. The exercise of free speech may also be counter-therapeutic.

Indeed, many great Supreme Court decisions have transcended some professional's judgment in order to vindicate an individual's constitutional rights. *West Virginia Board of Education v. Barnette*,[382] *Brown v. Board of Education*,[383] and *Tinker v. Des Moines Independent Community School District*,[384] would have been decided otherwise by panels of professional educators in West Virginia, Kansas, and Iowa—indeed, these cases were before the Court precisely because professionals *had* decided otherwise. The same can be said of *O'Connor v. Donaldson*,[385] *Wisconsin v. Yoder*,[386] and any of a number of other cases in which the Court consulted the Constitution rather than the judgment of professionals.

Furthermore, historical decisions widely regarded as shameful are replete with language of deference to professional judgment. *Korematsu v. United States*[387] upheld the internment of Japanese Americans in deference to military authorities.[388] Prior to *Barnette*, in *Minersville School District v. Gobitis*,[389]

381. Block v. Rutherford, 468 U.S. 576, 593-94 (1984) (Blackmun, J., concurring) (citation omitted).

382. 319 U.S. 624 (1943) (holding that requiring flag salute by public school children whose religion forbade it violates First Amendment).

383. 347 U.S. 483 (1954) (forbidding racial segregation of public school children).

384. 393 U.S. 503 (1969) (upholding students' rights to wear black armbands in protest).

385. 422 U.S. 563 (1975) (nondangerous person capable of surviving alone or with willing help of others may not be involuntarily confined).

386. 406 U.S. 205 (1972) (granting Amish parents religion-based right to teach children at home, despite state's mandatory public school laws).

387. 323 U.S. 214 (1944).

388. *Id.* at 218 ("[W]e cannot reject as unfounded the judgment of the military authorities.").

389. 310 U.S. 586 (1940).

the Supreme Court had justified forcing children to salute the flag against their religious convictions by declaring that "the courtroom is not the arena for debating issues of educational policy."[390] Today, *Goldman v. Weinberger*[391] and *United States v. Stanley*[392] follow in that tradition, and they, too, are filled with the language of deference to professionals.[393]

The claim of an individual seeking relief from government intrusion on her rights is not answered by the assurance that the state action arose from a professional judgment. For institutionalized people and other unwilling clients, this assurance amounts to no more than a constitutional right to have professional judgment exercised on their behalf in exchange for all their other rights. Rights to privacy, free speech, freedom from unreasonable search and seizure, and Due Process are extinguished at the will of professionals exercising their judgments in the name of appropriate treatment.

In cases in which the constitutional claim is that the plaintiff was entitled to professional judgment and did not receive it, such as claims of ineffective assistance of counsel, claims for treatment, or claims for services in foster care, the professional judgment standard is an appropriate benchmark. But when the plaintiff seeks refuge in the courts to protect her autonomy from intrusions by state professionals—to protect the manifold idiosyncracies and acts of courage that the Bill of Rights and the Fourteenth Amendment shield from the professional ministrations of the majoritarian state—then the professional judgment standard is akin to a white flag raised by the Court, surrendering those who sought judicial asylum to the tender mercies of professionals whose mandates do not include sensitivity to constitutional rights.

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390. *Id.* at 598 (1940).

391. 475 U.S. 503 (1986) (upholding Air Force prohibition of wearing yarmulkes required by officer's religion).

392. 483 U.S. 669, 681 (1987) (denying federal remedy for serviceman secretly given LSD because "the injury arises out of activity 'incident to service'").

393. *See Goldman*, 475 U.S. at 507 ("In the context of the present case, when evaluating whether military needs justify a particular restriction on religiously motivated conduct, courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest."); *Stanley*, 483 U.S. at 682-83 ("A test for liability that depends on the extent to which particular suits would call into question military discipline and decisionmaking would itself require judicial inquiry into, and hence intrusion upon, military matters. . . . Even putting aside the risk of erroneous judicial conclusions (which would becloud military decisionmaking), the mere process of arriving at correct conclusions would disrupt the military regime.").