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# INFORMED CONSENT FOR MEDICATION IN PERSONS WITH MENTAL RETARDATION AND MENTAL ILLNESS

*Joan L. O'Sullivan*<sup>†</sup>

*Breck G. Borcharding*<sup>††</sup>

Surgeons must be very careful  
When they take the knife!  
Underneath their fine incisions  
Stirs the culprit,—Life!<sup>1</sup>

## INTRODUCTION

**IN MARYLAND, SOME PERSONS** with mental retardation and mental illness, possibly long abandoned by their families, may be treated with psychotropic medications designed to ameliorate symptoms of psychiatric conditions. These treatments may enable them to live in the community, to work, and to enjoy life, but a small subgroup of patients with more disabling mental retardation may not have the capacity to consent to the treatment.

Maryland law forbids surrogate decisionmakers from taking any action regarding treatment for a mental disorder.<sup>2</sup> The situa-

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<sup>1</sup> EMILY DICKINSON, COLLECTED POEMS 106 (Peter Siegenthaler ed., 1991).

<sup>2</sup> See MD. CODE ANN., HEALTH-GEN. I, § 5-605(d)(2) (2000), *amended by Act of Apr. 20, 2001, ch. 189, 2001 Md. Laws 189* (reenacting statute without changes).

tion has existed for many years, since before the Health Care Decisions Act was passed in 1993. The previous law prevented family members and substituted consent-givers from consenting to "observation, diagnosis, treatment, or hospitalization for a mental disorder."<sup>3</sup> This is the case in many other states as well. Unfortunately, the symptoms of persons with mental retardation and mental illness can only be controlled with psychotropic medications. This state of affairs has continued for many years, with doctors claiming that the principle of beneficence, often invoked as a counterpoise to autonomy, finds its rightful but limited expression.<sup>4</sup> Autonomy in informed consent is the ability of the patient to understand the information provided by the doctor, including the doctor's duty to explain the procedure to the patient and to warn him of any material risks or dangers inherent in or collateral to the therapy, so as to enable the patient to make an intelligent and informed choice about whether to undergo such treatment.<sup>5</sup>

In section I, this article will discuss a hypothetical patient, outlining some practical difficulties in the treatment of mental health problems without true consent by persons with mental retardation and mental illness.

The article will go on to describe the history of informed consent in section II, and how doctors and caregivers may seemingly avoid informed consent issues when treating patients with mental illness and mental retardation, who have no surrogate decisionmaker.<sup>6</sup>

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<sup>3</sup> MD. CODE ANN., HEALTH-GEN. I, § 20-107(f)(1)(iii) (1987) (repealed 1993).

<sup>4</sup> See Jay Katz, *Informed Consent—Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 82-84 (1994) (discussing how the beneficence principle is rooted in the history of Hippocratic medicine and the maxim requiring physicians to do no harm).

<sup>5</sup> See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (discussing the duty to disclose where physician did not explain all the various possibilities surrounding the patient's proposed aortography).

<sup>6</sup> In a recent draft, the Inspector General stated that the use of psychotropic drugs in nursing homes was used properly in 85% of the cases. OFFICE OF INSPECTOR GEN., PSYCHOTROPIC DRUG USE IN NURSING HOMES, DRAFT REPORT NO. OIG-02-00-00490, at 8 (2001) (on file with author). In 8% of cases, the drugs were used inappropriately in that they were not medically necessary or reasonable. *Id.* In 7% of the cases, reviewers could not determine the appropriateness of psychotropic drug use due to insufficient medical record documentation. *Id.* The chemicals were not used as restraints, which is prohibited by 42 C.F.R. § 483.125(l) (2000), but the problems related to inappropriate dosage, chronic use, and unnecessary duplicate drug therapy.

Section III will deal with medical ethics in treating those who have both mental illness and mental retardation.

Section IV will describe the efforts of a newly formed committee, which will bring legislation before the Maryland General Assembly in 2002. The legislation will address the need for someone to be able to consent to authorize psychotropic medications for those who cannot consent themselves.

### SECTION I: PRACTICAL ASPECTS

The patient is a sixty-two-year-old man with profound mental retardation who has been living in a group home for fifteen years after a history of institutionalization at a state hospital going back to adolescence. A recent change in his group home program has given him a new treating psychiatrist. Chronic treatment with thioridazine (Mellaril) has occurred for as long as records are available. The patient record indicated that he had been diagnosed with "psychosis," although no history of these symptoms is available. The staff in his group home is convinced that the medication treatment has decreased self-injury and aggression and has assisted his sleep. There are no family members identified as being involved in his care.

Unfortunately, on examination, the patient was nonverbal, appearing generally unresponsive and overweight. In addition, the patient exhibited constant restless movements of his arms, legs, and trunk, and continuous chewing motions of his mouth. The patient's somnolence, obesity, and movement abnormalities are consistent with side effects of thioridazine. Specifically, the movement problems are categorized as "tardive dyskinesia," which is a progressive motor side effect most often developing after years of treatment with medications such as thioridazine. The movements may be quite debilitating, worsening over time. Tragically, they typically worsen acutely on withdrawal of medication or lowering of a dose, necessitating continuation or even eventual increase in the dose of the offending agent.<sup>7</sup>

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*Id.* at 13. This report presents a problem for nursing homes, in that 15% of nursing homes residents are treated inappropriately.

<sup>7</sup> For a full discussion of issues concerning psychotropic medication, see PSYCHOTROPIC MEDICATIONS AND DEVELOPMENTAL DISABILITIES: THE INTERNATIONAL CONSENSUS HANDBOOK (Steven Reiss & Michael G. Aman eds., 1998).

With the advent of newer medications that appear to have less potential for tardive dyskinesia, it is common practice to discuss with patients lowering the dose of the older thioridazine-type medication, replacing it with a newer medication if necessary. Even this does not preclude worsening movement problems, and either continuation of treatment as is or a change in medication is unpredictable in regards to outcome. In the current case, it is not even clear that the patient has ever had a true psychotic illness requiring medication treatment, and it is possible that thioridazine has been chronically used for behavioral control rather than for a specific psychiatric diagnosis.

Complicating the decision process further is the inability to obtain informed consent from the unresponsive patient for either continuation of medication, or its risky replacement with a less toxic agent. After examination, it is clear that the patient does not have the capacity to be involved in the decision process. There is no available family member with whom to confer. Clearly the group home's staff has a strong investment in continuation of a medication that has improved daily behavior and safety in the home. The treating physician is caught in a situation where there is an uncertain and risky outcome with any medication change and where there is no way to obtain patient consent either to change medication or to maintain the status quo.

Under Maryland law, even if family was available, the nature of the treatment as psychiatric negates the possibility of surrogate consent.<sup>8</sup> Guardianship is an expensive option that is generally seen in a negative light by the developmentally disabled community, which has embraced the concept of self determination. There is no clear path or support for the physician or patient in this case.

## SECTION II: A BRIEF HISTORY OF INFORMED CONSENT

The history of informed consent is rooted in the idea that doctors have the best interest of their patients at heart. Before the 1950's, physicians were supported by tradition in obtaining "implied consent" when patients did not object explicitly to an

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<sup>8</sup> See MD. CODE ANN., HEALTH-GEN. I, § 5-605(d)(2) (2000) (stating that a surrogate cannot authorize treatment for a mental disorder), *amended by* Act of Apr. 20, 2001, ch. 189, 2001 Md. Laws 189 (reenacting statute without changes).

ongoing course of treatment, discussed with patients or not. The conviction behind the Hippocratic Oath is that the physician has the best interest of their patients at heart. The Oath states: 'I swear by Apollo and Aesculepius [that] I will follow that system of regimen which according to *my* ability and judgment *I* consider for the benefit of *my* patients . . . .'<sup>9</sup>

The origin of informed consent appeared in a case decided by the Supreme Court, *Union Pacific Railroad v Botsford*.<sup>10</sup> Mrs. Botsford sued the Union Pacific Railway Company for negligence in the construction of an upper berth. While she was a passenger on the train, the upper berth fell on her head, bruising and wounding her, causing a concussion, and resulting in permanent injuries. In the first iteration of informed consent, the Supreme Court said:

No right is more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of the law. As well said by Judge Cooley, "The right to one's person may be said to be a right of complete immunity: to be let alone."<sup>11</sup>

The Court sustained the plaintiff's award and held she could not be examined by the defendant's surgeons.<sup>12</sup>

In *Schloendorff v. Society of New York Hospital*,<sup>13</sup> the plaintiff sued a hospital for its physicians operating on her without her permission. Although unsuccessful in her claim against the hospital, the opinion, written by Justice Cardozo, opined as follows:

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's con-

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<sup>9</sup> Katz, *supra* note 4, at 73 (alterations in original).

<sup>10</sup> 141 U.S. 250 (1891).

<sup>11</sup> *Id.* at 251.

<sup>12</sup> *Id.*

<sup>13</sup> 105 N.E. 92 (N.Y. 1914).

sent commits an assault, for which he is liable in damages.<sup>14</sup>

After these cases, physicians continued as they had been: making decisions for (and not with) their patients. The doctrine of informed consent did not make its way to the forefront of law until 1957, where in *Salgo v. Leland Stanford Jr. University Board of Trustees*,<sup>15</sup> a surgeon performed an aortography, without informing the patient about the nature of the procedure. In a brief statement called the “*Duty to Disclose*”, the Court of Appeal of California said the following:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.<sup>16</sup>

In 1960, this theory was elaborated on in *Natanson v. Kline*.<sup>17</sup> Physicians, who had always been in charge of their pa-

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<sup>14</sup> *Id.* at 93.

<sup>15</sup> 317 P.2d 170 (Cal. Ct. App. 1957).

<sup>16</sup> *Id.* at 181.

<sup>17</sup> 350 P.2d 1093 (Kan. 1960).

tients<sup>18</sup> were now faced with communicating to them and taking their opinions into account. This distressed physicians who feared the gap between doctors and patients was “unbridgeable both medically and socially.”<sup>19</sup> How much and what type of information is reasonable or required for physicians to disclose?

### A. The Elements of Informed Consent

In a discussion with the patient about treatment, using principles of informed consent, the physician or a nurse practitioner often discusses the nature of the decision or procedure; the reasonable alternatives to the proposed decision; the risks, benefits, and uncertainties related to each alternative; and the choice of doing nothing. There is an assessment of the patient’s understanding, and an acceptance or rejection of the proposed treatment.

The three elements of informed consent are (1) capacity; (2) understanding; and (3) voluntariness. When a physician determines whether a person with disabilities has the capacity to consent to treatment, it is often the most difficult hurdle a physician must face. The question is: does the person understand the information presented to him?

#### 1. Capacity

A book, *Assessing Competence to Consent to Treatment*,<sup>20</sup> written by Thomas Grisso and Paul Appelbaum, presents one standardized questionnaire a doctor can use to assess the capacity of a patient to understand the nature of the treatment being discussed. The form is the MacArthur Competence Assessment Tool for Treatment (MacCAT-T). It cites the diagnosis, the features of the disorder, and the course of the disorder. The form tells the doctor to tell the patient: “Now that is what we think is the problem in your case. If you have any reason to doubt that,

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<sup>18</sup> In 1847, when the American Medical Association promulgated its first Code of Ethics, it cautioned patients that their ‘obedience . . . to the prescriptions of [their] physician should be prompt and implicit. [They] should never permit [their] own crude opinions . . . to influence [their] attention to [their physicians].’ Katz, *supra* note 4, at 73 (alterations in original).

<sup>19</sup> *Id.*

<sup>20</sup> THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* 101-26 (1998).



I'd like you to tell me so. What do you think?"<sup>21</sup> The patient agrees, disagrees, or is ambivalent. If the patient disagrees or is ambivalent, the doctor writes the explanation of the patient. If the patient agrees, the doctor goes on to discuss the patient's understanding of the treatment. The form has places for each phase of the treatment to be discussed. It goes on to discuss the benefits and risks of the treatment; the patient responds to each benefit and risk. The form continues to discuss alternative treatments if the patient disagrees with the treatment presented and continues to the final choice of treatments elected by the patient. The last page of the form lists scores for understanding, appreciation, and reasoning of the patient. The optional choice scores an understanding of each alternative treatment.

The principles which would form the basis of informed consent are these:

- A person should be presumed to have the capacity to consent unless demonstrated otherwise;
- Capacity should not be presumed by age or diagnosis;
- Capacity is based on a person's actual functioning in a specific situation;
- Capacity is based on cognitive abilities and affective states (In other words, both the mental retardation and the mental illness must be considered when determining capacity.);
- Multiple assessments should be considered over a period of time to assess whether the person has capacity;
- Assessments should be conducted by familiar people and in familiar settings;
- Assessments should be made about the person's cultural and religious values so they may be taken into account;
- Assessments should evaluate environmental factors (setting, time of day, supports) so they may be taken into account;
- Assessments should be used to identify ways to enhance the person's decision-making capacity, through counsel-

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<sup>21</sup> *Id.* at 2.

ing, information, adjustment of medications or removal of barriers (physical, attitudinal, cultural).<sup>22</sup>

Incapacity usually means that the patient has limited ability

- to reason;
- to remember;
- to see the consequences of his/her actions;
- to plan for the future.

Intact capacity indicates that the person understands her situation, understands the risks associated with the decision, and communicates a decision based on that understanding.

Capacity to understand the information delivered by the doctor is probably the toughest obstacle to overcome when deciding on the administration of psychotropic medications. Many patients are able to give informed consent, to achieve respite from their psychiatric symptoms. For others with mental illness and mental retardation this is impossible, which puts the physician in an ethical bind. Coming to terms with the ethics of such a situation is one of the most challenging decisions facing doctors who treat patients with mental illness and mental retardation.

## 2. Understanding

Persons with disabilities may need more information than others about their choices. The person assisting should understand what the disabled person knows before supplying information. Often persons with mental retardation and mental illness are confused about their choices and do not understand what is available to them. The person presenting the information should make sure the listener is as cognitively available as possible.

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<sup>22</sup> Ruth I. Friedman, *Use of Advance Directives: Facilitating Health Care Decisions by Adults with Mental Retardation and Their Families*, 36 MENTAL RETARDATION 444, 452 (1998). Over several years, Ellis Craig and a committee developed a capacity assessment called Capacity Assessment For Self Care and Financial Management. He can be contacted at the Texas Department of Mental Health and Mental Retardation, 909 W. 45th St., Austin, TX 78711-2668.

Patience and understanding are crucial in presenting information to persons with mental illness and mental retardation. The person presenting the information should be sure to:

- Tailor the language to the person's ability;
- Assess the person's understanding along the way;
- Give information slowly and repeatedly;
- Give information in small segments;
- Use assistive devices when appropriate;
- Make sure written materials are at the appropriate reading level;
- Make sure consent forms are simple.

It is essential to present information in an appropriate format to a person who has mental retardation and mental illness. Rushing and trying to get the person to consent are fruitless efforts, which can only result in the person not understanding what has been presented, nullifying the attempt to obtain informed consent.

### 3. Voluntariness

Many people with mental retardation and mental illness have a great desire to please those in authority. People with mental retardation have been known to confess to crimes they did not commit because they wanted to please the authorities interrogating them. This is also the case with physicians, who the person may want to please, especially if they have had a long-standing relationship. They may sign the informed consent form accepting psychotropic medications when they have no understanding of what the drugs will do to them.

The patient's decision should not be coerced or pressured by anyone. Consider who should ask for the decision: a person who has a long-standing relationship with the person, someone who is more objective, or someone not well known to the patient.

When deciding whether the patient with mental retardation and mental illness has the capacity to consent, the physician should consider the dangers associated with the decision. An example of this is a person deciding whether to get a flu shot. If he gets the flu, it is usually of little risk. However, deciding

whether to have an operation for acute appendicitis is a more serious proposition, since without the operation the person could die from a ruptured appendix. Those around the person should be very sure that the person is making the decision with informed consent. Thus, the greater the risk, the greater the level of capacity needed to make the decision.

Due to the seriousness of the treatment, this concept puts physicians who treat those with mental retardation and mental illness in an ethical bind. Section three deals with the ethics of such a situation.

### B. Those with Mental Retardation and Informed Consent

The gulf between doctors and patients is never more obvious than when treating those with mental illness and mental retardation. Many of the patients who are treated have been abandoned by or separated from their families and have no surrogate to consent to medical care for them. Guardianship of most of these people is not practical, since social service budgets are limited, and agencies are unable to hire as many workers as would be required if all mentally ill and mentally retarded people were appointed guardians. In addition, guardianship is disfavored in the developmental disability community, for it impinges on the person's autonomy.

Patients are given psychotropic medications in order to control serious symptoms and relieve distress, and without such medication those with mental illness and mental retardation may require higher levels of care, let alone suffer serious discomfort. Some would be given the medication in a mental institution,<sup>23</sup> some would be put in restraints, some would be subjected to physical force, and some would be subject to behavior modification. With the deinstitutionalization occasioned by the *Olmstead*<sup>24</sup> decision, it is imperative that appropriate decision-

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<sup>23</sup> See MD. CODE ANN., HEALTH-GEN. I, § 10-708(b) (2000), amended by Act of April 10, 2001, ch. 15, 2001 Md. Laws. 15 (reenacting statute without changes). Maryland law establishes clinical review panels, which review the medication that institutionalized individuals are refusing to take. The statute states that medication may not be given to a patient who is refusing it unless, in an emergency, the patient is a threat to his own safety or others, or in a non-emergency, when the patient is involuntarily committed for treatment by order of the court and the medication is approved by the a panel under the dictates of the section. *Id.*

<sup>24</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999). In *Olmstead*, the Georgia Department of Human Resources institutionalized the plaintiffs, who were mentally disabled. The plaintiffs sued under 42 U. S. C. § 1983 and Title II of the Americans with

making for treatment of mental conditions be safely and reasonably supported. Many patients who are treated with antipsychotic medications have been taking the medications for so long that they may never be safely weaned from them, as in the patient with tardive dyskinesia, noted above. Many older patients have incomplete records of past treatments and symptoms, no clear histories for supporting information, and ever-changing caregiving staff in their residences. Getting adequate information on acute symptoms, let alone getting a past history, is often difficult for a physician. Because psychiatric disorders are often defined historically, this absence of information makes past reasoning for medication decisions obscure to the current treating physician.

Given the explosion in psychiatric medication treatments in the last decade, it is inevitable and appropriate that newer treatments will extend to all persons, even those with mental retardation. Although psychotropic medication use in this population has been to a large extent inappropriate, and correctly vilified for its past history, increasingly there is a role for medication in treating recognized psychiatric disorders in the population of those with mental retardation. Support for appropriate medical decisionmaking in difficult cases must follow.

### C. The Law Regarding Those Who Have No Capacity to Consent

The courts have long dealt with those who have no capacity to consent in emergency situations, when the person may die or will suffer grievous loss of function if no one acts immediately. Maryland law and the policymakers at the American Medical Association agree that a physician is allowed to treat a patient without consent if the patient would die or would lose function if no treatment is given.<sup>25</sup> This situation occurs most frequently

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Disabilities Act of 1990, for the failure of the State to place them in a community-based treatment program when their doctors said that placement was appropriate. *Id.* The Supreme Court held that the State's lack of resources was not a valid reason to deny the plaintiffs community-based placement, and that a court must take into account the cost of providing community-based care and the range of services provided to others with disabilities. *Id.*

<sup>25</sup> MD. CODE ANN., HEALTH-GEN. I, § 5-607 (2000). This law permits health care providers to treat a patient incapable of consent if the treatment is of an emergency nature, a person authorized to consent is unavailable, there is a substantial risk of death or immediate and serious harm, and delay would adversely affect the life or

in the emergency department of a hospital, when one has suffered an accident or an injury and is unconscious, and no one is there to consent to treatment.

The situation of treating those with mental illness and mental retardation usually occurs in the psychiatrist's office when the patient is brought in for renewal of her prescription for psychotropic medications. With no one to consent the doctor is faced with the impractical choice of refusing to refill the medication, or refilling it knowing that no one with capacity has consented. This puts the doctor in an ethical bind, which will be discussed in the third section.

The Supreme Court has spoken on this subject. In *Zinerman v. Burch*,<sup>26</sup> Burch sued the State of Florida because the staff at the mental hospital into which he was admitted knew that he was not competent. He was heavily medicated, disoriented, and apparently suffering from a psychotic disorder, and believed he was 'in heaven.'<sup>27</sup> The admission staff knew this. The Court held that Burch was entitled to sue the State, because the voluntary admission was a violation of his civil rights, depriving him of liberty without due process. If Burch had been involuntarily admitted, he would have had periodic hearings and the right to an attorney.<sup>28</sup> Mr. Burch was confined for some five months without a hearing or any other procedural determination to show that he had validly consented to admission or that he met the standard for involuntary placement. This clearly infringed on his liberty interest.<sup>29</sup> The Court explained:

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health of the patient, with a reasonable degree of medical certainty. *Id.* Similarly, the American Medical Association's policy on informed consent states:

Informed consent is a basic social policy for which exceptions are permitted: (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 8.08 (2000).

<sup>26</sup> 494 U.S. 113 (1990).

<sup>27</sup> *Id.* at 118.

<sup>28</sup> *Id.* at 134; see also *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) ("At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.").

<sup>29</sup> *Zinerman*, 494 U.S. at 131.

A patient who is willing to sign forms but incapable of informed consent certainly cannot be relied on to protest his "voluntary" admission and demand that the involuntary placement procedure be followed. The staff are the *only* persons in a position to take notice of any misuse of the voluntary admission process and to ensure that the proper procedure is followed.<sup>30</sup>

The Court allowed Mr. Burch to sue the State of Florida under an § 1983 action.<sup>31</sup>

In a similar case in New York, a thirty-nine-year-old woman, Josephine Buttonow, was converted from involuntary status to voluntary status after five years at Central Islip State Hospital.<sup>32</sup> The Court of Appeals of New York held the change in mental hygiene law from involuntary to voluntary status be read to mean that (1) the mental health patient be accorded the right to a judicial hearing and review of the change in status as well as her continued review of such changed status, and (2) that the mentally ill patient be afforded the same assistance from the Mental Hygiene Information Service as was furnished to involuntary patients.<sup>33</sup> Furthermore, the person who has been adjudicated incompetent has the legal capacity to request, consent, or agree to conversion of her status from involuntary to voluntary status.<sup>34</sup>

In a Wisconsin case, *Lessard v. Schmidt*,<sup>35</sup> Ms. Lessard contended she was denied her due process rights because:

- She was involuntarily committed for a maximum of 145 days without the benefit of a hearing;
- The State failed to make notice of all hearings mandatory;
- The State failed to give her adequate and timely notice of her right to a hearing;

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<sup>30</sup> *Id.* at 135.

<sup>31</sup> *Id.* at 139.

<sup>32</sup> *In re Buttonow*, 244 N.E.2d 677, 678 (N.Y. 1968).

<sup>33</sup> *Id.* at 682.

<sup>34</sup> *Id.*

<sup>35</sup> 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded* by 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

- The State failed to give her notice of her right to a jury trial;
- The State failed to assign counsel to her;
- The state failed to permit counsel to be at her psychiatric session;
- The State failed to provide for the exclusion of hearsay evidence and for the right against self incrimination;
- The State failed to provide her with an independent psychiatric examination by a physician of her choice;
- The State permitted a person to be involuntarily committed without a determination that the person was in need of institutionalization without proof of reasonable doubt;
- The State failed to describe the standard for commitment so that a person may be able to ascertain the standard of conduct under which they may be detained with reasonable certainty.<sup>36</sup>

The U.S. District Court for the Eastern District of Wisconsin discussed the requirements of due process and said that they are not static. Rather, they depend upon the importance of the interests involved and the nature of the proceedings. The court went on to say, “[w]ith these considerations and the common law background of our present civil commitment laws in mind, we turn to the justifications for permitting civil commitment without the stringent safeguards required in criminal proceedings.”<sup>37</sup>

The court opined:

In any event, the argument in favor of relaxed procedures on the basis of a subsequent right to treatment ignores the fact that unless constitutionally prescribed procedural due process requirements for involuntary commitment are met, no person should be subjected to “treatment” against his will. The argument also ignores the fact that many mental illnesses are untreatable., [sic] and the substantial evidence that any lengthy hospitalization, particularly where it is involuntary, may greatly

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<sup>36</sup> *Id.* at 1082.

<sup>37</sup> *Id.* at 1086.



increase the symptoms of mental illness and make adjustment to society more difficult.<sup>38</sup>

The court quoted the Supreme Court in *Robinson v. California*:

It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.<sup>39</sup>

Finally, on August 2, 2001, the Montana Supreme Court decided that an individual subjected to involuntary commitment has a constitutional right to effective assistance of counsel.<sup>40</sup> K.G.F., a woman subjected to involuntary commitment for ninety days, appealed a court ruling, saying she did not have effective assistance of counsel at her hearing.<sup>41</sup> In remanding the case for further fact finding concerning the effective assistance of counsel at a hearing, the court cited, as its starting point, the Montana Constitution's due process clause: 'No person shall be deprived of life, liberty, or property without due process of law.'<sup>42</sup>

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<sup>38</sup> *Id.* at 1087.

<sup>39</sup> *Id.* at 1088 (quoting *Robinson v. California*, 370 U.S. 660, 666 (1962)).

<sup>40</sup> *In re Mental Health of K.G.F.*, 29 P.3d 485 (Mont. 2001).

<sup>41</sup> *Id.* at 487-89.

<sup>42</sup> *Id.* at 492. Conceptions of informed consent vary with each jurisdiction. In *Tatman v. Fort Sanders Regional Medical Center*, a Tennessee court upheld an award of zero dollars given to a Jehovah's Witness who was given a blood product after instructing those around him that he did not want blood-products. No. E2000-02163-COA-R3-CV, 2001 Tenn. App. LEXIS 251 (Tenn. Ct. App. Aug. 16, 2001). Yet, in *In re Duran*, a Pennsylvania court reversed the trial court's decision to appoint an emergency limited guardian, who had consented to a blood transfusion, contrary to the patient's durable power of attorney stating that she refused any transfusion. 769 A.2d 497 (Pa. Super. Ct. 2001). The court upheld the woman's right under the common law to refuse blood-products. *Id.* at 503 (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (stating that 'no right is held more sacred, or is more

In addition, many federal courts have said that due process applies to involuntary commitment, for to go without due process would be to deprive the person of liberty in violation of the Fourteenth Amendment.

In the case of *Vitek v. Jones*,<sup>43</sup> the Supreme Court held that moving a prisoner from a jail to a mental hospital without notice, the right to a hearing or appointed counsel was a deprivation of liberty in violation of the Fourteenth Amendment, and violated due process. The Supreme Court said:

The District Court held that to afford sufficient protection to the liberty interest it had identified, the State was required to observe the following minimum procedures before transferring a prisoner to a mental hospital:

A. Written notice to the prisoner that a transfer to a mental hospital is being considered;

B. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;

C. An opportunity at the hearing to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;

D. An independent decisionmaker;

E. A written statement by the factfinder as to the evidence relied on and the reasons for transferring the inmate;

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carefully guarded, by the common law, than the right of every individual to the possession and control of his own person').

<sup>43</sup> 445 U. S. 480 (1980).

F. Availability of legal counsel, furnished by the State, if the inmate is financially unable to furnish his own; and

G. Effective and timely notice of all the foregoing rights.<sup>44</sup>

The Supreme Court affirmed the decision of the district court, saying that incarceration did not include transfer to a mental institution, without notice and right to counsel, because involuntary treatment in a mental hospital was not contemplated by those who served time in jail. The State's reliance on physicians and psychologists neither removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution.<sup>45</sup>

In another Supreme Court case, the Court decided that involuntary administration of medication did not violate an inmate's constitutional rights. In *Washington v. Harper*,<sup>46</sup> Harper argued that the involuntary administration of antipsychotic drugs violated his due process rights under the Fourteenth Amendment's right to refuse treatment. Harper was given antipsychotic drugs when he was placed in a Special Offender Treatment Center (SOC) for prisoners who suffer from serious mental disorders. Harper first was diagnosed as having manic-depressive illness and later was diagnosed as suffering from schizophrenia. Harper first consented to the administration of drugs and later refused to take them. His treating physician sought to medicate him against his will, according to the SOC's Policy 600.30. The policy was developed in response to *Vitek v. Jones*.<sup>47</sup> If a psychiatrist decides that the inmate should be treated with antipsychotic drugs, and the inmate refuses, the inmate may be subjected to drugs only if he "(1) suffers from a 'mental disorder,' and (2) is 'gravely disabled' or poses a 'likelihood of serious harm' to himself, others, or their property. Only a psychiatrist may order or approve the medication."<sup>48</sup> Second, an inmate who decides not to take the drug, has the right to a hearing at which a psychiatrist, a psychologist, and the

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<sup>44</sup> *Id.* at 494-95.

<sup>45</sup> *Id.* at 488-91.

<sup>46</sup> 494 U.S. 210 (1990).

<sup>47</sup> *Id.* at 215 (citing *Vitek v. Jones*, 445 U.S. 480 (1980)).

<sup>48</sup> *Id.*

Associate Superintendent of the SOC are present. None of these persons may be currently involved with the treatment or diagnosis of the inmate.<sup>49</sup> If the committee determines that the inmate suffers from a mental disorder and is gravely disabled or dangerous, the inmate may be medicated, provided the psychiatrist is in the majority.<sup>50</sup>

In reversing the Washington Supreme Court, the Supreme Court held:

As a matter of state law, the Policy itself undoubtedly confers upon respondent a right to be free from the arbitrary administration of antipsychotic medication. . . . Policy 600.30 is similarly mandatory in character. By permitting a psychiatrist to treat an inmate with antipsychotic drugs against his wishes only if he is found to be (1) mentally ill and (2) gravely disabled or dangerous, the Policy creates a justifiable expectation on the part of the inmate that the drugs will not be administered unless those conditions exist.<sup>51</sup>

The Supreme Court went on to say:

We have no doubt that, in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.<sup>52</sup> Upon full consideration of the state administrative scheme, however, we find that the Due Process Clause confers upon respondent no greater right than that recognized under state law.<sup>53</sup>

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<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at 215-16.

<sup>51</sup> *Id.* at 221 (citations omitted).

<sup>52</sup> Section One of the Fourteenth Amendment states:

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend XIV, § 1.

<sup>53</sup> *Harper*, 494 U.S. at 221-22 (citations omitted).

This reasoning has been applied by the U.S. Court of Appeals for the Fourth Circuit.<sup>54</sup>

In a more recent case, *Riggins v. Nevada*,<sup>55</sup> the Supreme Court held that the forced administration of the antipsychotic drug Mellaril (thioridazine) during the homicide and robbery trial of Riggins was a violation of his rights under the Sixth and Fourteenth Amendments. The Court said that the forced administration of Mellaril denied him 'a full and fair trial.'<sup>56</sup> Because Riggins was going to use insanity as a defense, the forced medication of Mellaril altered his mental state so that jurors did not see him in his true mental condition. The Court quoted *Harper*, stating, "[t]he forcible injection of medication into a nonconsenting person's body,' we said, 'represents a substantial interference with that person's liberty.'"<sup>57</sup>

The Court went on to say that in the case of an antipsychotic drug like Mellaril, that interference is particularly severe:

The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.<sup>58</sup>

The Court reversed the Nevada Supreme Court because the state courts had failed to make a finding sufficient to justify the forced administration of the drug during Riggins's trial. This error violated Riggins's rights under the Sixth and Fourteenth Amendments, including his right to a full and fair trial and his

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<sup>54</sup> See *United States v. Morgan*, 193 F.3d 252, 260-62 (4th Cir. 1999) (upholding the State's right to treat a prison inmate who has serious mental illness with antipsychotic drugs so long as the decisions are made under a proper medical professional and with adequate procedural safeguards); *Hogan v. Carter*, 85 F.3d 1113 (4th Cir. 1996) (holding that *Harper* had not established any particular procedure that must proceed a one-time dose of an antipsychotic drug in an emergency situation, and that the State retains the authority to administer these drugs in such a situation); see also *Morrison v. Garraghty*, 239 F.3d 648, 655 (4th Cir. 2001) (citing *Harper* for the proposition that the rationale basis standard of scrutiny applies to prison administration challenges even when the infringed right would otherwise call for strict scrutiny). Note that Maryland is in the Fourth Circuit.

<sup>55</sup> 504 U.S. 127 (1992).

<sup>56</sup> *Id.* at 133.

<sup>57</sup> *Id.* at 134 (quoting *Washington v. Harper*, 494 U.S. 210, 229 (1990)).

<sup>58</sup> *Id.* (quoting *Washington v. Harper*, 494 U.S. 210, 229 (1990)).

due process liberty interest in freedom from unwanted antipsychotic drugs.<sup>59</sup>

In a 1997 Maryland case, the Court of Special Appeals reversed the trial court in a case involving the involuntary administration of antipsychotic medication while a patient posed no danger to himself or others while involuntarily committed. The case, *Martin v. Department of Health and Mental Hygiene*,<sup>60</sup> asked whether a patient of a mental hospital who posed no danger to himself or others, could be forcibly medicated by a Clinical Review Panel, which operated in mental hospitals to override the protestations of patients who did not want to take their medications. The court began its analysis by considering the statute's requirement that the Clinical Review Panel may

approve the administration of medication or medications . . . if the panel determines that . . . without the medication, the individual is at substantial risk of continued hospitalization because of . . . remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others.<sup>61</sup>

The court held that since the General Assembly had written the text in the present tense, the valid meaning of the phrase meant that the person could not be forcibly medicated unless in the institution, the individual presented a danger to himself or to others.<sup>62</sup>

The following year, the General Assembly reenacted the legislation concerning the Clinical Review Panels, and changed the language so persons may be forcibly medicated in order for them to leave the institution. The section now says:

(g) Approval of medication by panel.— The panel may approve the administration of medication or medications and may recommend and approve alternative medications if the panel determines that:

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<sup>59</sup> *Id.* at 127-38.

<sup>60</sup> 691 A.2d 252 (Md. Ct. Spec. App. 1997), *cert. granted*, 695 A.2d 1230 (Md. 1997), *vacated as moot*, 703 A.2d 166 (Md. 1997).

<sup>61</sup> *Id.* at 255.

<sup>62</sup> *Id.* at 256.

(3) Without the medication, the individual is at substantial risk of continued hospitalization because of:

(i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others;

(ii) Remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause the individual to be a danger to the individual or to others; or

(iii) Relapsing into a condition in which the individual is in danger of serious physical harm resulting from the individual's inability to provide for the individual's essential human needs of health and safety.<sup>63</sup>

In *Steele v. Hamilton County Community Mental Health Board*,<sup>64</sup> the Ohio Supreme Court upheld the right of an involuntarily committed patient to be given antipsychotic drugs without his consent. The court based this decision on the *parens patriae*<sup>65</sup> authority of the State: the right of the State to care for its citizens who are unable to care for themselves.<sup>66</sup> The court said:

Because this power turns on a person's inability to care for himself/herself, it is legitimately invoked in forced-medication cases only when the patient lacks the capacity to make an informed decision regarding his/her treatment. . . . Thus, we hold that when an involuntary committed mentally ill patient, who does not pose an imminent threat of harm to himself/herself or others, lacks the capacity to give or withhold informed consent regarding his/her treatment, the state's *parens patriae*

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<sup>63</sup> MD. CODE ANN., HEALTH-GEN. I, § 10-708(g)(3) (2000), amended by Act of April 10, 2001, ch. 15, 2001 Md. Laws. 15 (reenacting statute without changes).

<sup>64</sup> 736 N.E.2d 10 (Ohio 2000), cert. denied, 121 S. Ct. 1376 (2001).

<sup>65</sup> *Parens patriae* means 'parent of his or her country,' and was based on the authority the King of England had to care for the property of subjects with legal disabilities. BLACK'S LAW DICTIONARY 1114 (6th ed. 1990). Today the authority rests in the State, as the provider of protection for those who are unable to care for themselves. *Id.*

<sup>66</sup> *Steele*, 736 N.E.2d at 18-21.

power may justify treating the patient with antipsychotic medication against his/her wishes.<sup>67</sup>

The court further stated:

Because of the significant liberty interest affected when an individual is medicated against his/her will with antipsychotic medication, we do not come this decision lightly. We have attempted to craft a decision that acknowledges a person's right to refuse antipsychotic medication, and yet recognizes that mental illness sometimes robs a person of the capacity to make informed treatment decisions. Only when a court finds that a person is incompetent to make informed treatment decisions do we permit the state to act in a paternalistic manner, making treatment decisions in the best interest of the patient.<sup>68</sup>

It is arguable that physicians who prescribe psychotropic medications to those who have mental retardation and mental illness are acting under the dictates of the *parens patriae* authority of the State. In order for them to be acting in this capacity, they would have to be tied to the State in some way. Perhaps the patient is receiving Medicaid, which might qualify the physician treating the patient to be acting under the authority of the State. This is a tenuous argument, however, since the *parens patriae* authority is usually given to departments within the State, such as the Department of Social Services, which can remove children from abusive or neglectful parents, and which can remove incapacitated adults from the care of abusive caretakers, or to the Bureau of Prisons, which can force prisoners to take antipsychotic medications.

When no one consents to accepting the long-term side effects of psychotic medications, it is to deprive the patient of a liberty interest without due process of law. To go without the protections of due process would leave the patient without treatment for her symptoms of mental illness, and subject her to the unfortunate effects of institutionalization. Physicians emphasize that principle of beneficence, as opposed to the autonomy advised in the informed consent doctrine.

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<sup>67</sup> *Id.* at 19.

<sup>68</sup> *Id.* at 21.



### SECTION III: THE ETHICS OF PRESCRIBING DRUGS FOR THOSE WITH MENTAL ILLNESS AND MENTAL RETARDATION

The *Principles of Medical Ethics*,<sup>69</sup> published by the American Medical Association, includes several principles that relate to physicians giving medication to those who are incapable of consent. The preamble to the principles says that they are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.<sup>70</sup>

The first principle of medical ethics states: "A physician shall be dedicated to the providing competent medical care, with compassion and respect for human dignity and rights."<sup>71</sup>

If the psychiatrist prescribing psychotropic medications for those with mental retardation and mental illness takes this principle at face value, she could be acting within the scope of the principle, because she is respecting the patient's human dignity and rights. To refuse to prescribe the medication would mean that the patient would become increasingly symptomatic and remain in discomfort. If the physician prescribed the medication, she would be acting to protect the human dignity of the patient, so that the patient's well being and functioning is enhanced.

The third principle of medical ethics states: "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."<sup>72</sup>

In the case of persons with mental retardation and mental illness, who have been abandoned by their families, physicians who seek a change in the law are acting in the best interests of the patient. To institutionalize a patient who, with medication, could function in a group home and who would be able to work and enjoy life, would be a travesty. Seeking a change in the law is the best solution for this problem, when no one has the authority to consent to the administration of medication, short of appointing a guardian for each and every person with mental

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<sup>69</sup> COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, <http://www.ama-assn.org/ama/pub/category/2512.html> (June 2001).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

retardation and mental illness. Appointment of a guardian would remove autonomy from each patient. Rarely do guardians consult with the ward when making decisions about their care.<sup>73</sup>

The fourth principle of medical ethics poses some problems for those who have mental retardation and mental illness. The principle states: "A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law."<sup>74</sup>

When a psychiatrist prescribes medications for those with mental retardation and mental illness, she cannot keep the confidences of the patient alone, for the patient does not have the capacity to consent. When the physician prescribes a drug, the discussion of the patient's behavior must be conducted with those who work with the patient on a daily basis. The patient cannot describe the effects of the medication on himself, and the physician must rely on those who have contact with him on a daily basis. This may be in the best interest of the patient, because those working with the patient can describe the side effects the medication is having, but the physician is not keeping the confidences of the patient and is breaching his privacy.

The eighth principle of medical ethics states: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."<sup>75</sup>

When the psychiatrist prescribes medication for the patient with mental retardation and mental illness, she regards responsibility to the patient as paramount. To refuse to prescribe medication would amount to a refusal to respect the dignity and rights of the individual patient. Treating the symptoms of those with mental retardation and mental illness respects the dignity of the individual, and respects the rights of those who care for the patient.

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<sup>73</sup> Cf. Michael D. Casasanto et al., *A Model Code of Ethics for Guardians*, 11 WHITTIER L. REV. 543, 548 (1989) (noting that guardians often do not have a prior relationship with the ward, and will need help from others in learning about the ward's wishes). The National Guardianship Association has adopted Casasanto's code of ethics. *A Model Code of Ethics for Guardians*, National Guardianship Association, at <http://www.guardianship.org/pdf/ModelCodeofEthics.PDF> (last visited July 24, 2001).

<sup>74</sup> COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 69.

<sup>75</sup> *Id.*

The ninth principle of medical ethics states: "A physician shall support access to medical care for all people."<sup>76</sup>

When the physician prescribes psychotropic medication for her patients with mental retardation and mental illness, she is supporting access to medical care for all people. To refuse to prescribe the medication might consign the patient to care in a less autonomous situation: where he might receive the medication under the dictates of the statute allowing for review of medication an involuntarily committed person is forced to take.<sup>77</sup>

The American Medical Association's policy on informed consent instructs that a patient must be fully informed to make a decision about his health care.<sup>78</sup> The physician must explain to the patient the treatment options, the alternatives, and the side effects. The physician must enable the patient to make medical choices among the treatment options. The policy does go on to say that if there is a medical emergency and the patient is unconscious and unable to give consent, the physician can act without providing informed consent.<sup>79</sup> In addition, if the psychological effects of explaining the treatment options to the patient would result in serious threat of psychological harm to the patient, then the physician may decide against describing them.<sup>80</sup>

When physicians consult with those who have no capacity to consent to their treatment, they often concentrate on caretakers and family, who can report about the effects of the medication on the person, and the person's reaction to the medication. This takes us back to the ancient principles of autonomy and beneficence.

To define autonomy, one can look to *The Principles of Bioethics*, written by Thomas Beauchamp and James Childress. "Autonomy is a form of personal liberty of action where the individual determines his or her own course of action in accor-

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<sup>76</sup> *Id.*

<sup>77</sup> See MD. CODE ANN., HEALTH-GEN. I, § 10-708(b) (2000) (authorizing involuntary medication in emergency and non-emergency situations), *amended by Act of April 10, 2001, ch. 15, 2001 Md. Laws. 15* (reenacting statute without changes).

<sup>78</sup> See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 8.08 (2000).

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

dance with a plan chosen by himself or herself.”<sup>81</sup> Respect for individuals as autonomous agents entitles them “to such autonomous determination without limitations on their liberty being imposed by others.”<sup>82</sup>

In contrast, the principle of beneficence

requires not only that we treat persons autonomously and not harm them but also that we contribute to their health and welfare. . . . [I]t is the duty to help others further their important and legitimate interests . . . . to *confer* benefits and actively to prevent and remove harms . . . . [and] to *balance* the good it is possible to produce against the harms that might result from doing or not doing the good.<sup>83</sup>

Some patients will never be able to understand the choices, alternatives, and side effects of the drugs they are taking. To obtain consent from such patients, one has to suspend disbelief that the person understands what the doctor is saying, and have the person sign on the dotted line. This happens in many situations, when the care staff knows that patients have no understanding about what they are signing. This reminds us of the case of Mr. Burch, who sued the State of Florida for voluntarily admitting him to a mental hospital when the staff knew he was delusional and believed he was in heaven.<sup>84</sup>

For physicians to accept the informed consent of someone they know is uncomprehending is to return to the principle of beneficence, as if informed consent did not exist. Unless the concept of joint decisionmaking becomes part of the ethos of the medical profession, informed consent will ever remain a “fairy tale.”<sup>85</sup> Some physicians have said that they first make a professional judgment about what treatment is best for the patient, and then they deliver a speech to the patient about the risks and benefits of *the* treatment.<sup>86</sup> Yet, consider that physicians may have great uncertainty in any forthright discussion of treatment alternatives. For many reasons, physicians may be

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<sup>81</sup> TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 56 (1979).

<sup>82</sup> *Id.* at 58.

<sup>83</sup> *Id.* at 135-36.

<sup>84</sup> *Zinermon v. Burch*, 494 U.S. 113, 118 (1990).

<sup>85</sup> Katz, *supra* note 4, at 91.

<sup>86</sup> *Id.* at 84.

averse to consciously consider this information themselves, and more averse to communicating it to patients.<sup>87</sup> The ethics of treating those with mental retardation and mental illness who have no ability to comprehend a discussion of the risks, benefits, and side effects of psychotropic medication is fraught with difficulty. Physicians must walk a thin line between treating without consent and recognizing that if they do not act, the patient's symptoms will be exacerbated, and the patient will be institutionalized, and live a conscripted life. The principle of beneficence serves the physician well in this instance, for to refuse to act would result in harm to the patient.

#### SECTION IV: THE COMMITTEE DESIGNING LEGISLATION IN MARYLAND

The Developmental Disabilities Administration (DDA) of the Maryland Department of Health and Mental Hygiene has formed a committee to address the needs of those who have no one to consent to the administration of psychotropic medication. The committee is made up of administrators from the DDA, and others who advocate for those with mental retardation and mental illness. The committee has been meeting since the spring of 2001 to draft legislation which will be introduced to the Maryland General Assembly in January 2002.

The committee is contemplating allowing those who are close to the patient to make decisions concerning informed consent. This is based on a model used in New York for those in institutions.<sup>88</sup> In New York, a committee of volunteers meets to decide about invasive medical treatment for patients who have no capacity to consent. The patient is appointed a lawyer to advocate for him and a hearing is held with four volunteers present. The volunteers listen to both pro and con arguments, and make a decision at the end of the hearing. The patient has the right to take the case to court if he does not agree with the decision.

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<sup>87</sup> *Id.*

<sup>88</sup> See Clarence J. Sundram & Paul F. Stavis, *Obtaining Informed Consent for Treatments of Mentally Incompetent Patients: A Decade Under New York's Innovative Approach*, 22 INT'L J.L. & PSYCHIATRY 170 (1999) (describing New York's Surrogate Decision-Making Program, which permits trained volunteers to exercise medical decisionmaking for the mentally disabled, when there are no authorized family members or guardians).

This is also similar to a Colorado law which allows those close to the patient to make treatment decisions. The Colorado statute allows relatives or friends who are close to the patient to make treatment decisions if the patient is incapacitated.<sup>89</sup> There is no restriction on the decisions that the surrogate decision-maker can make, including those dealing with mental health, except that in instances where the proxy wishes to withhold artificial nourishment or hydration, the attending physician, and a second independent physician trained in neurology, must certify that those means are merely prolonging the act of dying and are unlikely to restore the patient to independent neural functioning.<sup>90</sup>

Alaska and Massachusetts allow a court to dictate that psychotropic medications be given to those with mental retardation and mental illness. Alaska's statute allows the court to act if there have been crisis situations in the past and the facility wants to use psychotropic medication in the future, or if the facility wants to use psychotropic medication in the future and the patient is not able to give informed consent.<sup>91</sup> The patient has the right to an attorney, or if she has no attorney, the public defender shall provide one.<sup>92</sup> The court shall appoint a court visitor who can assist the court in deciding whether psychotropic medication can be used.<sup>93</sup>

The Massachusetts statute provides that a court may delegate to a guardian the authority to monitor the treatment process to ensure that an antipsychotic medication treatment plan is followed.<sup>94</sup> If the guardian is not suitable to be a monitor, the court shall appoint a monitor to ensure that the treatment plan is followed.<sup>95</sup> Expenses of monitoring shall be paid out of the estate of the disabled person, paid by the petitioner, or by the commonwealth, depending on the order of the court.<sup>96</sup> The mentally retarded person shall be in attendance, unless the court finds

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<sup>89</sup> COLO. REV. STAT. § 15-18.5-103 (2000).

<sup>90</sup> *Id.* § 15-18.5-103(6).

<sup>91</sup> ALASKA STAT. § 47.30.839(a) (Michie 2000).

<sup>92</sup> *Id.* § 47.30.839(c).

<sup>93</sup> *Id.* § 47.30.839(d).

<sup>94</sup> MASS. GEN. LAWS. ANN. ch. 201, § 6A(d) (West 1990).

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

extraordinary circumstances requiring his absence.<sup>97</sup> In that event, the disabled person's counsel shall be in attendance.<sup>98</sup>

The Maryland committee is fielding questions about who will put the team together, who will serve if no one is close to the patient, who will train the decisionmakers, whether a majority or unanimity of the group will be necessary for decisions, what will happen if the patient disagrees with the decision, and who in the legislature would be willing to sponsor such a bill. Part of the bill will be for more training for those who are capable of informed consent. The Developmental Disabilities Agency will take the lead in training those capable of informed consent.

### CONCLUSION

The issue of prescribing medications for those who have mental retardation and mental illness is fraught with difficulties. The use of newer psychotropic medications offers promise to those who suffer from psychiatric disorders, but requires careful weighing of risks and benefits. Some patients will never be able to consent to medical care, while others may be able to participate with much support. Physicians who work with those with mental retardation and mental illness face an ethical challenge whenever they deal with informed consent in prescribing medication. A change in the Maryland law will address this issue, but the road to such a legal change is challenging. The legislature must appropriate money to fund the project—at least to the extent of the position of an administrator for the program. Volunteers must be found and trained to help make decisions for those for whom they are acting. They must be able to discern what the patient would want, and under what circumstances. The lack of informed consent when prescribing medications to those who have no capacity to consent puts physicians in an ethical bind. They can believe that they are acting on the principle of beneficence, but addressing this problem with legislation would be a way for all States to take a step closer to making substituted informed consent available, when absolutely necessary.

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<sup>97</sup> *Id.* § 6A(e).

<sup>98</sup> *Id.*