TOURO COLLEGE
JACOB D. FUCHSBERG LAW CENTER
Where Knowledge and Values Meet

Touro Law Review

Volume 8 | Number 1 Article 2

1991

A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York State Constitutions

William M. Brooks
Touro Law Center, williamb@tourolaw.edu

Follow this and additional works at: https://digitalcommons.tourolaw.edu/lawreview

Part of the Civil Law Commons, Civil Rights and Discrimination Commons, Constitutional Law Commons, Courts Commons, Criminal Law Commons, Fourteenth Amendment Commons, Judges Commons, Psychiatric and Mental Health Commons, State and Local Government Law Commons, and the Supreme Court of the United States Commons

Recommended Citation

Brooks, William M. (1991) "A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York State Constitutions," *Touro Law Review*: Vol. 8 : No. 1 , Article 2.
Available at: https://digitalcommons.tourolaw.edu/lawreview/vol8/iss1/2

This Article is brought to you for free and open access by Digital Commons @ Touro Law Center. It has been accepted for inclusion in Touro Law Review by an authorized editor of Digital Commons @ Touro Law Center. For more information, please contact lross@tourolaw.edu.

TOURO LAW REVIEW

TOURO COLLEGE

Vol. 8, No. 1 | JACOB D. FUCHSBERG LAW CENTER | Fall 1991

A COMPARISON OF A MENTALLY ILL INDIVIDUAL'S RIGHT TO REFUSE MEDICATION UNDER THE UNITED STATES AND THE NEW YORK STATE CONSTITUTIONS

William M. Brooks*

INTRODUCTION

The right of a mentally ill and involuntarily hospitalized individual to refuse medication prescribed by a psychiatrist has divided the legal and psychiatric professions more than any other recent issue.[1] Whether an individual can refuse medication has

* B.A. Ohio Weslyan University 1976; J.D., State University of New York at Buffalo: Faculty of Law and Jurisprudence 1979; Assistant Professor, Touro College, Jacob D. Fuchsberg Law Center; Supervising Attorney, Mental Disability Law Clinic of Touro College Jacob D. Fuchsberg Law Center.

The author was formerly employed as an attorney for the Mental Hygiene Legal Service, Second Judicial Department, during which time he litigated *Rivers v. Katz.*

1. *See* Hickman, Resnick & Olson, *Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal*, 6 MENTAL DISABILITY L. REP. 122, 122 (1982) [hereinafter Hickman] (discussing a proposal which aims to protect the individual's right to make informed choices regarding psychotropic treatment, to insure treatment is given in a timely fashion if consented to, and to protect patients from abuses that may occur due to misuse of treatment by poorly trained physicians).

Published by Digital Commons @ Touro Law Center, 2020

understandably generated heated discussion. The legislature grants authority to the medical profession to deprive a mentally ill individual of liberty for the purpose of providing needed treatment.[2] Under such circumstances, many medical professionals have questioned, and indeed assailed, the propriety of permitting a patient, who theoretically fails to understand the need for treatment, to refuse the very medication a psychiatrist has prescribed to treat the mental illness from which the patient suffers.[3] Invariably, the criticism accuses the legal system of failing to take into account "clinical realities" when broadly defining the boundaries of a patient's right to refuse.[4] On the other hand, courts and both legal and medical commentators have recognized the devastating side effects that antipsychotic medication produces.[5]

2. *See* N.Y. MENTAL HYG. LAW §§ 9.01-.45 (McKinney 1988). Mental Hygiene Law (MHL) section 9.27 authorizes the involuntary hospitalization of a mentally ill individual when such person suffers from a mental illness for which care and treatment in a hospital is essential to the individual's welfare and his judgment is so impaired that he is unable to understand the need for such in-patient care and treatment. *Id.* §§ 9.01, .27. The MHL authorizes the involuntary hospitalization on an emergency basis of individuals deemed mentally ill and dangerous. *Id.* §§ 9.37-.45. However, such confinement may not last longer than fifteen days, and if a psychiatric facility wishes to further confine an individual, two physicians must certify that a patient satisfies the criteria of MHL section 9.27. *Id.* §§ 9.27, .39(b).

3. *See, e.g.*, Appelbaum, *The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect*, 145 AM. J. PSYCHIATRY 413, 417 (1988) [hereinafter Appelbaum]; Schwartz, Vingiano & Bezirganian, *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1049 (1988) [hereinafter Schwartz & Vingiano].

4. *See* Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 345 (1980) [hereinafter *Drug Refusal*]; Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306, 315 (1979) [hereinafter Appelbaum & Gutheil]; Schwartz & Vingiano, *supra* note 3, at 1049.

5. *See, e.g.*, Davis v. Hubbard, 506 F. Supp. 915, 928-29 (N.D. Ohio 1980); Rennie v. Klein, 462 F. Supp. 1131, 1138 (D.N.J. 1978); People v. Medina, 705 P.2d 961, 968 (Colo. 1985) (*en banc*); Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD.

Courts have disagreed as to the characterization of the issues involved. Some have concluded that whether physicians should permit a patient to refuse medication constitutes a medical determination.[6] Others have recognized that a determination of whether a patient has the capacity to refuse medication is a legal question.[7] Indeed, the vehemence in which both pro and anti-refusal sides disagree makes one wonder whether one group or the other can be so wrong.[8] Or are both sides correct and must the

---

PSYCHIATRY & L. 179, 183-87 (1980); Plotkin, *Limiting The Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 475-77 (1977) [hereinafter Plotkin]. Most right to refuse medication cases have expressly focused upon a patient's right to refuse antipsychotic medication. *See, e.g.*, Rogers v. Okin, 634 F.2d 650, 653 n.1 (1st Cir. 1980). However, limiting an individual's right to refuse medication to antipsychotic drugs ignores questions raised by the forcible administration, *inter alia*, of lithium, a psychotropic drug, that produces many debilitating side effects in its own right. *See infra* text accompanying notes 64-72; *see also* Hickman, *supra* note 1, at 124; Risch, Groom & Jonowsky, *The Effects of Psychotropic Drugs on the Cardiovascular System*, 43 J. CLINICAL PSYCHIATRY 16, 21-22 (1982).

6. *See, e.g.*, United States v. Charters, 863 F.2d 302, 307-08 (4th Cir. 1988) (*en banc*) (court held that base-line decision to forcibly medicate should be made by appropriate medical personnel of the custodial institution with judicial review available to guard against arbitrariness), *cert. denied*, 110 S. Ct. 1317 (1990); *see also* Stensvad v. Reivitz, 601 F. Supp. 128, 131 (W.D. Wis. 1985) (court found that a patient's "constitutional right to refuse antipsychotic drugs must be measured by whether the decision to administer such drugs is a substantial departure from accepted professional judgment, practice or standards").

7. *See, e.g.*, Riese v. Saint Mary's Hosp. & Medical Center, 209 Cal. App. 3d 1303, 1322, 243 Cal. Rptr. 241, 253 (1st Dist. 1988) (finding that an institutionalized patient's informed consent was required before antipsychotic drugs could be forcibly administered, the court held that the determination of a patient's competence to refuse such medication is "uniquely a judicial, not a medical function"); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 495, 458 N.E.2d 308, 314 (1983) (court rejected argument that doctors should be responsible for making treatment decisions for involuntarily committed patients, stating that "every competent adult has a right to forgo treatment . . . however unwise his sense of values may be in the eyes of the medical profession"); *In re* K.K.B., 609 P.2d 747, 751 (Okla. 1980) (competency of an involuntarily committed individual is not a medical decision and is independent from the commitment decision).

8. A psychiatrist's decision to administer medication to a mentally ill individual is a clinical decision, *see supra* note 6; *infra* text accompanying

law account for the interrelationship between law and medicine?

Focusing on whether the right to refuse medication constitutes a medical or legal question begs a more important question at hand. The right to refuse issue boils down to one of judicial ideology or philosophy. How much individual autonomy is a court willing to grant to an individual whom either psychiatrists or a court has determined suffers from mental illness, requires in-patient care and treatment for such illness, does not understand the need for such in-patient care and treatment, and possesses a substantial risk of physical harm to himself or others?[9]

In 1983, the Court of Appeals for the Second Circuit, in *Project Release v. Prevost*,[10] addressed the scope of a civilly

---

notes 181, 199-200, but also amounts to a legal determination because it impacts directly upon an individual's right to bodily integrity, *see supra* note 7; *infra* text accompanying notes 195-96. In other words, a physician's decision to administer drugs constitutes a medical decision with significant legal consequences. Accordingly, the characterization of a decision to forcibly medicate as "medical" or "legal" may be little more than attempts to justify the imposition of narrow or broad protection against forced drugging to a mentally ill individual. *See e.g.*, *Charters*, 863 F.2d at 306-10; *see supra* notes 6-7.

9. In New York, once the state hospitalizes an individual there is no automatic civil commitment proceeding. Rather, there is a right to a hearing within five days of a patient's request. *See* N.Y. MENTAL HYG. LAW §§ 9.27, .31 (McKinney 1988). While MHL section 9.27 does not require a finding of dangerousness, numerous New York appellate courts have required such a finding before the state may utilize the statute to involuntarily hospitalize an individual. *E.g.*, *In re* Carl, 126 A.D.2d 640, 640, 511 N.Y.S.2d 144, 144 (2d Dep't 1987) (holding that "the state must prove, by *clear and convincing evidence*, that the person is mentally ill *and* that he poses a substantial threat of physical harm to himself or others") (emphasis in original); *In re* Harry, 96 A.D.2d 201, 206, 468 N.Y.S.2d 359, 363-64 (2d Dep't 1987) (stating that it is "well established that if an individual can live safely in freedom and is not dangerous to himself or others, due process will not tolerate his involuntary commitment irrespective of whether treatment some may deem beneficial will be provided"); Scopes v. Shah, 59 A.D.2d 203, 205, 398 N.Y.S.2d 911, 913 (3d Dep't 1977) (holding that "substantive due process requires that the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others") (citation omitted).

10. 722 F.2d 960 (2d Cir. 1983); *see infra* text accompanying notes 97-101.

committed individual's right to refuse medication under the due process clause of the United States Constitution.[11] The court rendered an opinion that narrowly interpreted a patient's right to refuse medication, which resulted in the court permitting the state to forcibly administer medication under the same circumstances as it had prior to the lawsuit.[12] Three years later, the New York Court of Appeals addressed the same issue in *Rivers v. Katz.*[13] Relying upon the due process clause of the New York State Constitution,[14] the court issued a decision that one commentator has described as the "broadest right-to-refuse treatment opinion yet decided by an appellate court."[15] Recently, the United States Supreme Court in *Washington v. Harper*[16] clarified to a degree the scope of an individual's right to refuse antipsychotic drugs under the Federal Constitution. Although *Harper* involved the right of a mentally ill prisoner to refuse medication, much of the Court's analysis is pertinent to the issue of a civilly committed individual's right to refuse medication.[17]

This Article will compare a mentally ill individual's right to refuse medication under the United States and New York Constitutions. First, it will describe the nature of psychotropic medication. It will then examine how the Second Circuit in *Project Release*, the Supreme Court in *Harper*, and other federal courts have addressed this issue in both the substantive and procedural contexts. The Article will then compare the Federal constitutional analysis with the New York State constitutional analysis detailed in *Rivers*. This Article will conclude that the

---

11. U.S. CONST. amend. XIV, § 1 ("No State shall . . . deprive any person of life, liberty, or property, without due process of law . . . .").

12. *See infra* text accompanying notes 84-101.

13. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *see infra* text accompanying notes 207-16.

14. *Id.* at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78; N.Y. CONST. art. I, § 6 ("No person shall be deprived of life, liberty or property without due process of law.").

15. 2 M. PERLIN, MENTAL DISABILITY LAW § 5.43, at 339 (1989) [hereinafter PERLIN]. For a detailed discussion of *Rivers*, see *infra* text accompanying notes 207-36.

16. 110 S. Ct. 1028 (1990).

17. *See infra* text accompanying notes 207-37.

New York Court of Appeals' approach to the right to refuse medication is the preferable one. It provides patients greater individual autonomy by rendering it more likely that patients suffering from mental illness will make the same decisions that impact upon their bodily autonomy as the law permits individuals who do not suffer from mental illness. For the simple reason that the law should strive to treat individuals who suffer from mental illness, as much as possible, within practical limits, the same as the citizenry as a whole, the New York Court of Appeals' decision is sounder than decisions that have treated the right to refuse medication issue as a medical question to be determined by clinicians.

I. THE NATURE OF PSYCHOTROPIC MEDICATION

Psychotropic drugs include any medications that affect mentation,[18] *i.e.*, mental activity.[19] They include antipsychotic medication, sedatives, tranquilizers, and hypnotics.[20] Antipsychotic medications, also known as neuroleptics, aim to reverse the symptoms of psychosis,[21] which is a mental disorder characterized by loss of contact with reality.[22] Presently, drug therapy constitutes the primary source of treatment in state-operated psychiatric centers.[23] In many hospitals, for all intents and purposes, it amounts to the only treatment that patients receive.[24]

---

18. *See* Gutheil & Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 79 (1983) [hereinafter Gutheil & Appelbaum].

19. *See* WEBSTER'S MEDICAL DESK DICTIONARY 423 (1986) [hereinafter WEBSTER'S].

20. *See* Gutheil & Appelbaum, *supra* note 18, at 79.

21. *Id.*

22. *See* WEBSTER'S, *supra* note 19, at 588.

23. Cichon, *The Eighth Circuit and Professional Judgment: Retrenchment of the Constitutional Right to Refuse Antipsychotic Medication*, 22 CREIGHTON L. REV. 889, 952 (1989); Kemna, *Current Status of Institutionalized Mental Health Patients' Rights To Refuse Psychotropic Drugs*, 6 J. LEGAL MED. 107, 109 (1985) [hereinafter Kemna].

24. Brooks, *The Right to Refuse Antipsychotic Medications: Law and*

Today, "'[p]sychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia.'"[25] It has been argued that "antipsychotic drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of schizophrenic illness."[26] Additionally, "[t]he available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis."[27] Some professionals within the psychiatric community have concluded that "there is still no single substitute for [antipsychotic drugs] . . . for control of symptoms and prevention of relapse in the majority of chronic schizophrenic patients. Denying these patients the benefit of [antipsychotic drugs] . . . without offering any suitable alternative may be considered a clinical error."[28]

However, antipsychotic medication does not cure mental illness.[29] Rather, such medication suppresses such psychotic symptomatology as hallucinations, delusions, and paranoid ideation.[30] Furthermore, a physician often lacks the ability to predict the efficacy of drug therapy since there is no accurate method of determining how a patient will react to a particular drug.[31]

Antipsychotic medication produces a plethora of side effects that range from unpleasant to devastating and even life threatening. Many side effects fall within the category of extrapyramidal symptoms.[32] Extrapyramidal side effects involve an impairment

---

Policy, 39 RUTGERS L. REV. 339, 342 (1987) [hereinafter Brooks].

25. Washington v. Harper, 110 S. Ct. 1028, 1039 n.9 (quoting Brief for American Psychiatric Ass'n as *amicus curiae* at 10-11).

26. Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133, 134 (1987).

27. *Id.* at 142.

28. Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 AM. J. PSYCHIATRY 297, 306 (1981).

29. *See* Gutheil & Appelbaum, *supra* note 18, at 101; Kemna, *supra* note 23, at 110.

30. *See* Kemna, *supra* note 23, at 110.

31. *Id.* at 110-11.

32. *See infra* text accompanying notes 33-59.

of the motor system which controls muscular movement.[33] Many patients find life with chronic extrapyramidal effects unbearable.[34] One of the most common extrapyramidal symptoms is akathisia.[35] Uncontrollable physical restlessness, agitation, interminable pacing, anxiety and panic characterize this syndrome.[36] To say the least, many patients find akathisia discomforting.[37] Psychiatrists frequently have difficulty diagnosing akathisia,[38] as distinguishing between akathisia and psychotic excitement may be impossible.[39]

Patients who receive antipsychotic medication also suffer from akinesia. Akinesia is a behavioral state of diminished capacity characterized by unspontaneous speech, apathy, and difficulty in initiating activities.[40] Like akathisia, akinesia may be difficult to diagnose as it is extremely difficult to differentiate schizophrenic apathy from akinesia.[41]

Other types of extrapyramidal symptoms are dystonic reactions, which are manifested by muscle spasms, particularly in the eyes, neck, face and arms. Like akathisia, dystonic reactions are temporary and disappear when the administration of medication is terminated.[42] Antipsychotic medication also produces symptoms known as parkinsonism, which consist of a mask-like face, drooling, muscle stiffness, and rigidity.[43]

By far the most insidious extrapyramidal symptom, and the one

33. Kemna, *supra* note 23, at 112.

34. Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 ARCHIVE GEN. PSYCHIATRY 67, 70 (1974).

35. Brooks, *supra* note 24, at 348.

36. *Id.*

37. *See* Gelman, *Mental Hospital Drugs, Professionalism and the Constitution*, 72 GEO. L.J. 1725, 1744 (1984) [hereinafter Gelman].

38. Van Putten & Marder, *Behavioral Toxicity of Antipsychotic Drugs*, 48 J. CLINICAL PSYCHIATRY 13, 13 (1987) [hereinafter Van Putten & Marder]; Weiden, *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 AM. J. PSYCHIATRY 1148, 1151 (1987).

39. Van Putten & Marder, *supra* note 38, at 13.

40. *Id.* at 15.

41. *Id.*

42. *See* Plotkin, *supra* note 5, at 475.

43. *Id.*; Kemna, *supra* note 23, at 112.

that has generated the most discussion, is tardive dyskinesia. Tardive dyskinesia, which has been described as a significant public health hazard,[44] involves the involuntary movements of facial, arm, leg, or truncal musculature.[45] Such movements have been described as grotesque and humiliating; they frequently involve the sucking or smacking of the lips.[46] Although symptoms appear while the patient is taking medication, they may not become clinically evident until the drug is either decreased or discontinued.[47] While many courts have recognized the problems of tardive dyskinesia,[48] one court's focus illustrates why tardive dyskinesia is so problematic:

> In its most severe form, it may interfere with all motor activity, making speech, swallowing and breathing extremely difficult. Tardive dyskinesia is of special concern for several reasons. First, its symptoms often do not appear until late in the course of treatment and sometimes not until after the treatment is discontinued. Second, there is no known cure for the condition. Third, it is impossible to predict who will become a victim, aside from the tendency of the condition to affect patients on long-term high dosages of antipsychotic medications. Finally, the condition is fairly widespread as studies have indicated that the condition occurs in 10-40% of patients receiving long-term, high-dosage treatment.[49]

There is substantial disagreement over the prevalence of tardive dyskinesia. It has been reported that 10 to 40 per cent of patients who have been treated with antipsychotic medication suffer from tardive dyskinesia.[50] Two studies cited by the district court in

---

44. Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 AM. J. PSYCHIATRY 297, 297 (1981).

45. *See* Gutheil & Appelbaum, *supra* note 18, at 109.

46. *See* Brooks, *supra* note 24, at 349.

47. *See* Kessler & Waletzky, *Clinical Use of Antipsychotics*, 138 AM. J. PSYCHIATRY 202, 205 (1981).

48. *See infra* notes 51-52 and accompanying text.

49. People v. Medina, 705 P.2d 961, 968-69 (Colo. 1985) (citations omitted).

50. *See* Brooks, *supra* note 24, at 350; Gutheil & Appelbaum, *supra* note 18, at 109.

Rogers v. Okin[51] placed the prevalence of tardive dyskinesia at 50 and 56 per cent. The United States Supreme Court declared that a "fair reading of the evidence" places the incidence of tardive dyskinesia at 10 to 25 per cent.[52] Many authorities believe tardive dyskinesia is irreversible.[53] However, some psychiatrists assert that tardive dyskinesia often disappears,[54] or at least remains stable or improves if patients receive extended low or moderate dosages of antipsychotics.[55] Despite its frequency, physicians often fail to detect the disorder, particularly when its symptoms involve the extremities.[56] Over a substantial period of time, for whatever reasons, psychiatrists employed in state-operated psychiatric hospitals, including psychiatrists employed by the New York Office of Mental Health, almost never diagnosed the disorder.[57] Perhaps because many psychiatrists believe antipsychotic medication can do no wrong,[58] when confronted with patients who suffer from tardive dyskinesia, some psychiatrists accuse patients of faking their symptoms.[59]

In addition to extrapyramidal symptoms, other side effects of antipsychotics are well documented. Blurred vision, dry mouth, and interference with sexual functioning are common.[60] Antipsychotic drugs also produce low blood pressure, urinary retention, and constipation.[61] The medication can also result in

---

51. 478 F. Supp. 1342 (D. Mass. 1979).

52. Washington v. Harper, 110 S. Ct. 1028, 1041 (1990).

53. *See Id.*; Brooks, *supra* note 24, at 349; Gelman, *supra* note 37, at 1752.

54. Richardson & Casey, *Tardive Dyskinesia Status: Stability or Change*, 24 PSYCHOPHARMACOLOGY BULL. 471, 474 (1988); Gutheil & Appelbaum, *supra* note 18, at 109.

55. Casey, *Neuroleptic Induced Tardive Dyskinesia and Parkinsonism: Changes During Several Years of Continuing Treatment*, 22 PSYCHOPHARMACOLOGY BULL. 250, 251 (1986).

56. Weiden, *supra* note 38, at 1751.

57. Gelman, *supra* note 37, at 1755.

58. *Id.* at 1759.

59. *Id.* at 1756.

60. *Id.* at 1745.

61. *See* People v. Medina, 705 P.2d 961, 968 n.3 (Colo. 1985).

agranulocytosis (a hematological side effect characterized by sore throat, fever, fatigue, lethargy, and other signs of infection) as well as jaundice, skin discoloration, eye lesions, and on rare occasions, sudden death.[62] Accordingly, the nature of antipsychotic medication is such that one court has found that "[e]ven acutely disturbed patients may have good reason to refuse these drugs."[63]

Lithium is the treatment indicated for manic episodes of manic-depressive illness,[64] otherwise known as a bipolar disorder.[65] However, lithium also produces many debilitating side effects. Effects of lithium on the central nervous system range from commonly observed mild side effects to life-threatening irreversible brain damage in rare instances of severe toxicity.[66] Lithium toxicity can occur with patients whose lithium levels are well within ordinary therapeutic ranges.[67] Toxic effects of lithium are initially manifested by gross tremors, persistent headache, vomiting, mental confusion, and may progress to stupor, seizures, and cardiac arrhythmias.[68] Lithium may also impact on the immunological system of the body,[69] and has also contributed to cardiac failure of patients who have a familial history of heart disease.[70]

The administration of lithium can produce extrapyramidal

---

62. *See Id.*

63. Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979).

64. *See* PHYSICIAN'S DESK REFERENCE 1923 (45th ed. 1991). A manic episode is a distinct period of elevated, expansive mood, and associated symptoms of, *inter alia*, increased activity, a flight of ideas, inflated self esteem, decreased need for sleep, and an "excessive involvement in activities without recognition of the high potential for painful consequences." COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 765 (H. KAPLAN & B. SADECK (4th ed. 1985)) [hereinafter TEXTBOOK OF PSYCHIATRY].

65. TEXTBOOK OF PSYCHIATRY, *supra* note 64, at 765.

66. *Id.* at 879.

67. *See* Reisberg & Gershon, *Side Effects Associated with Lithium Therapy*, 36 AM. J. PSYCHIATRY, 879, 880 (1179) [hereinafter Reisberg & Gershon].

68. *See* THE MERCK MANUAL 1461 (15th ed. 1987).

69. *See* Shukla & Borison, *Lithium and Lupuslike Syndrome*, 248 J. AM. MED. ASS'N 921, 921 (1982).

70. *See* Reisberg & Gershon, *supra* note 67, at 882.

symptoms.[71] In fact, the combination of lithium and antipsychotic medication increases the risk of extrapyramidal symptoms occurring.[72]

II. THE RIGHT OF A PATIENT TO REFUSE MEDICATION UNDER THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT

A. The Second Circuit Analysis of a Patient's Substantive and Procedural Rights to Refuse Medication

When determining the scope of a patient's right to refuse medication under the Federal Constitution, a court must address three questions.[73] It must determine (1) whether the individual possesses a constitutionally protected interest in refusing medication; (2) what, if any, state interests outweigh such individual interest; and (3) what procedures, if any, a state must adhere to when determining whether such state interests exist.[74]

The Court of Appeals for the Second Circuit, in *Project Release v. Prevost*,[75] recognized the necessity of conducting this analysis when it examined the constitutionality of the administra-

71. *See* Kane, Rifkin, Quitkin & Klein, *Extrapyramidal Side Effects with Lithium Treatment*, 135 AM. J. PSYCHIATRY 851, 852 (1978); *see supra* text accompanying notes 33-59.

72. *See* Blair, *Risk Management for Extrapyramidal Symptoms*, 16 JOINT COMM'N ON ACCREDITATION OF HOSPS.; QUALITY REVIEW BULL. 116, 121 (1990).

73. *See* Washington v. Harper, 110 S. Ct. 1028 (1990). The United States Supreme Court defined these issues as follows:

> [T]he substantive issue involves a definition of th[e] protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance.

Id. at 1036 (quoting Mills v. Rogers, 457 U.S. 291, 299 (1982)); *infra* text accompanying notes 120-41.

74. *Harper*, 110 S. Ct. at 1036.

75. 722 F.2d 960 (2d Cir. 1983).

tive regulation promulgated by the New York State Office of Mental Health then in existence.[76] The regulation, title 14, section 27.8 of the New York Code Rules and Regulations (NYCRR), defined the circumstances in which a psychiatric hospital could forcibly administer medication.[77]

Although the regulation in question consisted of a three stage administrative review, it contained absolutely no substantive standards for the administrative reviewers to apply.[78] It enabled a

76. *Id.* at 977 (citing *Mills*, 457 U.S. at 299 (1982)).

77. N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8, (1962).

78. The relevant portions of the regulations contain the following language:

> (c) *Review of objection.* Prior to initiating a treatment procedure over the objection of a patient, such objection must be reviewed by the head of the service. The decision of the head of the service shall be communicated to the patient and his or her representative, if any, and to the Mental Health Information Service, and treatment may be initiated unless the patient or her or his representative chooses to appeal this decision to the director. The appeal procedure shall be in accordance with subdivision (e) of this section.
>
> (d) *Patient's right to representative.* Patients have the right to request that legal counsel or other concerned person represent them in the formal appeal procedures authorized in this section.
>
> (e) *Appeal.* (1) If the patient or a representative of the patient has appealed to the facility director from a decision of the head of the service with respect to an objection to treatment, the director shall consider the appeal and make a decision. The decision of the director shall be communicated to the patient and the patient's representative, if any, and to the Mental Health Information Service.
>
> (2) A patient shall also have the right to appeal to the director any decision to which he objects relating to his care and treatment at the facility.
>
> (3) In cases of facilities in the Department of Mental Hygiene, the patient may appeal from any such decision of the director to the regional director in the department. Such request for review must be filed with the director within five days, excluding Saturdays, Sundays, and holidays, after notification of the director's decision. The director of the department facility shall forthwith transmit the request to the regional director. When the regional director decides the issue, he shall notify the patient, the patient's representative, and the director of the Mental Hygiene Information Service of the decision.

Id. § 27.8, *quoted in* Rivers v. Katz, 67 N.Y.2d 485, 490-91 n.2, 495 N.E.2d 337, 339-40 n.2, 504 N.Y.S.2d 74, 77 n.2 (1986).

patient who disagreed with any treatment decision to appeal to an administrator known as the head of service.[79] If the patient disagreed with the head of service's decision, the patient could appeal to the hospital director.[80] If the director upheld the treatment decision, the patient could appeal to the regional director of the Office of Mental Health.[81]

In determining the scope of a patient's substantive right, the Second Circuit relied upon two recent Supreme Court decisions that addressed the scope of one's right to refuse medication, but the Second Circuit failed to squarely resolve the issue. In *Mills v. Rogers*,[82] the Supreme Court stated that "State law may recognize liberty interests more extensive than those independently protected by the Federal Constitution."[83] Accordingly, the Second Circuit, in *Project Release*, recognized that "it is clear" that state law can create a federally protected interest in refusing medication.[84] Having recognized that state law can create a protected liberty interest in refusing medication, the Second Circuit examined what it believed to be the relevant state law. The court recognized that title 14, section 27.8 of the NYCRR permitted a patient to refuse medication.[85] However, the court failed to note that the regulations contained no substantive standards for an administrative reviewer to apply. The court further utilized section 33.01 of the New York Mental Hygiene Law (MHL) as a guide to determine the scope of a patient's substantive right to refuse medication: "'Each patient in a facility and each person receiving services for mental disability shall receive care and treatment that is suited to his needs and skillfully, safely and humanely administered with *full respect for his dignity and personal integrity*.'"[86]

79. *Id.* § 27.8(c).
80. *Id.*
81. *Id.*
82. 457 U.S. 291 (1982).
83. *Id.* at 300.
84. Project Release v. Prevost, 722 F.2d 960, 979 (2d Cir. 1983).
85. *Id.*; *see supra* notes 78-79 and accompanying text.
86. *Project Release*, 722 F.2d at 960 (emphasis in original) (quoting N.Y. MENTAL HYG. LAW § 33.03(a) (McKinney 1988)).

The court recognized that such a state law right did not create an absolute right to refuse medication but had to be balanced against "relevant state interests."[87] Although the court failed to delineate what relevant state interests existed, it nonetheless concluded that the regulations in question satisfied due process.[88] The court's opinion remains somewhat unclear because the court reached such a conclusion prior to its analysis of the professional judgment standard.[89] However, one may assume that the court merely concluded that state law either did not create a constitutionally protected interest in refusing medication or did not set forth circumstances in which an individual could refuse drugs.[90]

After analyzing relevant state law as is required by *Mills*,[91] the Second Circuit then examined the Supreme Court's disposition of *Rennie v Klein*.[92] Like *Mills*, *Rennie* raised the issue of under what circumstances a civilly committed individual could refuse medication.[93] However, instead of focusing upon relevant state law as it did in *Mills*, the Supreme Court remanded *Rennie* in light of *Youngberg v. Romeo*.[94] In *Youngberg*, an action for

---

87. *Id.*

88. *Id.*

89. *See infra* text accompanying notes 97-101.

90. Assuming that title 14, section 27.8 of the NYCRR and section 33.01 of the MHL amounted to the relevant state law when determining whether state law created a federally protected interest in refusing medication, the court apparently reached the correct result for the wrong reasons. State law creates a federally protected interest only when it creates a "justifiable expectation" that the state will not forcibly administer medication except "upon the occurrence of . . . specified events." Vitek v. Jones, 445 U.S. 480, 489 (1980). This occurs only when state law contains language of an "unmistakenly mandatory character" which indicates clearly that the state will not forcibly medicate a patient absent "specified substantive predicates." Washington v. Harper, 110 S. Ct. 1028, 1036 (1990) (quoting Hewitt v. Helms, 459 U.S. 460, 471-72 (1983)). Neither title 14, section 27.8 of the NYCRR nor section 33.01 of the MHL, contained any such substantive predicates and hence, no law created an expectation that the state would not forcibly administer medication except under certain clearly delineated circumstances.

91. *See supra* text accompanying notes 82-83.

92. 458 U.S. 1119 (1982).

93. Rennie v. Klein, 720 F.2d 266, 267-68 (3d Cir. 1983).

94. 457 U.S. 307 (1982).

damages, the Court addressed the scope of a profoundly retarded individual's right to safety and freedom from bodily restraint.[95] Because of the need to avoid unnecessary restrictions placed upon clinical staff, the Court ruled that any decision pertaining to the safety and restraint of a mentally retarded individual is presumptively valid. Furthermore, a court may impose liability "only when 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."[96]

The Second Circuit in *Project Release v. Prevost*[97] utilized the professional judgment standard of *Youngberg* to evaluate the "standards set forth for objecting to treatment in New York State."[98] It reasoned that because title 14, section 27.8 of the NYCRR required three stages of administrative review, the regulation resulted in physicians exercising professional judgment.[99] The court concluded further that procedural due process does not require a judicial review of the decision to forcibly medicate; "informal, traditional medical investigative techniques" can satisfy due process.[100] The three levels of professional review mandated by the regulation after the initial decision by the treating physician satisfied procedural due process.[101]

Since *Youngberg* and *Project Release*, and at least prior to *Washington v. Harper*,[102] federal courts have measured a civilly committed individual's right to refuse medication by the *Youngberg* professional judgment standard.[103] Such a standard

95. *Id.* at 309.

96. *Id.* at 323 (footnote omitted).

97. 722 F.2d 960 (2d Cir. 1983).

98. *Id.* at 980.

99. *Id.* at 980-81.

100. *Id.* at 981 (quoting Parham v. J.R., 442 U.S. 584, 607 (1979)).

101. *Id.*

102. 110 S. Ct. 1028 (1990); *see infra* text accompanying notes 120-31.

103. *See* Dautremont v. Broadlawns Hosp., 827 F.2d 291, 300-01 (8th Cir. 1987) (section 1983 claim failed to prove that former psychiatric patient was denied due process since professional judgment was exercised when psychotherapeutic medication was forcibly administered); Johnson v. Silvers, 742 F.2d 823, 825 (4th Cir. 1984) (Plaintiff must establish that physician

provides virtually no protection to a patient who wishes to refuse medication. It requires a court to determine only if the clinician's decision to medicate constituted such a substantial departure from professional judgment as to amount to a decision not based upon professional judgment.[104] In other words, the clinical decision need only satisfy "professionally accepted minimum standards."[105]

Because antipsychotic medication constitutes the treatment of choice for psychoses within the psychiatric profession,[106] and lithium is the drug of choice for manic and depressive disorders,[107] proving a decision to administer these drugs was not based on professional minimal standards becomes a near impossibility when a patient carries the relevant diagnosis. Notwithstanding the debilitating nature of psychotropic drugs, particularly antipsychotic medication, a psychiatrist, in the exer-

---

required him to take antipsychotic drugs without exercising professional judgment); Rennie v. Klein, 720 F.2d 266, 269 (3rd Cir. 1983) (*en banc*) (involuntarily committed patients have a constitutional right to refuse antipsychotic drugs in accordance with the professional judgment standard); Stensvad v Reivitz, 601 F. Supp. 128, 131 (W.D. Wis. 1985) (Wisconsin's commitment statute, which does not afford involuntarily committed psychiatric patients the right to refuse medication, provides adequate due process safeguards because the administration of drugs is tested by professionally accepted standards); R.A.J. v. Miller, 590 F. Supp. 1319, 1321-22 (N.D. Tex. 1984) (although involuntarily committed patients cannot refuse treatment, their treatment decision is reviewable in accordance with the professional judgment standard).

104. *See* Society for Goodwill to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1248 (2d Cir. 1984) (residents of state-operated school for the mentally retarded have constitutional right to adequate food, shelter, clothing, and medical care; however, if restraints are placed on retarded individuals in accordance with judgment of qualified professionals, then the mental health facility has not failed to meet the constitutional due process standard).

105. Society for Goodwill to Retarded Children, Inc. v. Cuomo, 902 F.2d 1085, 1090 (2d Cir. 1990) (lower court misused expert testimony by treating it as evidence of alternate choices against which institution's treatment should be compared and, therefore, failed to determine whether treatment of state-operated facility for the mentally retarded departed from accepted professional judgment, as to support a finding of constitutional violations).

106. *See supra* notes 25-28 and accompanying text.

107. *See supra* note 64 and accompanying text.

cise of professional judgment, might well choose to ignore the risks of antipsychotic drugs.[108] Indeed, some commentators have argued that "opponents of medication dramatize their side effects, including dystonias [muscle spasms] and tardive dyskinesia [a lasting involuntary movement disorder] . . . the overwhelming preponderance of data supports a high benefit/risk ratio for these medications and a safety record commensurate with other powerful pharmacological agents."[109] Likewise, a psychiatrist may well conclude that proper monitoring can reduce the risk of the more serious forms of tardive dyskinesia.[110] Considering these circumstances, a court will nearly always conclude that a clinician's decision to administer medication does not fall below minimum professional standards.[111]

Indeed, upon scrutiny, the professional judgment standard affords absolutely no protection to individuals who wish to refuse medication. The utilization of a professional judgment standard to evaluate a decision to forcibly medicate is, at best, little more than a malpractice standard incorporated into the Federal Constitution. Upon scrutiny, however, this standard does not provide patients with even a constitutional right to remain free from treatment decisions to forcibly medicate which amount to malpractice. A malpractice standard imposes liability upon a physician only when a physician fails to possess the skill possessed by the average member of his profession, does not exercise ordinary and reasonable care in application of such skill,

---

108. *See supra* notes 50-55 and accompanying text.

109. Appelbaum & Gutheil, *supra* note 4, at 307; *see also* Baldessarini & Lipinski, *Risks of Antipsychotic Drugs Overemphasized*, 305 NEW ENG. J. MED. 588, 588 (1981).

110. *See* American Psychiatric Ass'n, TASK FORCE REPORT 18: TARDIVE DYSKINESIA, 137-53 (1980).

111. Adoption of the professional judgment standard of *Youngberg* raises another troubling issue: how can a patient establish that the decision to forcibly medicate violates the professional judgment standard? Such a question raises medical questions, and without expert testimony to controvert any explanations proffered by the treating physician, the illusory protection afforded by the *Youngberg* standard provide even less protection than originally anticipated. *See Goetz v. Crosson*, 769 F. Supp. 132, 135-37 (S.D.N.Y. 1991) (no right to independent psychiatric assistance in civil commitment proceedings).

or fails to exercise his best judgment in the application of such skill.[112]

When comparing the malpractice standard to the professional judgment standard, the Court of Appeals for the Third Circuit concluded that the professional judgment standard provides even less protection than malpractice laws.[113] The court stated that the professional judgment standard is a "substantially less onerous standard than negligence from the viewpoint of the public actor."[114] It requires a clinician only to exercise his professional judgment in choosing a course of conduct.[115] Negligence, however, requires a professional to choose "from among alternatives, a course of action consistent with the exercise of 'due care.'"[116] This requires a physician to reject negligent alternatives that might nonetheless satisfy the professional judgment standard.[117] The Third Circuit concluded that the professional judgment standard is akin to a recklessness or gross negligence standard and falls somewhere between simple negligence and intentional misconduct.[118] In sum, because antipsychotic medication remains the treatment of choice for schizophrenia or other psychoses,[119] the professional judgment standard virtually guarantees psychiatrists the opportunity to administer medication without interference from the legal system.

---

112. *E.g.*, Littlejohn v. State, 87 A.D.2d 951, 952, 451 N.Y.S.2d 225, 226 (3d Dep't 1982) (citing Pike v. Honsinger, 155 N.Y. 201, 209-10, 49 N.E. 760 (1898)) (liability denied in a medical malpractice action because the prison inmate failed to establish that state doctors did not possess the requisite knowledge and skill as is possessed by an average member of the medical profession, did not exercise ordinary and reasonable care in the application of that professional judgment, and did not use their best judgment in the application of that knowledge and skill).

113. *See* Shaw v. Strackhouse, 920 F.2d 1135, 1146 (3d Cir. 1990).

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *See supra* text accompanying notes 25-28.

B. The Supreme Court's Analysis of An Individual's Substantive Right to Refuse Medication in Washington v. Harper

In *Washington v. Harper*,[120] the Supreme Court examined the scope of an individual's substantive right to refuse medication. Although the Court granted *certiorari* to determine whether the state may involuntarily treat a mentally ill prisoner absent a judicial hearing,[121] the Court recognized that resolution of this question necessitated a determination of the "substantive rights at stake."[122] The Court, in fact, determined that its grant of *certiorari* encompassed both issues.[123]

In evaluating the protected liberty interests and the conditions under which competing state interests might outweigh them; the components of the substantive due process determination,[124] the Court recognized that state law created a protected liberty interest in refusing medication. State law creates a protected interest when it contains language of an "unmistakably mandatory character."[125] The Court noted that Washington law permitted a prison psychiatrist to forcibly medicate only if the prisoner suffered from a mental disorder and was "gravely disabled" or posed a "likelihood of serious harm" to himself or others.[126]

---

120. 110 S. Ct. 1028 (1990).

121. *Id.* at 1032.

122. *Id.* at 1036.

123. *Id.*

124. *Id.*; *see infra* notes 132-34 and accompanying text.

125. *Harper*, 110 S. Ct. at 1026 (quoting Hewitt v. Helms, 459 U.S. 460, 471-72 (1983)) (mere fact that state creates careful procedural structure to regulate use of administrative segregation does not indicate existence of protected liberty interest, but it is only when this procedural structure is clearly mandatory, and words such as "shall," "will," or "must" are used, that the state has created a protected liberty interest); *see supra* note 90.

126. *Harper*, 110 S. Ct. at 1033 n.3. The prison regulations adopted the definitions of "mental disorder," "gravely disabled," and "likelihood of serious harm" from the state's civil commitment law. *See* WASH. REV. CODE § 71.05.020 (1990). The statute defined "mental disorder" as "any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." *Id.* § 71.05.020(2). "Gravely disabled" was defined as:

> a condition in which a person, as a result of a mental disorder: (a) [i]s in

The Court found that this state law created "a justifiable expectation on the part of the inmate that the drugs will not be administered unless these conditions exist."[127]

In addition to state law, the Court found a constitutionally protected interest to exist under the due process clause of the fourteenth amendment.[128] However, the Court concluded that the Federal Constitution did not provide any greater protection to Mr. Harper than did state law.[129]

The context of a prison setting defined Mr. Harper's right to refuse medication.[130] The Court held that when scrutinizing a challenged practice in such a setting, a court must ask only if the regulation in question is "'reasonably related to legitimate penological interests.'"[131] Such determination required an evaluation of three factors. First, did a rational connection exist between the prison regulation and the governmental interest which the regulation served?[132] Second, how will accommodation of the constitutional right impact upon others within the prison setting and on the allocation of resources?[133] Finally, does the absence of ready

---

> danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

Id. § 71.05.020(1). The regulations defined "[l]ikelihood of serious harm" as:

> (a) [a] substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

Id. § 71.05.020(3).

127. *Harper*, 110 S. Ct. at 1036.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.* at 1037 (quoting Turner v. Safley, 482 U.S. 78, 89 (1987)).

132. *Id.* at 1038.

133. *Id.*

alternatives evince the reasonableness of the prison regulations?[134]

The Court found that the forcible administration of medication satisfied the very important government interest of maintaining prison safety and providing treatment that will further the prisoner's medical interests and effectuate a safe prison environment.[135] The challenged policy served as a rational way of furthering these state objectives.[136] The Court reasoned that little dispute exists within the psychiatric profession that antipsychotic drugs constitute one of the most effective ways of treating and controlling mental illness likely to cause violent behavior, and that the regulations permit a psychiatrist to administer such medication for treatment purposes only.[137]

Furthermore, although the prisoner in *Harper* was never found incompetent, the Court concluded that despite the absence of a finding of incompetence, a constitutional right to refuse all medication could not be successfully asserted.[138] The Court reasoned that a contrary holding would ignore the legitimate state interest in treatment for the purpose of reducing an inmate's dangerousness.[139] Additionally, the prisoner in *Harper* failed to establish that the use of seclusion and restraint served as effective substitutes for the administration of antipsychotic medication.[140] The Court reasoned that those methods pose a risk of injury to staff who promulgate such measures and place a toll on limited prison resources.[141]

The impact of *Harper* remains to be seen. The Court's analysis of a patient's right to refuse medication under the due process clause of the fourteenth amendment focused upon the right in the context of a prison setting.[142] Hence, this portion of *Harper* may

134. *Id.*
135. *Id.* at 1038-39.
136. *Id.* at 1037.
137. *Id.* at 1039.
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.* at 1036.

have limited impact upon a civilly committed individual's right to refuse drugs. However, *Harper* reaffirms the notion of *Mills v. Rogers*,[143] which holds that state law can serve as a source of an individual's interest in refusing medication.[144] Accordingly, when scrutinizing a civil patient's right to refuse medication under the Federal Constitution, *Harper* requires a court to scrutinize state law prior to adopting the professional judgment standard.

C. *Procedural Protection Under the Federal Constitution Afforded to Mentally Ill Individuals Who Wish to Refuse Antipsychotic Medication*

As a result of Washington v. Harper it is now well-settled that the United States Constitution does not require a judge to approve a decision to forcibly administer medication.[145] Rather, it may well be that the due process clause requires only a decision-making process which results in a clinician exercising professional judgment.[146] This portion of the Court's decision in *Harper* is consistent with other decisions interpreting the procedural protection imposed by the fourteenth amendment.[147]

Before *Harper*, the two courts, other than the Second Circuit in *Project Release v. Prevost*, that addressed the issue of the procedural requirements due prior to any forced drugging of a civil patient, determined that any sort of administrative scheme that reviewed a clinician's decision to medicate satisfied due process. Prior to the Supreme Court's remand, in *Rennie v Klein*,[148] the Third Circuit scrutinized an administrative scheme that provided for an internal review of a psychiatrist's decision to administer

143. 457 U.S. 291 (1982); *see supra* text accompanying notes 82-83.

144. *Harper*, 110 S. Ct. at 1036.

145. *Id.* at 1042.

146. *See* United States v. Charters, 863 F.2d 302, 306-09 (4th Cir. 1988) (*en banc*) (decision to administer medication by clinician constitutes base-line decision, and due process is satisfied provided clinician exercises professional judgment), *cert. denied*, 110 S. Ct. 1317 (1990).

147. *See infra* notes 148-79 and accompanying text.

148. 653 F.2d 836 (3d Cir. 1981) (*en banc*); *see supra* text accompanying notes 92-94.

medication over objection.[149] The review required the patient's treatment team to evaluate any decisions to medicate.[150] If, after such review, an impasse still existed, the procedures required the medical director of the hospital, or a designee, to examine the patient and review his hospital record.[151] If the director agreed with the physician's decision, the facility could forcibly administer the medication.[152]

In determining whether such procedures comported with the fourteenth amendment, the court applied the criteria enunciated in *Mathews v. Eldridge*.[153] *Mathews* required the Third Circuit, in *Rennie*, to scrutinize (1) the private interest involved, (2) the risk of an erroneous decision as a result of the present procedures and the value of any additional or substitute procedural safeguards, and (3) the governmental interest implicated by the proposed additional procedures, including any fiscal or administrative burdens that other procedural requirements would impose.[154]

In its opinion, the *Rennie* court recognized that a patient retains "'a residuum of liberty'"[155] and "correspondingly retains the right to be free from 'unjustified intrusions on [his] personal security.'"[156] The court found that the record below detailed

149. *Rennie*, 653 F.2d at 848-49 (citing New Jersey Division Of Mental Health And Hospitals Administrative Bulletin 78-3).

150. *Id.*

151. *Id.*

152. *Id.* at 848-49.

153. *Id.* at 848; *see* Mathews v. Eldridge, 424 U.S. 319 (1976). In *Mathews*, the Supreme Court examined the issue of whether due process requires the provision of an evidentiary hearing prior to the termination of social security disability benefits. *Mathews*, 424 U.S. at 322. The Court examined prior holdings that focused on the due process questions and concluded that due process requires application of the three distinct criteria detailed above. *Id.* at 335. *Mathews* has evolved into the seminal due process case with the Supreme Court relying upon its criteria whenever a procedural due process question has arisen. *See, e.g.*, Ake v. Oklahoma, 470 U.S. 68, 77 (1985) (provisions of psychiatric assistance to criminal defendant who raises the insanity defense); Little v. Streater, 452 U.S. 1, 6 (1981) (blood grouping tests provided to party in a paternity action).

154. *Rennie*, 653 F.2d at 848 (citing *Mathews*, 424 U.S. at 335).

155. *Id.* at 845 (quoting Vitek v. Jones, 445 U.S. 480, 491 (1980)).

156. *Id.* (quoting Ingraham v. Wright, 430 U.S. 651, 673 (1977)).

"dramatically"[157] how the forcible administration of antipsychotic medication impinged upon a patient's liberty interest.[158] The court noted that the plaintiffs suffered from akinesia, akathisia, and most significantly, tardive dyskinesia.[159] In addition, the court recognized that antipsychotic drugs also posed risks of a variety of minor physical effects such as blurred vision, dry mouth, constipation or diarrhea, skin rashes, faintness, and fatigue.[160]

However, the court concluded that the administrative procedures at issue posed only a "minor risk of erroneous deprivation,"[161] and the additional procedural protection imposed by the district court would not significantly reduce the risk involved.[162] The court reasoned that hospital staff spend more time with a patient than would an independent psychiatrist, and the "weeks or months"[163] of staff-patient contact provide a reliable basis for any decision to medicate.[164] The court relied upon the Supreme Court's decision in *Parham v. J.R.*,[165] which held that "informal

157. *Id.* at 843.

158. *Id.*

159. *Id.* at 843-44.

160. *Id.*

161. *Id.* at 850.

162. *Id.* The district court previously ordered defendants to hold hearings to determine whether the hospital could forcibly administer medication, appoint a 'patient advocate' to represent patients at the hearing, and hire independent psychiatrists to serve as the decision-maker at the hearings. *Id.* at 840.

163. *Id.* at 850.

164. *Id.*

165. 442 U.S. 584 (1979). In *Parham*, the Supreme Court examined the issue of what procedures the due process clause required when a parent or guardian sought to hospitalize a child for mental illness. *Id.* at 607. In holding that the due process clause does not require an adversarial hearing under these circumstances, the Court applied the criteria in Mathews v. Eldridge. *Id.; see supra* text accompanying notes 153-54. The Court held that the child possessed a protected interest in avoiding erroneous incarceration, but the parents possessed an interest in maintaining parental authority. *Parham*, 442 U.S. at 600-03. The state possesses an interest in avoiding the provisions of unnecessary obstacles that discourage the mentally ill or their families from seeking treatment. *Id.* at 605. The state also has a genuine interest in allocating its resources to treatment and avoiding "time consuming procedural minuets before the admission." *Id.* The Court further found that a formal adversarial

traditional medical investigative techniques"[166] do not violate due process.[167]

Finally, the Third Circuit examined the governmental interest in avoiding fiscal and administrative burdens imposed by requiring independent decision-makers. The court concluded that the requirements imposed by the district court would place a substantial financial burden on the state and require undue expenditures of staff time.[168] In addition, the court reasoned that an adversarial atmosphere would create stress rather than facilitate successful long-range treatment.[169] These concerns, together with the other *Mathews* factors involved, required a determination that the administrative procedures utilized by New Jersey satisfied due process.[170]

After the Supreme Court remanded *Rennie* in light of *Youngberg v. Romeo*,[171] an *en banc* panel again examined the procedures in question.[172] In an otherwise fragmented decision, eight of the nine judges concluded that the "professional judgment" standard of *Youngberg* controlled.[173] Although the *Youngberg* standard defines a patient's substantive legal rights, the judges concluded that utilization of the administrative regulations in question required hospital staff to exercise professional judgment whenever it decided to forcibly administer medication.[174]

---

hearing would not enhance the accuracy of the fact-finding procedure. *Id.* at 606-07. The Court concluded that under these circumstances, an informal examination conducted by a hospital physician does not violate due process. *Id.*

166. *Parham*, 442 U.S. at 607.

167. *Rennie*, 653 F.2d 836, 850 (3d Cir. 1981) (*en banc*).

168. *Id.* at 851.

169. *Id.*

170. *Id.*

171. *See supra* text accompanying notes 92-94.

172. Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983).

173. *Id.* at 269-70, 272. The primary disagreement among the judges consisted of whether due process required hospital staff to employ a "least intrusive means" test when deciding whether to forcibly administer medication. *Id.*

174. *Id.* at 270-71, 274, 277.

In addition to the courts in *Project Release v. Prevost* and *Rennie*, one additional federal court has examined the issue of what procedures a state must follow prior to forcibly administering medication to a civil patient.[175] In *R.A.J. v. Miller*, the court permitted forced drugging in the absence of a judicial determination that the patient lacked the capacity to make treatment decisions or otherwise satisfied any substantive criteria for forced drugging.[176] The court held that an administrative procedure that required a hospital clinical director to review the decisions of the treating physician satisfied due process.[177] The procedure required an additional review from a consulting psychiatrist if the clinical director determined that the patient understood the consequences of objecting to his proposed treatment.[178] The court held that conformity with such procedures resulted in the exercise of professional judgment, and that due process permits the forcible administration of antipsychotic medication in the absence of a judicial determination of incompetence.[179] If these cases left any doubt that the Federal Constitution does not require a judicial determination of incompetence and, in the absence of relevant state law, places substantial discretion within the hands of treating physicians to administer medication, the Supreme Court's decision in *Washington v. Harper*[180] answered this question with reasonable certainty.

In *Harper*, the prison regulations authorized a prison psychiatrist to determine whether to administer medication.[181] If the inmate refused the medication, the prison was required to convene a hearing before a special committee consisting of a psychiatrist, a psychologist, and the associate superintendent of the prison, none of whom could be involved with the patient's treatment or diagnosis.[182]

---

175. R.A.J. v. Miller, 590 F. Supp. 1319, 1322-25 (N.D. Tex. 1984).
176. *Id.* at 1322, 1325.
177. *Id.* at 1322-25.
178. *Id.* at 1326.
179. *Id.* at 1322-23.
180. 110 S. Ct. 1028 (1990).
181. *Id.* at 1033.
182. *Id.*

The regulations provided certain minimal procedural protection. They required the prison to provide the inmate with twenty-four hours notice of the hearing, and the regulations prohibited the prison from forcibly administering medication during this period.[183] The regulations further required the prison staff to provide the inmate with his tentative diagnosis, the factual basis for such diagnosis, and why staff believed medication was necessary.[184] The prisoner had the right to attend the hearing, present evidence, including witnesses, and cross-examine adverse witnesses.[185] A lay advocate, who was not involved with the inmate's care; and who understood psychiatric issues, assisted him.[186] The regulations also required the prison to take minutes and provide a copy of the minutes to the prisoner.[187] If the inmate disagreed with the committee's determination, he could appeal the decision to the prison superintendent whom the regulations required to resolve the appeal within twenty-four hours.[188] The inmate could seek judicial review of any committee determination.[189]

The regulation also required periodic review of any committee decision.[190] Prison staff could medicate for fourteen days after the initial hearing. The regulation permitted medication for an additional 180 days after approval by the same committee who reviewed the initial determination. After expiration of this latter time period, the law required an additional review.[191]

Prior to the hearing to examine the decision to medicate Mr. Harper, prison staff met with the review committee on an *ex parte* basis.[192] The committee then conducted a hearing, and a nurse practitioner from another facility assisted the prisoner.[193]

183. *Id.*
184. *Id.*
185. *Id.*
186. *Id.* at 1033-34.
187. *Id.* at 1034.
188. *Id.*
189. *Id.*
190. *Id.*
191. *Id.* n.4.
192. *Id.* at 1034.
193. *Id.*

The committee determined that the inmate posed a danger to others as a result of mental disease or disorder and approved the forcible administration of antipsychotic medication.[194]

Once the Court determined the boundaries of Mr. Harper's right to refuse medication, it focused upon what procedures the Federal Constitution required the state to adhere to when reaching a decision as to whether to forcibly medicate. In determining what process the fourteenth amendment conferred, the Court focused upon the criteria enunciated in *Mathews v. Eldridge.*[195]

The Court described a prisoner's interest in refusing antipsychotic medication as "not insubstantial."[196] The Court recognized that the purpose of the drugs is to alter the brain's chemical balance, and that the drugs produce numerous debilitating side-effects including acute dystonia, akathesia, neuroleptic malignant syndrome, and tardive dyskinesia.[197]

Nevertheless, the Court concluded that the challenged procedures adequately protected the prisoner's interest in avoiding unwarranted medication and, perhaps, provided better protection than a judicial hearing.[198] The Court reasoned that because drug refusers frequently change their minds, a judge, whom the prisoner sought to serve as the ultimate decision-maker, often lacks the capacity to adequately assess the individual's intentions.[199] In addition, the Court found no reason why an untrained judge could make a better decision than a specialist, and that a judicial

---

194. *Id.*

195. *Id.* at 1041. The criteria include the private interest at stake, the governmental interest, including avoiding any administrative and procedural burden, and the value of additional or substitute procedural safeguards. *See* Mathews v. Eldridge, 424 U.S. 319, 335 (1976); *supra* text accompanying notes 153-54.

196. *Harper,* 110 S. Ct. at 1028.

197. *Id.*

198. *Id.* at 1042.

199. *Id.* One must question the Court's focus upon a patient's intentions to determine the adequacy of additional procedural safeguards. At the time of refusal, the individual's intentions are clear, otherwise the government would not seek to override the patient's decision. The role of the decision-maker is to determine whether or not circumstances exist under which the state may override the patient's expressed intentions.

hearing would divert both the financial and personnel resources of the prison.[200]

The Court noted still other factors in concluding that the available procedures provided adequate process to the prisoner.[201] It found that the decision-making committee did not lack adequate independence since none of the committee members participated in the inmate's treatment or diagnosis, and, in the absence of factual findings, there was no reason to believe institutional bias affected the committee's decision.[202] The Court also noted that the regulations provided the prisoner with notice and the right to cross-examine witnesses, which enabled him to meaningfully challenge the decision to forcibly medicate.[203]

Finally, the Court believed that neither the absence of a clear and convincing evidentiary standard, nor the absence of counsel violated due process.[204] The Court reasoned that such a standard "is neither required nor helpful" when medical personnel make the kind of judgments that the regulations require.[205] Similarly, the Court concluded that little reason existed as to why due process required counsel, finding that the provision of an independent lay advisor who understands psychiatric issues does not violate due process.[206]

III. THE RIGHT TO REFUSE MEDICATION UNDER THE NEW YORK STATE CONSTITUTION

Rivers v. Katz[207] provided New York courts with an opportunity to evaluate the right of a mentally ill individual to refuse

---

200. *Id.* at 1042-43.
201. *Id.* at 1043-44.
202. *Id.* at 1043.
203. *Id.* at 1044.
204. *Id.*
205. *Id.*
206. *Id.* In debunking the necessity of counsel, the Court opined that "'[i]t is less than crystal clear why *lawyers* must be available to identify possible errors in medical judgment.'" *Id.* at 1044 (quoting Walters v. National Ass'n of Radiation Survivors, 473 U.S. 305, 330 (1985) (emphasis in original)).
207. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

medication under state law. In *Rivers*, three patients involuntarily hospitalized at Harlem Valley Psychiatric Center sought to enjoin the forcible administration of antipsychotic medication.[208] One of the patients also sought to refuse lithium.[209] The patients in the initial action were found to be "in need of involuntary care and treatment," which meant, *inter alia*, that their judgment was so impaired that they were unable to understand the need for inpatient care and treatment that was essential to their welfare.[210] All three patients then objected, pursuant to title 14, section 27.8 of the NYCRR,[211] to their proposed treatment regimen.[212] The administrative decision-maker overruled the patients' objection to treatment, and the individuals petitioned the court for relief.[213]

The trial court rejected the patients' applications to refuse medication. The court reasoned that because these individuals were in need of involuntary hospitalization, the findings necessarily resulted in a determination that the patients lacked the ability to make a competent treatment decision.[214] The Supreme Court, Appellate Division, Second Department, affirmed on the grounds provided by the lower court.[215] However, the court of appeals reversed holding that "the due process clause of the New

208. *Id.* at 490-91, 495 N.E.2d at 339-40, 504 N.Y.S.2d at 76-77. *Rivers* was a declaratory judgment proceeding commenced by two of the patients. *Id.* at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77. The third individual commenced a proceeding pursuant to the Civil Practice Law and Rules article 78. *Id.* at 492, 495 N.E.2d at 340, 504 N.Y.S.2d at 77. The appellate division consolidated both cases. *Id.*

209. *Id.* at 491, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

210. *Id.* at 490, 495 N.E.2d at 339, 504 N.Y.S.2d at 76; *see supra* note 2. Such findings necessarily contained a determination that in the absence of involuntary hospitalization, the patients posed a substantial threat of physical harm to themselves or others. *See* cases cited *supra* note 9.

211. *See supra* note 77-78.

212. *Id.* at 490-92, 495 N.E.2d at 339-41, 504 N.Y.S.2d at 76-78. For a detailed description of the administrative procedures pursuant to which defendants medicated the patients, see *supra* note 78.

213. *Rivers*, 67 N.Y.2d at 490-92, 495 N.E.2d at 339-41, 504 N.Y.S.2d at 76-78.

214. *Id.* at 491-92, 495 N.E.2d at 340, 504 N.Y.S.2d at 77.

215. Rivers v. Katz, 112 A.D.2d 926, 491 N.Y.S.2d 1011 (2d Dep't 1985), *rev'd*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

York State Constitution (art. 1, section 6) affords involuntarily committed mental patients a fundamental right to refuse antipsychotic medication."[216]

The New York Court of Appeals found that New York common law provided the patients with a right to refuse medication as "every individual 'of adult years and sound mind has a right to determine what shall be done with his own body'"[217] and "'control the course of his medical treatment.'"[218] The court carefully detailed the need to extend this common law right to individuals suffering from mental illness, concluding that the state may not treat them "as persons of lesser status or dignity because of their illness,"[219] and stating: "'[I]f the law recognizes the right of an individual to make decisions about . . . life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill.'"[220] Not only does common law protect a mentally ill individual, but the "fundamental common-law right is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution."[221]

The court did not grant the individuals an absolute right to refuse medication. A compelling state interest will override such right.[222] However, only when a patient is presently creating a danger to himself, or others within the institution, does the state have a compelling interest that overrides a competent patient's refusal. Furthermore, the state may justify the forced administration of medication on a temporary basis only for as long as the emergency exists.[223] The court specifically rejected the assertion

---

216. *Rivers*, 67 N.Y.2d at 492, 495 N.E.2d at 340-41, 504 N.Y.S.2d at 78.

217. *Id.* (quoting Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) (Cardozo, J.).

218. *Id.* (citing *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)).

219. *Id.* at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78 (citing Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)).

220. *Id.* (quoting *In re* K.K.B., 609 P.2d 747, 752 (Okla. 1980)).

221. *Id.* at 493, 495 N.E.2d at 343, 504 N.Y.S.2d at 78.

222. *Id.* at 495, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

223. *Id.* at 495-96, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

that other state interests will override a patient's interest in determining the course of his own treatment. In fact, the court held that whether considered individually or collectively, the state's interests in providing a therapeutic environment, in conserving staff resources, facilitating the process of deinstitutionalization, and maintaining the ethical integrity of the medical profession, do not outweigh the patient's fundamental right.[224]

Absent an emergency or other temporary dangerous situation, only a determination that the patient lacks the capacity to make a reasoned treatment decision justifies the overriding of a patient's interest in determining his own course of treatment.[225] However, the previous findings that the patients' judgments were so impaired that they did not understand that in-patient care and treatment was essential to their welfare did not serve as a sufficient basis to conclude they lacked the capacity to make treatment decisions.[226] The court reasoned that mental illness frequently impairs functioning on a limited basis, leaving other areas unimpaired, and many mentally ill individuals are able to function in a competent manner.[227]

By concluding that a determination that (1) a person is in need of in-patient care and treatment essential to his welfare and (2) the patient is unable to understand the need for in-patient care and treatment does not constitute a determination of incompetence, the court of appeals corrected a significant error committed by the courts below in which they ignored the "profound distinction"[228] between commitment and incompetence.[229] A determination that a patient lacks the ability to understand the need for care and treatment deemed essential to his welfare means only that a doctor or legal fact-finder has determined that the individual did not understand the utility of in-patient care and treatment

224. *Id.* at 495 n.6, 495 N.E.2d at 343 n.6, 504 N.Y.S.2d at 80 n.6.

225. *Id.* at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

226. *Id.* at 493-94, 495 N.E.2d at 341-42, 504 N.Y.S.2d at 78-79.

227. *Id.* at 494, 495 N.E.2d at 342, 504 N.Y.S.2d at 79.

228. Boyd v. Board of Registrars of Voters of Belchertown, 368 Mass. 631, 633, 334 N.E.2d 629, 632 (1975).

229. *Rivers*, 67 N.Y.2d at 493-94, 495 N.E.2d at 341-42, 504 N.Y.S.2d at 78-79.

at the time of hospitalization. In other words, because the patient rejects the option of in-patient treatment, such individual does not understand that in-patient treatment is more important to him than the loss of liberty from which he suffers as a result of commitment.

However, whether or not care and treatment "is essential" to one's welfare is simply a value judgment rendered by a physician at the time of admission and by a judge at the conclusion of a retention proceeding. For instance, one judge may conclude that treatment will raise one's standard of living, constituting treatment that is essential to welfare; another fact-finder may disagree.

Consequently, a hearing to determine whether or not an individual is in need of involuntary care and treatment focuses on criteria different from what a fact-finder must address when assessing competence. The latter focuses upon whether or not a patient is so lacking in his mental faculties that he lacks the ability to comprehend the nature of the proposed treatment.[230] In other words, a competence determination focuses upon whether or not an individual can adequately understand and appreciate the nature and consequences of the proposed treatment.[231] A patient found to require "involuntary care and treatment" who wishes to refuse medication might have rational reasons for both. For instance, he may contest any attempts to hospitalize him because he does not want to risk losing his present living arrangement. Furthermore, he may choose liberty instead of living behind locked doors on a ward full of dangerous individuals. Nor may he want to utilize what may amount to limited resources, such as a social security check, to pay for hospitalization.[232] Once hospitalized, a patient may merely disagree with the dosage or the particular drug prescribed. When one recognizes that psychiatrists in public

---

230. *See* Aldrich v. Bailey, 132 N.Y. 85, 87-88, 30 N.E. 264, 265 (1892).

231. *See* N.Y. MENTAL HYG. LAW § 80.03(c) (McKinney 1988).

232. *See Id.* §§ 43.01-.11 (Commissioner of Mental Health permitted to assess care and treatment charges); Kriegbaum v. Katz, 909 F.2d 70, 74 (2d Cir. 1990) (state permitted to bill against social security benefits to satisfy care and treatment charges).

psychiatric hospitals frequently err when diagnosing patients,[233] even in the absence of any side effects, a patient may have good reason to refuse the proposed treatment. Furthermore, the fear of side effects may well result in a patient refusing medications,[234] but the prescribing psychiatrist may well minimize or ignore such problems when deciding to administer the treatment.[235] Under such circumstances, the decision to refuse medication may well be reasoned. Thus, a decision that a patient requires involuntary care and treatment does not amount to a determination that such individual lacks the ability to make a reasoned decision to reject medication. One commentator has noted that:

> [a]t issue in deciding whether to respect a person's hospitalization and treatment refusal is his decision making competence, that is, the person's ability, within reasonable, culturally determined limits, to attend to and weigh data relevant to the decision whether to accept or reject hospitalization and treatment. This type of determination focuses on the person's ability to perform the *process of deciding* rather than on the final decision. Focusing on this process avoids the logical fallacy of assuming that because a decision seems inexplicable, disturbing, or irrational in a given instance or series of instances, it must be true that the decisionmaker is incapable of rational decisionmaking.[236]

Accordingly, the court of appeals recognized that despite mental illness, many individuals retain the capacity to make knowledgeable decisions about medication. Simply because a

233. Gelman, *supra* note 37, at 1755; Brooks, *supra* note 24, at 352 n.42.

234. *See supra* text accompanying notes 32-72.

235. *See supra* text accompanying notes 54-55.

236. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 632-33 (1978) (emphasis added) [hereinafter Morse]. Mental health laws that permit forced treatment on the basis of a determination of the need for care and treatment are premised upon the syllogism that since a patient needs treatment and has not obtained it, the decision not to seek treatment is wrong and indicates that the individual is incompetent. The decision-making capacity of a person deemed incompetent under this standard is not necessarily awry. *See also* Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatments*, 134 AM. J. PSYCHIATRY 279, 281 (1977).

patient disagrees with a psychiatrist's judgment about the benefit of medication does not mean that such a decision is an incompetent one.[237]

Furthermore, by equating a finding of the need for involuntary care and treatment to a finding of incompetence, the lower courts violated the most basic tenets of due process, as set forth in *Cole v. Arkansas*.[238] New York law states unequivocally that:

> No order or determination . . . that a person is in need of involuntary care and treatment or that there was need for retention of such person shall be construed or deemed to be a determination or finding that such person is incompetent or is unable adequately to conduct his personal or business affairs.[239]

Hence, New York law notifies a patient that his decision-making capacity is not an issue in a retention proceeding.[240] Accordingly, because the administration of antipsychotic medication implicates a constitutionally protected liberty interest that requires due process protection,[241] the state may not piggyback a finding of incompetence upon a finding that an individual requires involuntary care and treatment.

In *Cole*, the state charged and convicted three defendants of violating section 2 of an Arkansas statute that prohibited unlawful assemblage at a labor dispute.[242] The defendants appealed, asserting, *inter alia*, that the evidence was insufficient to support their convictions.[243] Instead of addressing the defendants' contentions, the state supreme court recognized that the defendants were charged with the use of violence, and section 1 of the same statute under which the defendants were convicted prohibited

237. Rivers v. Katz, 67 N.Y.2d 485, 495, 495 N.E.2d 337, 342, 504 N.Y.S.2d 74, 79 (1986).

238. 333 U.S. 196 (1948); *see infra* text accompanying notes 242-47.

239. N.Y. MENTAL HYG. LAW § 29.03 (McKinney 1988).

240. Little question exists that if the state wished to challenge a patient's competence, due process requires the state to provide adequate notice. *See* Chaloner v. Sherman, 242 U.S. 455, 461 (1917); Dale v. Hahn, 486 F.2d 76, 78-79 (2d Cir. 1973), *cert. denied*, 419 U.S. 826 (1974).

241. Washington v. Harper, 110 S.Ct. 1028, 1036 (1990).

242. *Cole*, 333 U.S. at 197-98.

243. *Id.* at 197.

such violence.[244] Under these circumstances, the court affirmed the convictions "without invoking any parts of § 2 of the Act."[245] In other words, the court affirmed the convictions as though the state had tried defendants for violating section 1, an offense for which they were neither tried nor convicted.[246]

The United States Supreme Court overturned the convictions holding that due process required notice of the specific charges and an opportunity to contest the issues raised by that charge:

> If, as the State Supreme Court held, petitioners were charged with a violation of § 1, it is doubtful both that the information fairly informed them of that charge and that they sought to defend themselves against such a charge; it is certain that they were not tried for or found guilty of it. It is as much a violation of due process to send an accused to prison following conviction of a charge on which he was never tried as it would be to convict him upon a charge that was never made.[247]

Consequently, if the Supreme Court prohibited the State of Arkansas from convicting defendants of crimes for which they were not charged, New York could not then equate the need for involuntary care and treatment with a finding of incompetence.

Accordingly, the New York Court of Appeals held that if the state wishes to establish that a patient lacks the capacity to make a treatment decision, it must obtain this finding in court,[248] as "[s]uch a determination is uniquely a judicial, not a medical function."[249] Furthermore, the state must prove a patient's incompetence by "clear and convincing evidence,"[250] and at the hearing, the state must provide the patient with counsel.[251]

Additionally, the state may not automatically forcibly medicate a patient upon a finding of incompetence. If a court determines a

244. *Id.* at 200-01.

245. *Id.* at 200.

246. *Id.* at 201.

247. *Id.* (citing De Jonge v. Oregon, 299 U.S. 353, 362 (1937)).

248. Rivers v. Katz, 67 N.Y.2d 485, 497, 495 N.E.2d 337, 343-44, 504 N.Y.S.2d 74, 81 (1986).

249. *Id.* at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

250. *Id.* at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

251. *Id.*

patient to be incompetent, it must further determine that "the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest."[252] Such a determination requires scrutiny of the patient's best interest, the side effects associated with the treatment, and any less intrusive treatments.[253]

IV. CONTRASTING THE RIGHT TO REFUSE MEDICATION UNDER THE FEDERAL AND THE STATE CONSTITUTIONS

The contrasting decisions of *Rivers*, on one side, and *Project Release v. Prevost*[254] and *Washington v. Harper*,[255] on the other, serve to highlight the differences in approach taken by the New York courts and the federal courts. In *Rivers*, both common law and the state constitution served as a basis for a patient's right to refuse. By utilizing common law as a basis for its decision, the court of appeals required the finder of fact to focus upon the patient: did the patient possess the capacity to refuse medication? By utilizing incompetence as a threshold which the state must prove in order to have the ability to override a patient's refusal, the court of appeals signaled that it viewed the issue of refusal as legal.[256] Once it recognized that competence amounted to a determination that "is uniquely a judicial, not a medical function,"[257] the court, although it eschewed any authority, had substantial basis to impose a clear and convincing standard upon the state.[258] Unlike the Supreme Court in *Washington v. Harper*,[259]

252. *Id.*

253. *Id.* at 497-98, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

254. 722 F.2d 960 (2d Cir. 1983); *see supra* text accompanying notes 75-90.

255. 110 S. Ct. 1036 (1990); *see supra* text accompanying notes 120-44.

256. MHL article 78 sets forth the procedures for declaring a citizen incompetent. N.Y. MENTAL HYG. LAW §§ 78.01-.31 (McKinney 1988). Section 78.01 confers jurisdiction upon state supreme court to determine this issue. *Id.* § 78.01. Hence, while such a determination may require expert medical testimony, by definition, it constitutes a legal determination.

257. *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80.

258. *See* Addington v. Texas, 441 U.S. 418, 427 (1979) (clear and

the New York Court of Appeals found that the right to counsel attaches at a medication hearing.[260]

The Court in *Harper* rejected the notion that in non-emergency situations the issue of competence defines the boundaries of an individual's right to refuse.[261] Rather, the Court concluded that the state possessed an interest in maintaining institutional order and safety, and as long as the decision to forcibly medicate was reasonably related to such interest, the fourteenth amendment does not prohibit forced drugging.[262] Although the Supreme Court found that, pursuant to the fourteenth amendment, a prisoner possesses a protected liberty interest in refusing medication,[263] the Court held that the state's prison regulations adequately protected that interest.[264] Under the regulations, the decision to forcibly medicate an inmate required a determination of two medical questions: did the prisoner suffer from mental illness, and if so, did the prisoner, as a result of the illness, pose a danger to himself, others, or property?[265] Because the prison regulations addressed medical determinations, the Court held that a clear and convincing evidentiary standard was neither "required nor helpful."[266] Similarly, the Court held, reasoning in a rather

---

convincing standard of proof required in a commitment hearing because, *inter alia*, "[t]he individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state").

259. *Harper*, 110 S. Ct. at 1044; *see supra* text accompanying notes 204-06.

260. *Rivers*, 67 N.Y.2d at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81. The court of appeals apparently based its conclusion on the fact that counsel attaches not on constitutional law, but rather state statutory law. *Id.* The court cited as authority Judiciary Law section 35(1)(a) which authorizes, *inter alia*, assignment of counsel in habeas corpus proceedings of an individual alleged to suffer from mental illness and confined to a state institution, or in civil proceedings to commit or transfer a person to a state institution. *Id.* (citing N.Y. JUD. LAW § 35(1)(a) (McKinney 1990)).

261. *Harper*, 110 S. Ct. at 1037.

262. *Id.* at 1037-38.

263. *Id.* at 1036.

264. *Id.* at 1042-43.

265. *Id.* at 1042.

266. *Id.* at 1044.

conclusive fashion, that the fourteenth amendment did not require counsel.[267]

Like the Supreme Court in *Harper*, the Second Circuit in *Project Release v. Prevost*[268] also adopted a deferential standard to clinicians, concluding that a physician can forcibly medicate as long as such decision satisfied minimally accepted professional standards.[269] By holding that the procedures in question satisfied due process, the court correctly recognized that the United States Constitution does not require a court to approve the forcible administration of medication.[270] The regulations at issue in *Project Release* authorized the use of counsel.[271] Hence, the case did not require the court to resolve this issue. It also did not address the issue of burden of proof. However, because the court upheld the regulations in question, the court implicitly found that due process does not impose such a standard.

To the extent that laws define societal norms and moral precepts,[272] decisions by the New York State Court of Appeals, United States Supreme Court, and the Court of Appeals for the Second Circuit, reflect societal values. Accordingly, to the extent that these courts either broadly or narrowly define a patient's substantive right to refuse medication, or provide or withhold substantial procedural protection, the decisions by these courts reflect a societal interest in defining the scope of individual autonomy provided to mentally ill individuals. These decisions also reflect a societal recognition in providing sufficient protection in order to ensure that the state does not erroneously override a patient's interest in refusing medication while, at the same time, minimizing the administrative and fiscal obstacles to the state in

267. *Id.* ("the provision of an independent lay advisor who understands the psychiatric issues involved is sufficient protection").

268. 722 F.2d 960, 980 (2d Cir. 1983).

269. *Id.* at 980.

270. *Id.* at 981.

271. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8(d) (1962); *supra* note 78.

272. *See, e.g.*, Fiss, *The Supreme Court, 1978 Term-Forward: The Forms of Justice*, 93 HARV. L. REV. 1, 29-30 (1979) (function of a judge is "to give proper meaning to our public values").

its attempt to further a legitimate state interest.[273]

In determining the scope of an individual's substantive right to refuse medication, a court must balance "'the liberty of the individual' and 'the demands of an organized society.'"[274] This requires a court to weigh "the individual's interest in liberty against the State's asserted reasons for restraining individual liberty."[275] Hence, by concluding that (1) all hospitalized patients are presumed competent and (2) not only does state common and statutory law afford patients a right to refuse medication,[276] but so does the state constitution, the New York Court of Appeals merely holds that an individual's interest in determining his own course of treatment, which includes the right to reject drugs that may produce debilitating side effects, outweighs the state interest in providing treatment that a professional deems necessary or appropriate. On the other hand, by adopting the professional judgment standard in *Project Release*,[277] or the reasonably related to penological objectives standard in *Harper*,[278] the federal courts subscribe to doctrines that render irrelevant the decision-making capacity of the individual. Instead, such standards require the patient to prove the inappropriateness of the decision to medicate.

The decision in *Rivers* is the far wiser approach. Both state and federal courts have recognized that the state interest in providing necessary medical treatment does not, in the absence of dangerousness, outweigh a patient's interest in physical liberty under the fourteenth amendment.[279] Furthermore, the fourteenth amend-

273. *See* Mathews v. Eldridge, 424 U.S. 319, 334-35 (1976); *see supra* note 153.

274. Youngberg v. Romeo, 457 U.S. 307, 320 (1982) (quoting Poe v. Ullman, 367 U.S. 497, 522 (1961) (Harlan, J., dissenting)).

275. *Id.*

276. *See* N.Y. MENTAL HYG. LAW § 33.01 (McKinney 1988) (stating that no person shall forfeit any civil right solely because he receives services for mental disability), *cited with approval in*, Rivers v. Katz, 67 N.Y.2d 485, 494, 495 N.E.2d 337, 342, 504 N.Y.S.2d 74, 79 (1986).

277. Project Release v. Prevost, 722 F.2d 960, 980 (2d Cir. 1983); *see supra* notes 268-69 and accompanying text.

278. *Harper*, 110 S. Ct. at 1036; *see supra* text accompanying notes 130-41.

279. *See* Jones v. United States, 463 U.S. 354, 368 (1983) ("committed

ment protects the right of a competent patient to refuse unwanted medical treatment.[280] Historically, the right to bodily autonomy has been deemed fundamental.[281] This, in and of itself, may require that the Federal Constitution impose broad substantive protection since the Supreme Court has strongly suggested that the fourteenth amendment protects the same liberties that the common law protects.[282] It is well-settled that common law protects the right of a competent individual to refuse treatment that a physician may deem beneficial.[283] If the due process clause protects common law rights, why shouldn't the fourteenth amendment afford institutionalized individuals with a broad right to refuse medication; a right that is consistent with common law?

One authority responds to this assertion by arguing that it is the existence of mental illness that should enable the state to treat individuals differently.[284] He argues that civil commitment ex-

---

[insanity] acquittee is entitled to release when he has recovered his sanity *or* is no longer dangerous") (emphasis added); O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) (state may not confine a nondangerous individual who can survive safely in freedom); Project Release v. Prevost, 551 F. Supp. 1298, 1304 (E.D.N.Y. 1982) ("due process does not tolerate the involuntary commitment of a nondangerous individual"), *aff'd*, 722 F.2d 960 (2d Cir. 1983); *In re* Harry, 96 A.D.2d 201, 206, 468 N.Y.S.2d 359, 363-64 (2d Dep't 1987) (due process does not countenance the involuntary hospitalization of a nondangerous individual even if the state provides treatment some deem beneficial).

280. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2851 (1990) (Court held that Constitution does not preclude the State of Missouri from applying a clear and convincing evidentiary standard when determining whether an incompetent individual expressed wishes regarding the withdrawal of life-sustaining treatment).

281. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) (stating that "[n]o right is held 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 . . .").

282. *See* Ingraham v. Wright, 430 U.S. 651, 679 n.47 (1977); Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (liberty includes the enjoyment of all privileges recognized by common law as essential to the pursuit of happiness).

283. Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1736 & n.148 (1982).

284. Appelbaum, *supra* note 3, at 417.

emplifies how the law permits the state to intervene clinically.[285] As one court noted, "[n]onconsensual treatment is what involuntary commitment is all about."[286] However, these assertions are not correct.

It is not the existence of mental illness that permits the state to treat such individuals differently than their non-mentally ill counterparts; it is the existence of dangerousness.[287] If there was any doubt as to the proposition that dangerousness triggers the state interest in confinement, the Supreme Court began to erase it when it held that the state may preventively detain a defendant before trial to prevent his alleged danger to the community.[288] In *Salerno*, arrestees challenged the provisions of the Bail Reform Act which included, *inter alia*, a provision authorizing the pretrial detention of a defendant charged with certain serious felonies if release conditions will not reasonably ensure the safety of any other person in the community.[289] The Court concluded that this legislation did not amount to punishment but amounted to a valid regulatory scheme designed to prevent danger to the community.[290] The Court recognized that "the Government's regulatory interest in community safety can, in appropriate circumstances, outweigh an individual's liberty interest."[291] The

285. *Id.* (In favoring a treatment driven model for a patient's right to refuse antipsychotic medication over a rights driven model, Appelbaum reasons that the "[d]eprivation of liberty of the mentally ill rests on the prospects that their disorders will be treated -benefitting both society and the patients themselves - and that treatment will allow them to be restored to freedom.") *Id.* at 414-17.

286. Stensvad v. Reivitz, 601 F. Supp. 128, 135 (W.D. Wis. 1985).

287. *See* cases cited *supra* notes 9, 279.

288. United States v. Salerno, 481 U.S. 739 (1987) (pre-trial detention of arrestees charged with thirty-five counts under the Racketeer Influenced and Corrupt Organizations Act did not constitute deprivation of their due process or eighth amendment rights because arrestees posed a potential danger to society). The Supreme Court may further clarify this issue. It will soon decide State v. Foucha, 563 So. 2d 1138 (La. 1990), *cert. granted*, No. 90-5844 (1991) (WESTLAW, Supreme Court library) (Can a state require an insantity-acquittee, who no longer suffers from mental illness, to also prove he is no longer dangerous before he can be released?).

289. *See* 18 U.S.C. § 3142(e) (1982).

290. *Salerno*, 481 U.S. at 746-48.

291. *Id.* at 748.

Touro Law Review, Vol. 8, No. 1 [2020], Art. 2

Court also recognized that it had held in numerous other contexts that the state could confine individuals who present a danger to the community.[292] The Court stated that under these circumstances, preventative detention does not offend "some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental."[293]

After *O'Connor v. Donaldson*[294] and its progeny,[295] civil commitment is about both preventing harm to oneself or others *and* providing treatment.[296] However, from a constitutional perspective, the provision regarding treatment is only secondary.[297]

In virtually every state today, an involuntarily hospitalized patient remains legally competent.[298] The prevalence of such practice indicates that the notion that institutionalized mentally ill individuals remain competent is so rooted in the law that the due process clause should incorporate this principle.[299] Accordingly,

292. *Id.* at 748-49 (citing Addington v. Texas, 441 U.S. 418 (1979)); *see supra* note 258.

293. *Salerno*, 481 U.S. at 751 (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934).

294. 422 U.S. 563 (1975).

295. *See* cases cited *supra* note 279.

296. *See* Project Release v. Prevost, 551 F. Supp. 1298, 1308 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983) (purpose of confinement is treatment).

297. *See* Society For Goodwill to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1250 (2d Cir. 1984) (right to only such treatment that will prevent basic self-care skills from deteriorating); Youngberg v. Romeo, 457 U.S 307, 330 (1982) (Burger, C.J. concurring) (other than assistance to avoid unnecessary restraint and harm, the Constitution does not place an affirmative duty upon the state to provide any sort of training). *Youngberg* and *Society For Goodwill* involved mentally retarded plaintiffs. The nature of the disability, mental retardation, resulted in the courts addressing the right to "treatment" as the right to "habilitation." *See Youngberg*, 457 U.S. at 309 n.1. From a legal standpoint, no principled distinction exists between the requirements of providing treatment to a mentally ill individual and habilitation to a mentally retarded person. *See* Rennie v. Klein, 720 F.2d 266, 273 n.1 (3d Cir. 1983) (Seitz, C.J., concurring).

298. *See* S. BRAKEL, J. PARRY & B. WEINER, THE MENTALLY DISABLED AND THE LAW 405-08 (3d ed. 1985).

299. *See* Schall v. Martin, 467 U.S. 253, 268 (1984) (quoting Leland v. Oregon, 343 U.S. 790, 798 (1952)) ("The fact that a practice is followed by a

by failing to define the right of a civilly committed individual to refuse medication in non-emergency situations by competence, the Second Circuit and all other courts that adopted the professional judgment standard, trivialize the notion that involuntarily hospitalized patients should have any substantial degree of autonomy. The professional judgment standard results in courts construing any decision to medicate as a "base-line decision,"[300] which is presumptively valid.[301] Indeed, the recognition that there is general disagreement between the psychiatric and psychological professions as to the severity of side effects[302] hardly justifies shifting the risk of error to the patient. Rather, because states universally treat civil committees as competent adults, the constitution should permit these individuals to individually assess the risks and benefits.

The justification for permitting physicians to administer antipsychotic medication over objection is the notion that physicians are better trained to make treatment decisions, and patients should trust doctors to make these decisions.[303] Such a concept, coupled with the notion that a broad right-to-refuse interferes with clinical management,[304] results in the adoption of the professional judgment standard. However, ample reason exists to believe that doctors do not know what is best; they err regularly and frequently,[305] and a treatment bias pervades many of their

large number of states is not conclusive in a decision as to whether that practice accords with due process, but it is plainly worth considering in determining whether the practice 'offends some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental.'").

300. United States v. Charters, 863 F.2d 302, 308 (4th Cir. 1988).

301. *Id.* at 310 (citing *Youngberg*, 457 U.S. at 323 & n.30).

302. *Id.* at 310-11.

303. *See* Appelbaum, *supra* note 3, at 414; Kaufmann, Roth, Lidz & Meisel, *Informed Consent and Patient Decisionmaking*, 4 INT'L J. L. & PSYCHIATRY 345, 346 (1981) [hereinafter Kaufmann & Roth].

304. *See, e.g.*, Rennie v. Klein, 720 F.2d 266, 273 (3d Cir. 1983) (Seitz, C.J., concurring) (hospital staff must make complex decisions, which they are in the best position to evaluate).

305. *See* Brooks, *supra* note 24, at 352 n.42; Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 708-09 (1974).

decisions.[306] Moreover, even if one chooses to believe that psychiatrists are substantially wiser than their mentally ill patients, the law should not confer decision-making authority on treating physicians.

If psychiatrists are wiser than their mentally ill patients, they are no doubt wiser than the general adult population whom the state does not confine, at least in respect to questions of medicine. Yet, the law, through the concept of informed consent, permits non-mentally ill individuals to overrule any suggestion by their physicians.[307] For no reason other than the state should treat mentally ill individuals as similarly as possible to individuals who do not suffer from a mental disability until a court adjudicates an involuntarily hospitalized patient incompetent, the civilly committed patient should have the right to make his own treatment decisions. Under this view, it is not mental illness that justifies different treatment; rather it is a determination that the individual labeled "mentally ill" lacks the ability to make a reasoned treatment decision.

Critics of *Rivers v. Katz* and other broad right to refuse treatment holdings argue that most patients refusing medication are not competent and, furthermore, patients do not refuse drugs because of the side effects.[308] They point out further that invariably a court will override a patient's refusal and authorize treatment.[309] Finally, psychiatrists lament the difficulty in treating patients when patients can assert a right to refuse.[310] However,

306. *See* Morse, *supra* note 236, at 599; Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 100 (1971).

307. Indeed, just as many psychiatrists oppose a broad right to refuse medication, the medical profession has attacked the concept of informed consent. *See* Kaufmann & Roth, *supra* note 303, at 345. Similar to the notion that mentally ill individuals lack the ability to make reasoned decisions, many physicians believe they are better trained than their patients to make medical decisions. *See, e.g.*, Kaufmann & Roth, *supra* note 303, at 346; Schwartz &Vingiano, *supra* note 3, at 1054.

308. *See, e.g., Drug Refusal, supra*, note 4, at 342-44; Appelbaum & Gutheil, *supra* note 4, at 310-14; Schwartz & Vingiano, *supra* note 3, at 1049.

309. *See, e.g.*, Appelbaum, *supra* note 3, at 417.

310. *Drug Refusal, supra* note 4, at 345.

these critics argue fallaciously because neither the court of appeals in *Rivers*, nor any other court has found that patients possess an absolute right to refuse.[311] Rather, these courts merely start from the premise that an involuntarily hospitalized patient does not automatically forfeit a substantial degree of autonomy because of involuntary hospitalization. Accordingly, the New York Court of Appeals subscribes to a judicial philosophy that chooses to maximize patient autonomy; a philosophy inherently different from the notion that "[i]nvoluntary confinement represents a transfer from the patient to the State of the authority to make certain decisions affecting the patient's welfare,"[312] and the state is empowered to make additional decisions that affect the patient's welfare.[313]

The New York Court of Appeals still permits the state to forcibly medicate those individuals who lack the ability to make a reasoned treatment decision.[314] Furthermore, studies that detail the rate in which courts override a patient's refusal should not justify elimination of such a starting point.[315] They fail to account for the ability of patients to negotiate a treatment regimen with their psychiatrist as a result of the psychiatrist no longer being able to impose his authority without subjecting such decision to judicial scrutiny. Patients now possess far greater ability to submit to a treatment regimen in which they and their doctor concur.[316] This ability to negotiate results from physicians choosing to reach an amicable accommodation with a patient instead of preparing for and appearing in court.[317]

Additionally, the requirement of a court hearing does not create

---

311. *See supra* text accompanying notes 222-23.

312. Rennie v. Klein, 720 F.2d 266, 273 (3d Cir. 1983) (Seitz, C.J., concurring).

313. *Id.* Chief Judge Seitz justified such transfer of authority upon the state's interest in aiding the patient's welfare. *Id.* However, he relied on no authority for this assertion, and the state's interest in assisting a competent individual through treatment has not been deemed compelling. *See supra* note 279.

314. *See supra* text accompanying note 225.

315. *See* Washington v. Harper, 110 S. Ct. 1028, 1043 n.13 (1990).

316. Brooks, *supra* note 24, at 369.

317. *Id.*

Touro Law Review, Vol. 8, No. 1 [2020], Art. 2

an insurmountable burden. New York law authorizes a party seeking relief of a summary nature to institute a special proceeding.[318] This enables the facility seeking to override a patient's objection to present its case within eight days.[319] If there is a reason for a hearing within a shorter amount of time, the facility can place the matter on the court calendar by means of an order to show cause,[320] which will result in the court determining the hearing date.[321] Eight days is not much longer than the five days an involuntarily hospitalized patient must wait prior to obtaining a court hearing to challenge his hospitalization.[322] It is substantially shorter than the length of time it took the New York State Office of Mental Health to complete its administrative review of patients pursuant to NYCRR section 27.7 prior to *Rivers*.[323]

Similarly, a court rather than an administrative reviewer should serve as the fact-finder. Whether or not a medical professional who serves as a fact-finder adequately protects a patient's interest[324] should not justify the countenancing of administrative review by a professional. There may be many instances in which an unbiased fact-finder might serve, or appear to serve, the interests of individuals whose rights are at issue. For instance, could a legislature delegate to a special agency the authority to resolve all allegations of malpractice? Might the legislature direct that all other tort claims be resolved by means of an alternative dispute resolution in which the fact-finder does not apply the rules of evidence? I do not believe so.

American society, whose rule of law is derived from the common law model, relies upon the "courts, or other quasi-judicial official bodies"[325] to resolve disputes and define the scope of

318. N.Y. CIV. PRAC. L. & R. §§ 401-411 (McKinney 1990).

319. *Id.* § 403(b).

320. *Id.* § 403(d).

321. 2A J. WEINSTEIN, H. KORN & A. MILLER, NEW YORK CIVIL PRACTICE ¶ 2214.04 subdiv. d, at 77 (1991).

322. N.Y. MENTAL HYG. LAW § 9.31 (McKinney 1988).

323. Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986) (Appellant's Memorandum In Opposition to Motion to Reargue at 13).

324. Washington v. Harper, 110 S. Ct. 1028, 1042 (1990).

325. Boddie v. Connecticut, 401 U.S. 371, 375 (1971).

individuals' rights and duties. Accordingly, instead of focusing upon whether medical professionals can adequately serve a patient's interest, one should focus upon whether the decision to forcibly administer medication impacts upon the individual interest in maintaining bodily autonomy to such a degree that a court should serve as the body that resolves the dispute between a patient and his doctor. If the law requires a court to adjudicate allegations of malpractice or the administration of medication in the absence of informed consent, and the boundaries of the Constitution are frequently included upon the common law's definition of rights and obligations,[326] why shouldn't the Constitution require a judicial determination when the state seeks to violate the bodily integrity of an individual by administering, over objection, medication that can produce the most debilitating of effects?[327]

The rationale provided by the Supreme Court to justify utilization of an administrative review is particularly disturbing. The Supreme Court cited *Youngberg v. Romeo*[328] and *Parham v. J.R.*[329] as authority for examples when the Court permitted medical professionals to make decisions that impacted upon the legal rights of patients. These decisions hardly amount to persuasive authority. The Constitution required the professionals in *Youngberg* to make decisions about patient treatment in their capacity as service providers,[330] an action far different than serving as an administrative fact-finder to determine whether or not the criteria for overriding a patient's objection existed. Similarly, *Parham* addressed the issue of whether a decision by an admitting psychiatrist to hospitalize a minor whose parents sought such hospitalization satisfied due process.[331] The *Parham* Court recognized the need to avoid an entirely adversarial posture within

326. *See supra* text accompanying notes 280-82; Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2859-60 (1990) (Scalia, J., concurring).

327. *See supra* text accompanying notes 32-72.

328. 457 U.S. 307 (1982).

329. 442 U.S. 584 (1979); *see supra* note 165.

330. *Youngberg*, 457 U.S. at 322.

331. *Parham*, 442 U.S. at 601-02.

commitment proceedings of minor juveniles. In reaching its decision, the Court relied upon, *inter alia*, the need to maintain parent-child relations and the inherent authority of parents to make decisions about matters affecting their children.[332] These concerns are not present when a clinician wishes to administer medications over the objection of a legally competent adult.

The Court in *Harper* justified utilization of an administrative review because patients often change their minds and a court will lack the ability to assess the intentions of the refusing individual.[333] However, the independent decision-makers countenanced by the Court in *Harper* were not involved in the inmate's current treatment or diagnosis.[334] Are such individuals better suited than a court to assess an individual's intentions? Finally, the Court, relying upon *Parham*, concluded that requiring a judicial proceeding will divert both money and staff from the care of mentally ill inmates.[335] This may amount to an unjustified concern. Psychiatry is a profession that, as a whole, seeks to ensure that patients receive treatment deemed beneficial.[336] Accordingly, one may anticipate and would certainly hope that those phychiatrists, whom the law requires to appear in court, would simply work longer hours to ensure that patients receive appropriate treatment. Hospital administrators should send the following message to those psychiatrists whose time in court results in less time for patient care: "You are professionals -- work harder." Any psychiatrist who would sacrifice patient care because of the administrative-like details connected with a judicial proceeding should not be employed in public psychiatric facilities.

In addressing whether the Constitution requires the appointment

---

332. *Id.* at 602, 610; *see supra* note 165.

333. Washington v. Harper, 110 S. Ct. 1028, 1042 (1990).

334. *Id.* at 1043.

335. *Id.* at 1042.

336. *See* Appelbaum & Hamm, *Decisions to Seek Commitment: Psychiatric Decision Making in a Legal Context*, 39 ARCH. GEN. PSYCHIATRY 447 (1982); Mulvey & Lidz, *Back to Basics: A Critical Analysis of Dangerousness Research in a New Legal Environment*, 9 L. HUMAN BEHAVIOR 209, 214 (1985); Wexler & Scoville, *supra* note 306, at 101.

of counsel to those individuals who refuse medication, the Supreme Court failed to address relevant concerns. Whether the right to counsel attaches requires a balancing of the criteria detailed in *Mathews v. Eldridge*,[337] which a court must then measure against the presumption that counsel does not attach because the state does not seek to deprive an individual of physical liberty.[338] Because this evaluation requires a balancing of individual and state interests,[339] the outcome may well depend upon a court's determination of the extent of an individual interest in avoiding medication. Those of us who believe the patient possesses an extremely significant interest in avoiding forced drugging will conclude that such interest, together with the value of counsel in avoiding erroneous determinations, results in a determination that the Constitution requires counsel; those who place less significance upon this patient interest, will not.

Compounding the difficulty in assessing whether counsel attaches have been the inconsistent approaches the Supreme Court has taken when defining the contours of the fourteenth amendment's right to counsel. In the absence of a judicial proceeding, the administrative proceedings provided to a patient may be formal and complex or they may be simple and straight-forward.[340] Under such circumstances it may be "'neither possible nor prudent to attempt to formulate a precise and detailed set of guidelines to be followed in determining when the providing of counsel

337. 424 U.S. 319 (1976); *see supra* text accompanying notes 153-54.

338. Lassiter v. Department of Social Servs., 452 U.S. 18, 26-27 (1981).

339. *See supra* note 195 and accompanying text.

340. *Compare* Rennie v. Klein, 462 F. Supp. 1131, 1150-51 (D.N.J. 1978) (codification of the administrative procedures at issue within the case, namely, the New Jersey Division Of Mental Health And Hospitals Administrative Bulletin 78-3, was appended to the court's decision and provides for an informal medical review conducted by the medical director of the hospital (or a designee) granting discretion on the part of the director to obtain an independent psychiatric consultation) *with* MD. HEALTH-GEN. CODE ANN. §§ 10-708(a)(2), (c)(1) (1990) (statutory provisions contain a detailed administrative procedure held before a clinical review panel, affording the opportunity, *inter alia*, to present witnesses, to cross-examine those witnesses called by the clinical review panel and to utilize counsel at the phase of review before an administrative law judge).

is necessary to meet the applicable due process requirements . . . .'"[341] Under this view, the complexity of the administrative proceeding or the individual patient's clinical condition might determine whether or not counsel is necessary.

On the other hand, the Supreme Court has also concluded that a court must measure due process by the generality of cases to which the procedural requirement in question applies.[342] In other words, what "is sufficient for the large majority [of cases] . . . is by constitutional definition sufficient for all of them."[343] Under this view, the complexity of the question of whether mental illness exists, taken together with the relevant substantive standard, be it competence, professional judgment, best interest, least intrusive, or a combination of such, militates towards a determination that counsel should attach.[344] The state possesses an interest in avoiding the expense of counsel. However, this interest is hardly significant.[345] Moreover, those states like New York that establish an organization to provide legal services to institutionalized individuals in matters of commitment and/or care and treatment,[346] could utilize the state funded legal service organizations to represent patients. While counsel might alter the nature of the proceeding by making it more adversarial,[347] because a patient's interest in bodily autonomy is so great, application of the *Mathews* criteria results in overcoming the presumption that counsel should not attach because the state does not seek to de-

341. *Lassiter*, 452 U.S. at 32 (quoting Gagnon v. Scarpelli, 411 U.S. 778, 790 (1973)).

342. Walter v. National Ass'n of Radiation Survivors, 473 U.S. 305, 330 (1985) ("'[P]rocedural due process rules are shaped by the risk of error inherent in the truth-finding process as applied to the generality of cases, not the rare exceptions.'") (quoting Mathews v. Eldridge, 424 U.S. 319, 344 (1976)).

343. *Id.*

344. *Cf. Lassiter*, 452 U.S. at 32 (no right to counsel for petitioner because, *inter alia*, "no expert witnesses testified, and the case presented no specially troublesome points of law").

345. *Id.* at 28.

346. N.Y. MENTAL HYG. LAW §§ 47.01-.03 (McKinney 1988).

347. Walter v. National Ass'n of Radiation Survivors, 473 U.S. 305, 325 (1985).

prive an individual of liberty.

CONCLUSION

There are numerous reasons why *Rivers* is a significant decision.[348] However, its most important aspect may be that the New York Court of Appeals found that the state constitution permits a patient to refuse medication, not because such individual possesses an inherent interest in refusing potentially debilitating drugs, but rather because, despite hospitalization, such person possesses the right to determine his own course of treatment.[349] Pursuant to *Rivers*, not only may a patient refuse medication, but because the court of appeals based its holding upon the common law right of an individual to control his own course of treatment,[350] hospital staff must provide affirmative treatment in accordance with a patient's wishes. Accordingly, *Rivers* arguably gives new meaning to an old adage, and one can envision proponents of a narrow right to refuse decrying about, inmates running the asylum. But is this an accurate assessment of *Rivers*?

I do not believe so. *Rivers* simply accords greater individual autonomy to patients whose day to day activities, while hospitalized, are controlled by others.[351] The decision exemplifies how society no longer views the institutionalized mentally ill as people that society shuns and who are not deserving of the same legal protection afforded to "normal" individuals.[352] As a result of *Rivers*, civil commitment does not result in a patient forfeiting the exercise of one of the most basic rights belonging to individuals -the right of bodily autonomy.[353] Because *Rivers* enables the state to treat, over objection, those patients who lack the capacity to make reasoned decisions, as someone who values strongly individual liberty, I believe *Rivers* strikes the proper balance be-

348. *See* PERLIN, *supra* note 15, at 346-49.

349. Rivers v. Katz, 67 N.Y.2d 485, 492-93, 495 N.E.2d 337, 342-43, 504 N.Y.S.2d 74, 78 (1986).

350. *See supra* notes 217-20 and accompanying text.

351. *See, e.g.*, E. GOFFMAN, ASYLUMS 149-52 (1961).

352. *See supra* note 220 and accompanying text.

353. *See supra* notes 216-21 and accompanying text.

tween individual autonomy and the relevant state interests. Those individuals who value bureaucratic or professional efficiency, those who wish to conserve at all cost staff resources, will disagree. Beyond amounting to a philosophical reaffirmation of individual liberty, *Rivers* is more consistent with prior Supreme Court doctrine than are *Project Release* and other federal decisions that adopt the professional judgment standard.[354] When the Supreme Court finally addresses the issue, it remains to be seen whether it carries over *Harper* from the prison[355] to the civil hospital context or relies upon the historical underpinning of liberty derived from common law.[356] How the Court decides the issue will tell us all how much respect the Court has for the dignity and individual autonomy of those individuals confined because of mental illness.

354. *See supra* text accompanying notes 103-05.
355. *See supra* notes 181-206 and accompanying text.
356. *See supra* notes 281-83 and accompanying text.