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Steven Shobat

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PATHWAY THROUGH THE PSYCHOTROPIC JUNGLE: THE RIGHT TO REFUSE PSYCHOTROPIC DRUGS IN ILLINOIS

Medicine has not yet found a cure for the terrible pain of mental illness. The law cannot assist in this endeavor. But the constitution can and does prevent those who have suffered so much at the hands of nature from being subjected to further suffering at the hands of man.*

Commitment to a mental hospital, for whatever purpose,¹ constitutes "a significant deprivation of liberty that requires due process protection."² Mental health advocates have struggled to ensure that commitment standards comport with due process requirements.³ Yet, as great a deprivation as civil commitment may be, it is

* Rennie v. Klein, 476 F. Supp. 1294, 1319 (D.N.J. 1979).

1. See Jones v. United States, 103 S. Ct. 3043, 3048 (1983) (commitment following insanity acquittal); Vitek v. Jones, 445 U.S. 480, 491-92 (1980) (commitment as result of prison transfer to mental institution); Addington v. Texas, 441 U.S. 418, 425 (1979) (involuntary civil commitment); *In re Stephenson*, 67 Ill. 2d 544, 554, 367 N.E.2d 1273, 1279 (1977) (commitment of defendant found unfit to stand trial); see also Youngberg v. Romeo, 457 U.S. 307, 315 (1982) (commitment of mentally retarded patient); O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring) (commitment of nondangerous mentally ill); Humphrey v. Cady, 405 U.S. 504, 509 (1972) (commitment of deviate sexual offender); Jackson v. Indiana, 406 U.S. 715, 730 (1972) (commitment following finding of incompetency to stand trial); Dixon Ass'n for Retarded Citizens v. Thompson, 91 Ill. 2d 518, 530, 440 N.E.2d 117, 124 (1982) (commitment of mentally retarded).

2. Jones v. United States, 103 S. Ct. 3043, 3048 (1983); *In re Stephenson*, 67 Ill. 2d 544, 554, 367 N.E.2d 1273, 1279 (1977).

3. The increased advocacy in mental health issues has resulted in a number of reforms in mental health law. Judicial activism has been the source of most of the advancements, and when the legislatures have acted, their action has often resulted from the "threat of judicial invalidation of traditional commitment schemes." Dix, *Major Current Issues Concerning Civil Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137, 137 (1982). Much of this litigation has fallen into three areas of concern: the standards for involuntary commitment, the procedures that must be accorded the mentally ill during commitment, and the rights of the psychiatric patient once institutionalized. See generally *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974) [hereinafter cited as *Developments*]. A compilation of current civil commitment requirements is provided in Beis, *State Involuntary Commitment Statutes*, 7 MENTAL DISABILITY L. REP. 358-69 (1983).

In Illinois, each of these areas has given rise to litigation. Cf. *United States ex rel. Mathew v. Nelson*, 461 F. Supp. 707 (N.D. Ill. 1978) (Illinois civil commitment statute satisfies due process even though no overt act required); *Dixon Ass'n for Retarded Citizens v. Thompson*, 91 Ill. 2d 518, 440 N.E.2d 117 (1982) (adequate, humane care and services constitutionally required for mentally retarded patients); *People v. Lang*, 76 Ill. 2d 311, 391 N.E.2d 350 (dangerousness required in civil commitment), *cert. denied*, 444 U.S. 954 (1979); *In re Stephen-*

only the first in a series of deprivations that await the mental patient once he is inside the hospital. Deprived by nature, the psychiatric patient confronts a "therapeutic orgy"⁴ of treatment techniques designed to improve his condition. One such technique is the use of psychotropic drugs.⁵

Psychotropic medication has revolutionized the mental health profession.⁶ Psychotropics are potent, mind-altering drugs which reduce the major, disruptive manifestations of mental illness.⁷ Unfortunately, they produce equally disruptive side effects.⁸ An

son, 67 Ill. 2d 544, 367 N.E.2d 1273 (1977) (burden of proof necessary in civil commitment is clear and convincing evidence); Matter of Janovitz, 82 Ill. App. 3d 916, 403 N.E.2d 583 (1983) (mental illness defined). The increase in the number of mental patients' rights, as well as increased social concern for the plight of the institutionalized patient, led to the complete revision of the Illinois Mental Health Code of 1967. Former Governor Dan Walker signed an executive order establishing the Governor's Commission for Revision of the Mental Health Code of Illinois (Commission) in 1973. See Report, *Governor's Commission for Revision of the Mental Health Code of Illinois*, 1976 at 217 [hereinafter cited as *Commission Report*]. Three years later, the Commission published its first report. Most of its suggestions and proposals were adopted by the General Assembly. The new code was enacted into law in 1978 and became effective January 1, 1979. See The Mental Health and Developmental Disabilities Code, ILL. REV. STAT. ch. 91 1/2, § 1-100 *et seq.* (1983). See also *infra* notes 88-101 and accompanying text.

4. Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977). Plotkin describes the "psychiatric armamentarium" of treatment procedures that are available to a psychiatric hospital. *Id.* at 465-82. These treatments range from the less intrusive techniques such as restraints, aversion therapy, behavior therapy, and seclusion, to the more intrusive ones such as electroconvulsive therapy (shock treatment), psychotropic drugs, and psychosurgery (lobotomy). The focus of this comment is on psychotropic drugs, and in particular, on antipsychotics. Other treatment modalities are compared when such comparison is necessary or fruitful, such as in a discussion of the least restrictive alternative. See *infra* notes 96 & 174 and accompanying text.

5. Psychotropic drugs are those that are used in treating psychiatric problems, and therefore naturally "affect psychic functions and behavior." Symonds, *Mental Patients' Right to Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment*, 7 HASTINGS CONST. L.Q. 701, 702 (1980). Psychotropic drugs are alternatively known as major tranquilizers or neuroleptics primarily because they induce sedation without sleep and control symptoms of acute and chronic psychoses. Plotkin, *supra* note 4, at 474 n. 75 and text. The most commonly prescribed of the major tranquilizers are Thorazine (chlorpromazine), Stelazine (tri-fluoperazine), Prolixin (fluphenazine), Haldol (haloperidol), Mellaril (thioridazine), Trilafon (perphenazine), and Novane (thiothexene). *Id.* at 474 n.77. See also *infra* notes 12-16 and accompanying text.

6. DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patients Justify Involuntary Treatments?*, 60 MINN. L. REV. 1149, 1151 (1976); Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness and Libertarian Theory*, 31 EMORY L.J. 375, 378-80 (1982); Comment, *Involuntary Commitment and the Right to Refuse Treatment with Antipsychotic Drugs*, 16 CREIGHTON L. REV. 719, 722-24 (1983).

7. See *infra* text accompanying notes 12-16.

8. For a discussion of the side effects of psychotropic drugs, see *infra* notes 17-30 and accompanying text. See generally Gaughan & LaRue, *The Right of a*

awareness that the patient ought to be involved in the decision to administer these drugs, and as a corollary to this involvement, that he ought to be able to refuse them, has caused the use of psychotropic drugs to become embroiled in legal controversy.⁹

When Illinois recently revised its mental health code, it enacted a statutory provision granting mental patients the right to refuse "generally accepted" medication and other psychotherapeutic treatment.¹⁰ As of this writing, no court has interpreted precisely what that right to refuse entails.¹¹ The purpose of this comment is to interpret Illinois' right to refuse treatment statute from the per-

Mental Patient to Refuse Antipsychotic Drugs in an Institution, 4 LAW & PSYCHOLOGY R. 43, 46-57 (1978) (details side effects of antipsychotics).

9. See Project Release v. Prevost, 722 F.2d 960, 979 (2d Cir. 1983) (right to refuse granted); Jamison v. Farabee, No. C 780445 WHO (N.D. Cal. April 26, 1983) (consent decree) (right to refuse granted), reprinted in 7 MENTAL DISABILITY L.R. 436-39 (1983); Osgood v. District of Columbia, 567 F. Supp. 1026, 1033 (D.D.C. 1983) (right to refuse recognized); Davis v. Hubbard, 506 F. Supp. 915, 938 n.32 (N.D. Ohio 1980) (right to refuse recognized); Rogers v. Okin, 478 F. Supp. 1342, 1366-67 (D. Mass. 1979) (right to refuse granted), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded on procedural grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); Rennie v. Klein, 462 F. Supp. 1131, 1148 (D.N.J. 1978) (single action) and 476 F. Supp. 1294, 1309 (D.N.J. 1979) (class action) (right to refuse granted), *aff'd in part, rev'd in part*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 119 (1982), *reinstated on remand*, 720 F.2d 266 (3d Cir. 1983); *In re Boyd*, 403 A.2d 744, 748 (D.C. 1979) (right to refuse granted); Rogers v. Commissioner of Dept. of Mental Health, 349 Mass. 390, 489, 458 N.E.2d 308, 314 (1983) (right to refuse granted); *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) (right to refuse granted); Matter of B., 156 N.J. Super. 231, 233, 383 A.2d 760, 763 (1977) (right to refuse denied). See also Dubose, *supra* note 6; Gaughan & LaRue, *supra* note 8; Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.—C.L. L. REV. 363 (1980); Symonds, *supra* note 5; Comment, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720 (1982); Comment, *supra* note 6; Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 ST. LOUIS U.L.J. 100 (1975).

10. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983). The section is printed verbatim *infra* note 111. This section discusses the right to refuse treatment generally. For analytical purposes, this comment will only focus on the right to refuse psychotropic drugs. While there are peculiar attributes of psychotropic medication that make an analysis of it unique, see *infra* notes 12-30, the discussion of the philosophy of section 2-107, its legislative history, and the requisites necessary to override a patient's refusal are generally applicable to all forms of psychiatric treatment. See *infra* notes 111-71 and accompanying text.

11. Although the language of section 2-107 is not patently ambiguous, some terms are left undefined. See *infra* note 111. Its standards are necessarily broad enough to encompass a great number of factually distinct situations. This section is more an announcement of a state policy incorporating several endorsed concepts rather than a strictly defined rule of law. These principles were stated in the Governor's Commission Report in its summary of this section:

[The right to refuse] [r]equires that a mentally disabled person be told what treatment or habilitation, including medication, is intended to be given to him. Provides that treatment or habilitation may not be administered if he objects, unless he is likely to cause serious physical injury to himself or others.

Commission Report, supra note 3, at 28.

spective of psychotropic medication. The comment first discusses psychotropic drugs and concludes that the dilemma they create is an inherent result of both their efficacy and their intrusiveness. A survey of other jurisdictions' decisions that have dealt with this precise issue follows. Much of their reasoning is echoed in Illinois case law and in the new code; those parallels are drawn in the third part of this comment. While the case law of other jurisdictions provides a set of factors to resolve the narrow issue of the right to refuse, this comment posits that these critical factors have established, independent roots in Illinois statutory and case law. Finally, the statutory provision itself is examined and interpreted. Particular emphasis is given to the substantive nature of the statutory right and to its limitations.

PSYCHOTROPIC DRUGS AND THE CHOICE

Psychotropic drugs are used to treat the psychoses, particularly schizophrenia.¹² They have become the most frequently prescribed class of drugs for the most common mental illness of institutionalized patients.¹³ These drugs block chemical transmissions to the

12. Psychotropic medication can be classified into four categories: anti-psychotics (major tranquilizers), antidepressants, lithium, and anti-anxiety drugs (minor tranquilizers). Symonds, *supra* note 5, at 704. Antipsychotics, in particular, are used to treat the symptoms of acute, chronic, psychotic patients, while the minor tranquilizers are more frequently prescribed for the milder neuroses. *Id.* Right-to-refuse litigation has been generated mostly around the antipsychotics and lithium because they are the more powerful drugs and have the more serious side effects, and also because they are used more frequently and in greater dosages than the other drugs. See generally *Osgood v. District of Columbia*, 567 F. Supp. 1026, 1029 (D.D.C. 1983) (Haldol); *Rogers v. Okin*, 478 F. Supp. 1342, 1360 (D. Mass. 1979) (Haldol, Thorazine, Prolixin, Mellaril), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded on procedural grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1148 (D.N.J. 1978) (single action) (Thorazine), *aff'd in part, rev'd in part*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 119 (1982), *reinstated on remand*, 720 F.2d 266 (3d Cir. 1983).

The psychoses, schizophrenic disorders, and the major affective disorders are greater forms of mental disturbance than the neuroses and are different in nature than organic brain syndromes such as brain tumors. See generally E. MAGGIO, *THE PSYCHIATRY-LAW DILEMMA* 207-21 (1981). Schizophrenia is characterized by disordered thought patterns, inappropriate affect (absence of any emotion, or excessive emotion), ambivalence, withdrawal into fantasy, both auditory and visual hallucinations, and delusions (inability to distinguish fantasy from reality). *Id.* at 212-20; Rhoden, *supra* note 9, at 377. Antidepressants and lithium are the more frequently prescribed medications for the affective disorders. Rhoden, *supra* note 9, at 378.

13. Symonds, *supra* note 5, at 704. Psychotropic drugs are the most "firmly established of the pharmacological therapies in the treatment of mental illness." Plotkin, *supra* note 4, at 474. See also *Davis v. Hubbard*, 506 F. Supp. 915, 926 (N.D. Ohio 1980). Faced with statistical evidence that over 73% of all patients were receiving psychotropic drugs and that they were being administered by licensed and nonlicensed physicians at the recommendations of supporting staff, the *Davis* court declared that "[p]sychotropic drugs are not only over-

brain, affecting both activatory and inhibitory¹⁴ functions, thereby altering behavior, thinking, and moods. Indeed, their effectiveness and usefulness depend on their ability to alter the psychic functions and the behavior of the patient. While they cannot cure mental illness, they can severely diminish some of its most halting, disturbing, and oppressive symptoms, especially those symptoms that force an otherwise freely-functioning person to become institutionalized.¹⁵ The predominance of antipsychotics as the preferred treatment for schizophrenia has contributed greatly to the deinstitutionalization of psychiatric patients, has shortened the average hospital stay, and has allowed the inpatient to work and live in more meaningful employment and social settings.¹⁶ In this sense, the advent of psychotropic drugs has freed both the mind and the body of the mentally ill patient from the most debilitating and painful symptoms of mental illness.

This increased freedom, however, often comes at a very high price: the drugs' side effects are serious, long-lasting, and potentially more disruptive than the illness itself. Among these consequences are short term, muscular side effects which disappear when the drug is terminated,¹⁷ such as dystonia,¹⁸ akathisia,¹⁹ dyskine-

prescribed, they are freely prescribed." *Id.* Furthermore, schizophrenia, the mental illness for which psychotropics are most frequently prescribed, is the most frequently diagnosed mental illness among institutionalized patients. Rhoden, *supra* note 9, at 377 n. 61 (50% of all mental hospital beds are occupied by schizophrenics); DuBose, *supra* note 6, at 1151 (a diagnosis of schizophrenia is frequently all that is necessary for a commitment to a mental hospital because schizophrenics are considered inherently dangerous).

14. It is not clear how psychotropic medication works. At least part of this uncertainty stems from the lack of knowledge of the precise cause(s) of mental disorders. While schizophrenia and other mental illnesses may result from a "combination of genetic, biochemical, and environmental factors," the currently accepted theory is that mental disorders are caused by a chemical imbalance in the brain. Rhoden, *supra* note 9, at 379. Acute psychotic episodes are "accompanied by an imbalance in the limbic system, the brain center that regulates emotion and motivation." Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 WIS. L. REV. 497, 498. The drugs block the transmission of dopamine, thereby reducing the psychotic symptoms. *Id.* For a more complete and sophisticated medical explanation of how the drugs work, see E. MAGGIO, *supra* note 12, at 207-35. See also *Mills v. Rogers*, 457 U.S. 291, 293 n. 1 (1982) ("It is not disputed that such drugs are 'mind altering.'").

15. DuBose, *supra* note 6, at 1169; Rhoden, *supra* note 6, at 378; Symonds, *supra* note 5, at 704.

16. Rhoden, *supra* note 6, at 378-80; Comment, *supra* note 14, at 497 n. 4.

17. Psychotropic medication has an immediate sedative effect on patients, but many of the anti-psychotic effects do not develop until two or three weeks into the therapy. Rhoden, *supra* note 9, at 378. Many of the short term symptoms do not develop until the anti-psychotic effect has begun. While a particular drug may be terminated because of side effects or idiosyncratic reactions to it, another is often substituted, and many patients spend all of their institutionalization on some sort of medication. *Id.* at 475-77.

sia,²⁰ and a parkinsonian syndrome.²¹ In addition, there are a number of non-muscular, autonomic²² reactions to the drugs. Among these are dry mouth and throat, blurred vision, drowsiness, dizziness, fainting, loss of sexual desire, low blood pressure, skin discoloration and sensitivity, and depression.²³ At times, there are even hazardous consequences of the treatment, including the possibility of death.²⁴

Several other factors complicate the dangers of these side effects. Clinicians cannot determine, prior to administering a certain drug, what the effect on a particular patient will be. Once an appropriate drug is discovered, there are continuing concerns about the proper dosage to administer, idiosyncratic reactions to the drug, and the possibility of permanent, disabling side effects that do not develop until late into the treatment.²⁵

One such side effect is a condition known as tardive dyskinesia.²⁶ This condition is frequently irreversible, and there is cur-

18. Dystonia refers to an extrapyramidal condition characterized by "bizarre muscle spasms, primarily in the head and neck, often combined with facial grimaces, involuntary spasms of the tongue and mouth interfering with speech and swallowing, convulsive movements of the arms and head, bizarre gaits, and difficulty in walking." Symonds, *supra* note 5, at 707 n. 37.

19. Akathisia is an extrapyramidal syndrome characterized by motor restlessness, commonly known as "the jitters." E. MAGGIO, *supra* note 12, at 225. The patient cannot remain still because of an omnipresent urge to move about and pace. Symonds, *supra* note 5, at 707 n. 36.

20. Dyskinesia is also an extrapyramidal syndrome that is characterized by "alterations of muscle tone and involuntary movements." E. MAGGIO, *supra* note 12, at 225. The syndrome consists of "bizarre tongue, face, and neck movements" such as tongue protrusion, licking the lips, and eye blinking. Symonds, *supra* note 5, at 707 n. 38. The facial movements are accompanied by difficulty in swallowing, breathing, speaking, and eating. *Id.*

21. The parkinsonian syndrome shares similar symptoms with Parkinson's disease. It is characterized by "muscular rigidity, tremor at rest, a mask-like face, salivation, motor retardation, shuffling gait, and pillrolling hand movements." Symonds, *supra* note 5, at 707 n. 35. *See also* authorities cited in Plotkin, *supra* note 4, at 475 n. 86; Rhoden, *supra* note 6, at 380 & n. 87.

22. *See* Plotkin, *supra* note 4, at 476; Symonds, *supra* note 5, at 705.

23. E. MAGGIO *supra* note 12, at 226; Gaughan & LaRue, *supra* note 8, at 51-52; Plotkin, *supra* note 4, at 476; Symonds, *supra* note 5, at 705; Comment, *supra* note 14, at 535-36 n. 177.

24. Comment, *supra* note 14, at 535-39. The administration of psychotropic medication can be fatal. The drugs affect the heartbeat of patients and may "precipitate fatal cardiac tachyarrhythmias." *Id.* at 537 & n. 179. They may also cause a fatal blood condition known as blood dyscrasias, *id.* at n. 180, or fatal paralytic disturbances of the gastrointestinal system. *Id.* at n. 181.

25. Plotkin, *supra* note 4, at 475; Comment, *supra* note 14, at 539-42.

26. Tardive dyskinesia is a "neurological syndrome characterized by stereotyped involuntary movements, [is] relatively common among patients who have received antipsychotics for several years, and is generally considered to be irreversible." Rhoden, *supra* note 9, at 381 (citations omitted). *See also* E. MAGGIO, *supra* note 12, at 227-31. Some of its more prominent symptoms are lipsmacking, jaw lateralization, and involuntary tongue movements. These symptoms become exaggerated during anxiety or active use of the afflicted parts of the

rently no effective treatment for it. It is characterized by involuntary muscle movements, particularly of the mouth, lips, and tongue. In its more serious forms, oral communication becomes incomprehensible, and swallowing and breathing become difficult.²⁷ What makes the condition more frightening is that the first symptoms frequently do not appear until well into the use of the drugs. At this point, immediate withdrawal may be too late to prevent the onset of the condition.²⁸ Additionally a change in medication may not prevent the onset of symptoms. More commonly, however, the positive results in the mental condition of the patient may convince a physician that the benefits of continuing treatments outweigh the risk or even the actuality of tardive dyskinesia.²⁹ Thus, the nature of psychotropic drugs presents the patient and the physician with a fundamental dilemma: to treat or not to treat, to be treated or not to be treated.³⁰

body. E. MAGGIO, *supra* note 12, at 227. Tardive dyskinesia's prevalence among institutionalized patients runs between 50-56%. *Id.* See also *Rogers*, 478 F. Supp. at 1360 (50-56% of patients suffering from tardive dyskinesia); *Rennie*, 462 F. Supp. at 1145 (estimated between 25-50% of patients suffered from tardive dyskinesia).

27. Plotkin, *supra* note 4, at 476-77; Symonds, *supra* note 5, at 708 & n. 41.

28. E. MAGGIO, *supra* note 12, at 28-29; Plotkin, *supra* note 4, at 477.

29. See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131, 1140 (D.N.J. 1978) (individual action) (despite presence of tardive dyskinesia, Rennie's psychiatrist continued to prescribe and administer a combination of lithium and an antidepressant) and 476 F. Supp. 1294 (D.N.J. 1979) (class action), *aff'd in part, rev'd in part*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 119 (1982), *reinstated on remand*, 720 F.2d 266 (3d Cir. 1983).

30. Throughout the case law on the right to refuse, there is a pervading concern over the proper roles for the parties to play in the decision to override a patient's refusal. The three principal actors have been the patient, his psychiatrist, and the court. Each has interests worthy of protection and consideration. Most of the decisions are made at the doctor-patient level, but courts have become intimately involved in this process as the arbitrator of disputes and the enforcer of norms.

The patient's interest is, of course, the most personal of the three. It is his life that is the subject of discussion, his body that will or will not be forcibly medicated, and his decision which will or will not be respected. There are a number of constitutional and statutory claims he can advance if he is maltreated. See *infra* notes 42 & 64. He is in the best position to faithfully weigh the risks and benefits because he alone has experienced the advantages and disadvantages of being medicated and unmedicated. *Rogers*, 478 F. Supp. at 1361. It is "difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risks of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risks is a uniquely personal decision." *Rennie*, 462 F. Supp. at 1145.

The court's role and the physician's role are related. Simply stated, the court views its function as one of extraordinary deference to the physician's/hospital's decision. This deference is based on two grounds. First, the psychiatrist more likely knows what is best for his patient, and has expertise in solving medical problems the court does not have. The court "may not substitute its idea of what is best for the resident in lieu of the [psychiatrist's] decision." *Dixon Ass'n for Retarded Citizens v. Thompson*, 91 Ill. 2d 518, 533, 440 N.E.2d 117, 127 (1982). After all, psychiatrists are professionals, not advocates.

Historically, only the first aspect of this question has been addressed. Based on his professional knowledge of the known benefits and detriments of a given treatment, the physician calculated the appropriate treatment plan for the patient and acted upon his medical decision.³¹ The physician did not always have the patient's best interests in mind, however, and faced with the realities and pressures of running an orderly and disciplined hospital, the physician frequently prescribed "treatment" that more closely resembled punishment than anything else.³²

This one-actor decision making process is subject to both potential and actual abuse. In fact, the heightened awareness in mental

In re Pates, 99 Ill. App. 3d 847, 850, 426 N.E.2d 275, 277 (1981). As such, they have the responsibility to exercise their professional judgment in formulating a treatment plan. Indeed, due process demands that at the very least the psychiatrist exercise professional judgment. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982). If such a judgment is made, that decision is "presumptively valid." *Id.* at 323.

Courts are also deferential because of the patient-physician relationship. Courts have realized that a "therapeutic alliance between psychiatrist and patient [is a] fundamental concept for treating the mentally ill," and without it, very little progress can be achieved. *Rogers*, 478 F. Supp. at 1136. The "sympathetic relation" between patient and psychiatrist evincing the best in "medical diagnostic techniques" is not amenable to procedural due process. *In re Ottolini*, 73 Ill. App. 3d 971, 975-76, 392 N.E.2d 736, 739 (1979) (citations omitted). As part of that alliance, the psychiatrist owes the patient a "careful canvas of alternatives" upon which the patient's decision can be made. *Covington v. Harris*, 419 F.2d 617, 625 (D.C. Cir. 1969).

Nevertheless, the courts are not entirely deferential to the medical decision. It is clearly within "the realm of judicial authority" to protect residents of institutions from deprivations of their due process rights. *Dixon*, 91 Ill. 2d at 533, 440 N.E.2d at 127. As one commentator has noted: "It is the legal system, and not psychiatry, that has the moral and constitutional obligation to decide whether citizens may be treated without their consent." Plotkin, *supra* note 4, at 465. As this issue continues to be litigated, the tension between the proper roles of these parties will persist. Whether the courts will become less deferential to medical decisions and more carefully scrutinize hospital motives remains to be seen.

31. See *Covington v. Harris*, 419 F.2d 617, 621 (D.C. Cir. 1969). In *Covington*, Justice Bazelon stated that giving physicians "unchecked and unbalanced power over essential liberties" was contrary to notions of judicial review and the scheme of American government. *Id.* "It is not the doctor's nature," Bazelon wrote, "but human nature which benefits from the prospect and fact of supervision." *Id.*

32. *E.g.*, *Nelson v. Heyne*, 491 F.2d 352, 357 (7th Cir. 1974) (thorazine administered to control excited behavior without patient's consent was cruel and unusual punishment); *Knecht v. Gillman*, 488 F.2d 1136, 1140 (8th Cir. 1973) (apomorphine, a drug that induces vomiting, administered solely as punishment, was found to be cruel and unusual punishment). In *Mackey v. Procunier*, 477 F.2d 871, 878 (9th Cir. 1973), a prisoner suffered recurring nightmares after being medicated with succinylcholine, a drug that creates the sensation of suffocation and impending death, as a means of punishment for his disobedience. The drug was administered as part of a prison-wide aversion therapy to encourage good conduct. The Ninth Circuit found that such "therapy" raised serious eighth amendment problems and possibly constituted "impermissible tinkering with the mental processes." *Id.*

patients' rights has stemmed, at least in part, from the realization of this systemic potential for abuse.³³ The *ad hoc* victories of mental patients deprived of their constitutional rights were simply insufficient to emancipate the mentally ill; the system of decision making itself had to be changed. The recognition that the question was not merely a medical one, but a highly personal one, naturally meant that the patient's input had to be considered and incorporated into the decision. When patients do refuse treatment, it is generally because they wish to avoid the unpleasant side effects.³⁴ An accurate assessment of the risks and benefits of any treatment, of course, is an essential issue that must be decided. More basic, and more controversial, is the issue of who may make that decision.³⁵ In other words, the question first is whether the patient, if competent to do so, should be permitted to decide for himself what drugs he should be given, and second, when, if ever, his wishes must succumb to either the expertise of his physician or the competing interests of other patients or society.

THE RIGHT TO REFUSE: A SURVEY

Courts which have faced the right to refuse psychotropic drugs issue have grappled with this dilemma and have tried to reconcile the competing interests of the parties involved. Courts have examined the state's interest in administering the drugs, the underlying bases for the civil commitment, and the patient's interest in receiving or not receiving the medication.³⁶ They have examined the nature of the patient's right and have balanced that right against the claims of the state in effecting its mental health policy. At times, courts have found the state's interest overriding; at other times, courts have struck down statutory provisions and hospital procedures to protect the constitutional rights of the disadvantaged psychiatric patient.³⁷

33. Litigation entails a long, laborious process that has only a limited impact. See *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980) (order only affected procedures at one mental hospital in Ohio). To successfully eviscerate the systemic inequities of the mental health system, progressive legislation that is vigorously implemented is necessary. See *Commission Report*, *supra* note 3, at vi-viii.

34. Gaughan & LaRue, *supra* note 8, at 47. "In summary, it appears that whether or not the effectiveness of the drugs has been exaggerated, their dangers have been vastly underestimated." Plotkin, *supra* note 4, at 376. Thus, both the benefits and the risks of a prescribed treatment must be weighed fairly, by both parties. Only then can the right to refuse be given its fullest meaning.

35. See also Comment, *supra* note 14, at 500 (the critical issue in the right to refuse cases is the "allocation of the decisionmaking power to mental patients rather than their physicians.")

36. See *infra* notes 40-84.

37. See *infra* notes 40-84.

A survey of the case law demonstrates that several emerging lines of thought and recurring analytical approaches have formed the bases for resolution of the right to refuse issue.³⁸ These themes are important because they appear again, in statutory form, in the Illinois Mental Health and Developmental Disabilities Code (Code) and provide a backdrop against which the Code may be understood and analyzed.³⁹

The Origins of the Right to Refuse

Many of the early decisions dealing with the right to refuse medication were criminally based.⁴⁰ Generally, they involved the rights of prisoners, insanity acquitees, or those found unfit to stand trial. Indeed, much of the litigation directly affecting the rights of the mentally ill can be traced to the criminal commitment context.⁴¹ At least part of the purpose behind the commitment then was to protect society from criminally dangerous mental patients and to punish them as much as to treat them.

For this reason, the eighth amendment prohibition against cruel and unusual punishment provided the first real basis for granting a right to refuse medication.⁴² In the typical medication-

38. *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971). Realizing that an ordinary patient could not be forcibly medicated absent his informed consent, the *Winters* court posed the following inquiry: "The question then becomes at what point, if at all, does the patient suffering from a mental illness lose the rights he would otherwise enjoy in this regard." *Id.* at 68.

39. See *infra* notes 89-99 and accompanying text.

40. Cf. *Jones v. United States*, 103 S. Ct. 3043 (1983) (insanity acquitee); *Vitek v. Jones*, 445 U.S. 480 (1980) (convicted felon); *Humphrey v. Cady*, 405 U.S. 504 (1972) (sexual deviate); *People v. Lang*, 76 Ill. 2d 311, 391 N.E.2d 350 (1979) (defendant indicted for murder found unfit to stand trial); *In re Ottolini*, 73 Ill. App. 3d 971, 392 N.E.2d 736 (1979) (defendant indicted for murder found unfit to stand trial).

41. In most states, there are at least some distinctions made in the procedures for criminal and civil commitment. Comment, *Commitment Following an Insanity Acquittal*, 94 HARV. L. REV. 605, 605 n. 3 (1981). Much of the problem arises because a single definition of mental illness must encompass a number of different legal standards such as insanity, incompetency, and unfitness to stand trial. See *People v. Lang*, 76 Ill. 2d 311, N.E.2d 350 (1972) (criminal defendant was found unfit to stand trial but did not meet requirements of civil commitment). Criminal commitments raise a plethora of issues that are beyond the scope of this comment. For a thoughtful discussion of one such issue, see Comment, *Standards for Involuntary Civil Confinement of Incompetent Defendants Must Include Present Dangerousness*, 3 WHITTIER L. REV. 591 (1981).

42. See *Scott v. Plante*, 532 F.2d 939, 946-47 (3d Cir. 1976); *Nelson v. Heyne*, 491 F.2d 352, 357 (7th Cir. 1976); *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973); *Knecht v. Gillman*, 488 F.2d 1136, 1140 (8th Cir. 1973); *Welsch v. Likins*, 373 F. Supp. 487, 503 (D. Minn. 1974) (dicta); *Sawyer v. Sigler*, 320 F. Supp. 690, 694 (D. Neb. 1970). But see *Osgood v. District of Columbia*, 567 F. Supp. 1026, 1032-33 (D.D.C. 1983) (treatment does not inflict unnecessary or wanton pain); *Rennie*, 462 F. Supp. at 1143 (psychotropic drugs are effective and therapeutic, and therefore are not punishment).

as-punishment case, a drug was forcibly administered⁴³ to an inmate as punishment for belligerent or uncooperative behavior.⁴⁴ The institution's claim that administering the drugs constituted treatment was rejected, and courts used the eighth amendment to vindicate inmates' rights.⁴⁵ Similarly, common law battery and false imprisonment claims were based on the notion that the forcible administration of drugs amounted to an unconsented, harmful or offensive touching of the person. These claims had limited success, however, because the institution's right to care for the inmate was overriding.⁴⁶

As courts began to gradually recognize that institutionalized persons had a right to humane care and services, the connection between treatment and punishment became more strained,⁴⁷ and eighth amendment challenges failed with greater frequency. If the institution had an obligation to provide treatment, reasoned the courts, then surely the patient had the obligation to receive it.⁴⁸ At

43. For purposes of this comment, the phrases "forcibly medicated" or "forcibly administered" refer not only to the injection of the patient with a drug against his will, but also to the submission of the patient to treatment through undue influence, duress, or coercion by hospital personnel.

44. See, e.g., *Knecht v. Gillman*, 488 F.2d 1136, 1137 (8th Cir. 1973) (forcibly administering an emetic as punishment for getting up late, talking, swearing, giving cigarettes to other inmates, and lying).

45. See, e.g., *Scott v. Plante*, 532 F.2d 939, 946-47 (3d Cir. 1976); *Mackey v. Procnier*, 477 F.2d 877, 878 (9th Cir. 1973).

46. The major difficulty with these tort claims is that the patient has given implied consent to be treated when he is admitted either voluntarily or involuntarily into the institution. *O'Donoghue v. Riggs*, 73 Wash. 2d 814, 820 n. 2, 440 P.2d 823, 828 n. 2 (1968); *Belger v. Arnot*, 344 Mass. 679, 183 N.E.2d 866 (1962). See also W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 101-02 (4th ed. 1971).

47. The emerging right to treatment evinced a recognition that mental hospitals were under an obligation to take positive steps to either improve the condition of mental patients or ameliorate the hazards of institutional life. If minimally adequate humane services and care were being given, a patient would have difficulty demonstrating that forced medication was punishment. The standards for cruel and unusual punishment were more difficult to meet. To state an eighth amendment claim, a patient had to prove that the recommended treatment, or lack of it, amounted to "indifference or intentional mistreatment," or that it was "sufficiently unusual, exceptional, and arbitrary." *Sawyer v. Sigler*, 320 F. Supp. 690, 694-96 (D. Neb. 1970). Such a showing was no longer possible, and psychotropic drugs, if not administered sadistically, were found therapeutic and effective, and not cruel and unusual. *Rennie*, 462 F. Supp. at 1143.

48. There can be little doubt that the right to treatment and the right to refuse treatment issues are closely interrelated. Courts and commentators have not always agreed, however, on just how the two concepts are connected. Compare *Katz, The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 778 (1969) (involuntarily committed patient has no right to refuse treatment despite existence of right to treatment) with Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 ST. LOUIS U.L.J. 100, 108-15 (1975) (refusal of drug treatment becomes valid waiver of right to treatment). At their most basic level, the two concepts seem to be contradictory, perhaps mutually exclusive. The right to treatment imposes an obligation on the hospital to provide, at the least, minimally adequate care and services.

the very least, no patient could claim he was being punished when

Youngberg v. Romeo, 457 U.S. 307 (1982). The Court in *Youngberg* held that the constitutional minimums a hospital must afford are "reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests." *Id.* at 324. In its most progressive and liberal form, the right to treatment requires that a hospital provide a patient with a "realistic opportunity to be cured or to improve his or her mental condition." *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (preliminary injunction), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). The right to refuse treatment, however, creates a right in the patient to deny the very treatment proposed by the hospital. The *Rogers* district court identified this dilemma when it posed the question of "whether the hospital's duty to provide necessary treatment carries with it an implicit right to impose such treatment contrary to a patient's expressed wishes." *Rogers*, 478 F. Supp. at 1365.

As the *Rogers* court realized, the two concepts need not be seen as contradictory at all. In fact, the existence of a right to treatment has most often been a precursor to the recognition that a patient has a right to refuse the very same treatment. *Scott v. Plante*, 532 F.2d 939, 947 n. 9, (3d Cir. 1976) (right to treatment and right to refuse may both exist); *Nelson v. Heyne*, 491 F.2d 352, 356, 359 (7th Cir. 1974) (finding both right to "effective treatment" and right to refuse major tranquilizers administered as punishment); *Davis v. Hubbard*, 506 F. Supp. 915, 921, 930-33 (N.D. Ohio 1980) (recognizing right to treatment in Ohio mental hospital existed, court granted right to refuse psychotropic drugs); *Rogers*, 478 F. Supp. at 1365 (recognizing right to treatment and right to refuse were different rights); *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (preliminary injunction) (finding a right to treatment) and 344 F. Supp. 373, 380 (M.D. Ala. 1972) (permanent injunction) (finding right to refuse aversion therapy, electroconvulsive therapy, lobotomies, and other "hazardous" treatment), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). The simultaneous acceptance of both rights can be reconciled if both rights are viewed as enhancing the integrity and autonomy of the patient. See Comment, *supra* note 14, at 502-03. It is the quality of the life of institutionalized patients that is being served in both instances.

Moreover, the existence of both rights demonstrates a demand for honesty and accountability in the confinement and treatment of institutionalized patients. "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." *Wyatt*, 325 F. Supp. at 785. Not only must confinement for the purpose of treatment provide treatment, the services provided must truly be treatment and not mere custodial care or punishment. This is the essence of the right to refuse. Thus, the two rights together provide limits on the state intrusion of forcibly medicating while requiring minimally adequate treatment.

The right to treatment and the right to refuse were again inter-connected in the revision of the Mental Health Code of 1967. In the new code, both rights exist. See ILL. REV. STAT. ch. 91 1/2, §§ 2-102(a) & 2-107 (1983). See also ILL. REV. STAT. ch. 91 1/2, § 1-128 (1983) (defining treatment similar to *Wyatt*). When the Governor's Commission proposed the right to refuse statute, it was viewed as perhaps establishing a "new right." See *Commission Report, supra* note 3, at vi. Prior to granting that right, however, the Commission frankly stated its policy regarding treatment.

In the past, intervention in the lives of people often was justified by a promise of treatment, rehabilitation or habilitation; a promise that was not always fulfilled. It is our hope that the old shortcomings and some of the hypocrisy in dealing with the mentally disabled will be replaced with statutory honesty. There is a *quid pro quo* in our proposals. It is the Commission's intent that the State make no promises that it does not intend to fulfill. The only justification for an involuntary restriction on the freedom of a mentally disabled person in a civil proceeding is the provision of ade-

the institution was only carrying out its obligation to treat. Therefore, if a right to refuse medication existed, it had to be based on the right to refuse medication as treatment, and not as punishment.

The Right to Refuse Treatment

The first court to address the right to refuse psychotropic drugs as treatment issue was the district court of New Jersey in *Rennie v. Klein*.⁴⁹ The decision in *Rennie* was rendered just prior to *Rogers v. Okin*,⁵⁰ which was decided by the district court of Massachusetts. Together, these cases and their subsequent procedural developments,⁵¹ announced governing principles in the law on the right to refuse treatment and provided its most comprehensive discussion. Both courts found a right to refuse medication on constitutional grounds at the district court level. The subsequent litigation modified and refined this basic principle and more fully explained the limits of the patient's right and the exceptions to it.⁵²

The district court in *Rennie* held that a patient's right to refuse psychotropic drugs was based on an individual's right to protect his

quate treatment, rehabilitation or habilitation. Unless such promises are kept, there can be no deprivation of liberty. Liberty and treatment are interrelated.

Commission Report, supra note 3, at vi-vii. It was against the backdrop of this insistence on a right to treatment that the Commission proposed the right to refuse treatment. Thus, the two concepts again were inextricably linked.

49. 462 F. Supp. 1131 (D.N.J. 1978) (individual action) and 476 F. Supp. 1294 (D.N.J. 1979) (class action), *aff'd in part, rev'd in part*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 119 (1982) (in light of Supreme Court's decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982)), *reinstated and modified on remand*, 720 F.2d 266 (3d Cir. 1983).

50. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded on procedural grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982) (in light of intervening state case *In re Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981)).

51. While *Rogers* and *Rennie* were proceeding through the appellate process, other courts were deciding the issue in favor of a patient's right to refuse psychotropic drugs. In *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980), the United States District Court for the Northern District of Ohio held that mental patients have a right to refuse psychotropic drugs based on the first amendment and the constitutional right to privacy. *Id.* at 938 n. 32. Like the *Rennie* court, it found that procedural due process required a hearing with an impartial decisionmaker before the patient could be forcibly medicated. *Id.* at 939. In *Osgood v. District of Columbia*, 567 F. Supp. 1026 (D.D.C. 1983), the United States District Court for the District of Columbia stated that there may be a right to refuse psychotropic drugs on first amendment grounds, specifically focusing on the free exercise of religious belief protection. In *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983), the Second Circuit held that mental patients had a right to refuse psychotropic drugs based on their fourteenth amendment liberty interests. *Id.* at 979. The court also required an opportunity for a hearing to review the decision to administer the medication, but did not require the hearing to be judicial in nature. *Id.* at 981. Thus, courts are more frequently recognizing that mental patients do have a right to refuse treatment.

52. See *infra* text accompanying notes 67-82.

mental processes from governmental interference and the individual's right to autonomy over his body.⁵³ The court found that these were clearly aspects of the penumbral right to privacy, protected by the fourteenth amendment due process clause.⁵⁴ Rennie had been diagnosed as a paranoid schizophrenic, and his "abusive and assaultive" behavior had been controlled by forcibly medicating him with thorazine and prolixin.⁵⁵ Rennie had also begun to demonstrate early symptoms of tardive dyskinesia. Nevertheless, his physician maintained that the best treatment for him was to continue being medicated.⁵⁶ The district court denied Rennie's request for an injunction because the hospital was already administering the least restrictive treatment.

The court repeated its holding that mental patients had a right to refuse psychotropic drugs in a subsequent class action involving the same hospital and granted a preliminary injunction.⁵⁷ The court recognized that the right to refuse drugs was not absolute, and therefore, focused its analysis on how to decide when a patient could refuse treatment. The court found that the decision had to be an individualized one based on several factors.⁵⁸ Additionally, the hospital had to follow certain outlined procedures before it could override a patient's right to refuse.⁵⁹ The court then held that in an emergency situation, where there was a sudden and significant change in the patient's condition which created danger to either the patient or others, that patient can be forcibly medicated without a due process hearing.⁶⁰

53. *Rennie*, 462 F. Supp. at 1144-45.

54. *Id.*

55. *Id.* at 1136-40.

56. *Id.* at 1140. According to his psychiatrist, the best treatment for Rennie was a combination of lithium and an antidepressant. *Id.* Moreover, this was the least intrusive alternative available according to the psychiatric staff.

57. *Rennie*, 476 F. Supp. at 1309.

58. The *Rennie* court identified four factors that must be considered in deciding whether to grant the patient a right to refuse treatment in a particular case. Those factors were:

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

Rennie, 476 F. Supp. at 1297. The court reasoned that any decision based on these factors would amount to an accepted balance of the risks and benefits of a prescribed treatment. *Id.*

59. *Id.* at 1303-11. The *Rennie* court also thoroughly analyzed the procedures that were necessary to administer these drugs and to override the patient's refusal. *Id.* at 1298-1312. The court concluded that procedural due process requires an independent review of the refusal decision especially where there was a history of compelled medication. *Id.* at 1306.

60. *Id.* at 1313-14; see *infra* note 174.

In *Rogers v. Okin*,⁶¹ the court also held that patients had a right to refuse psychotropic medication absent a medical emergency. The court based its holding on two constitutional grounds. Like the *Rennie* court, it based the right to refuse medication on the privacy interest of the patient to make the intimate decision regarding the administration of psychotropic medication.⁶² The court stated that the patient's right to decide such an issue was basic to any notion of privacy.⁶³ The court also found a first amendment⁶⁴ aspect to the right to refuse. The right to decide important matters affecting one's personal life is a basic right, and necessarily entails the decision to be treated with psychotropic medication.⁶⁵ Nevertheless, the court did not maintain that the right was absolute. The court stated that in an emergency situation, where failure to forcibly medicate would result in "a substantial likelihood of physical harm" to the patient, to other patients, or to staff members of the hospital, a patient may be forcibly medicated.⁶⁶

The United States Court of Appeals for the First Circuit affirmed the *Rogers* opinion finding it "intuitively obvious" that a per-

61. 478 F. Supp. at 1365, 1371.

62. *Id.* at 1366.

63. *Id.*

64. "Congress shall make no law . . . abridging the freedom of speech." U.S. CONST. amend. I. The first amendment was made applicable to the states in *Gitlow v. New York*, 268 U.S. 652 (1925). The first amendment claim for the right to refuse treatment has two distinct branches. The one accepted by the *Rogers* court was the right to generate one's own thoughts, to think how one wishes, and to give expression to those thoughts. See *Paris Adult Theater I. v. Slaton*, 413 U.S. 49, 67 (1973) ("The fantasies of a drug addict are his own and beyond the reach of government.") See also *Stanley v. Georgia*, 394 U.S. 557, 565 (1969) ("Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds."). This is very similar to the autonomous decision branch of privacy. See *infra* note 117. See also *Scott v. Plante*, 532 F.2d 939, 946-47 (3d Cir. 1976) (forcibly medicating patients may raise first amendment problems); *Mackey v. Proconier*, 477 F.2d 877, 878 (9th Cir. 1973) (drug induced condition may constitute impermissible interference with mental process); *Davis v. Hubbard*, 506 F. Supp. 915, 938 n. 2 (N.D. Ohio 1980) (psychotropic drugs invade patient's ability to think and communicate freely and violate first amendment rights); *Kaimowitz v. Department of Mental Health*, Civ. No. 73-19434-AW (Cir. Ct. Wayne County, Mich. July 10, 1973), reported in, A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 902 (1974) (psychosurgery impairs power to generate ideas violating first amendment).

The other branch of the first amendment claim encompasses the right of the person to freely exercise his religious beliefs. A patient may assert the right to deny treatment on religious grounds. See *Osgood v. District of Columbia*, 567 F. Supp. 1026, 1034-36 (D.D.C. 1983) (Christian Scientist may have right to refuse psychotropic drugs); *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir. 1971) (Christian Scientist's first amendment right protects her refusal of medical treatment). See also ILL. REV. STAT. ch. 91 1/2, § 102(b) (1983) (right to choose only religious healing).

65. *Rogers*, 478 F. Supp. at 1367.

66. *Id.* at 1365. See *infra* text accompanying notes 145-149. The emergency exception appears to be the only valid limit on the patient's right to refuse that the *Rogers* court recognized.

son has constitutionally protected privacy, bodily integrity, and personal security interests in deciding whether to take psychotropic medicine.⁶⁷ The First Circuit, however, took a more tolerant view of the state's interest in forcibly medicating mental patients. It identified three overriding interests to the patient's privacy interest: the *parens patriae* power in preventing a patient's mental condition from deteriorating,⁶⁸ the police power in preventing the patient from causing harm to other patients or to himself,⁶⁹ and the economic interest in imposing extra burdens on the state in operating mental health facilities.⁷⁰ After weighing these factors, the court criticized the district court's holding as an "attempt to fashion a single [standard] instead of requiring individualized balancing" of the particular individual's interest and the state's interest.⁷¹

The United States Court of Appeals for the Third Circuit af-

67. 634 F.2d 650, 653 (1st Cir. 1980), *aff'g* 478 F. Supp. 1342 (D. Mass. 1979), *vacated and remanded on procedural grounds sub nom.* Mills v. Rogers, 457 U.S. 291 (1982).

68. *Id.* at 657-61. The *parens patriae* power refers to the power of the state to act as guardian over persons "under disability" such as homeless children, incompetents, and idiots. *Developments, supra* note 3, at 1207-22. It is one of the two principal interests the state can assert to justify the deprivation of liberty entailed by civil commitment. *O'Connor v. Donaldson*, 422 U.S. 563, 581-83 (1975); *see also In re Germich*, 103 Ill. App. 3d 626, 431 N.E.2d 1092 (1981) (demonstrating the classic example of *parens patriae* commitment where patient refused to eat, bathe, or clothe himself and had no one to take care of him); *Developments, supra* note 3, at 1211-22.

The *parens patriae* power has been criticized as a basis of supporting the state's override of a competent patient's right to refuse. *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980), *vacated and remanded on procedural grounds sub nom.* Mills v. Rogers, 457 U.S. 291 (1982) ("the *sine qua non* for the state's use of its *parens patriae* power as justification for the forceful administration of mind-altering drugs is a determination that [patient is incompetent]."); *Davis v. Hubbard*, 506 F. Supp. 915, 938 (1980). In *Davis*, the court flatly stated "neither the State's obligation to provide treatment, its interest in caring for its citizens, its interest in protecting the safety of its charges, nor any other legitimate interest justifies the State's administration of psychotropic drugs absent the informed consent of the patient [except for the police power protection of others]." *Davis*, 506 F. Supp. at 938. *See generally* DuBose, *supra* note 5.

69. *Rogers*, 634 F.2d at 657-61. For a discussion of the police power, see *infra* notes 161-66 and accompanying text.

70. *Id.* at 661. The additional burden placed on the state was recognized as an important consideration in determining what procedure is due in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). Furthermore, the required hearing need not be judicial in nature, but only an independent one made by a neutral factfinder. *See Parham v. J. R.*, 442 U.S. 584, 606-07 (1979). *See also supra* note 58 & *infra* note 174.

71. *Rogers*, 634 F.2d at 656-57. The court reasoned that the particular nature of each person's illness, the special relationship between a patient and his physician, the idiosyncratic reactions to the drugs, the individual patient's history of belligerence, and the hospital's history of forcibly medicating patients may differ from case to case. The decision to override, then, is necessarily a fact-based decision not amenable to a fixed standard. *Id.*

firmed the district court's holding in *Rennie*.⁷² The court also recognized the right to refuse as a "right of personal security," a liberty interest that could only be overcome by a compelling state purpose.⁷³ It also placed a greater emphasis on the state's interests in protecting the patient and others from harm. The court stated that the decision involved "a careful balancing" of all competing interests.⁷⁴ Furthermore, the "choice of treatment [must strike] a proper balance between efficacy and intrusiveness."⁷⁵ In essence, the court applied a least intrusive alternative⁷⁶ analysis in the decision to administer psychotropic drugs. Therefore, before psychotropic medication can be administered to the patient, there must be no effective, less intrusive treatment to prevent the patient from harming himself or others.

Although the United States Supreme Court granted certiorari to both *Rennie* and *Rogers*,⁷⁷ it did not decide either case on the merits. At the same time it was considering *Rennie* and *Rogers*, it was also considering the issue of whether a mentally retarded patient had a constitutional right to treatment. It dismissed *Rennie*⁷⁸ in light of its decision in *Youngberg v. Romeo*.⁷⁹ It considered, but did not decide *Rogers*⁸⁰ because of an intervening state case.⁸¹ The

72. 653 F.2d 836 (3d Cir. 1981), *aff'g* 476 F. Supp. 1294 (D.N.J. 1979) (class action), *vacated and remanded*, 102 S. Ct. 3506 (1982), *reinstated on remand*, 720 F.2d 266 (3d Cir. 1983).

73. *Id.* at 844. See also *Jamison v. Farabee*, No. C 780445 WHO (N.D. Cal. April 26, 1983) (consent decree), *reported in*, 7 MENTAL DISABILITY L. R. 436, 436 (1983); *Davis v. Hubbard*, 506 F. Supp. 915, 929 (N.D. Ohio 1980); *Welsch v. Likins*, 373 F. Supp. 487, 503 (D. Minn. 1974).

74. *Rennie*, 653 F.2d at 847.

75. For a discussion of the intrusiveness of these drugs, see *infra* note 174.

76. *Rennie*, 653 F.2d at 847. For a discussion of the least restrictive alternative analysis, see *infra* note 96.

77. At the same time that the Supreme Court was considering *Rennie* and *Rogers*, it was also considering *Youngberg v. Romeo*, 457 U.S. 307 (1982). Thus, the Court was considering the constitutional right to treatment at the same time it was considering the constitutional right to refuse treatment, further demonstrating that the two issues are closely related. See *supra* note 48. In the end, the Court avoided deciding the difficult aspects of both issues. See *infra* notes 79-87.

78. 102 S. Ct. 3506 (1982).

79. 457 U.S. 307 (1982). In *Youngberg*, the Court decided the issue of whether involuntarily committed mentally retarded patients have a due process right to minimally adequate training or habilitation. *Id.* at 309. It concluded that they do, but the Court did not reach the larger question of a right to treatment. *Id.* at 326 (Blackmun, J., concurring). The Third Circuit understood the Court's remand of *Rennie* in light of *Youngberg* as a rejection of the right to refuse treatment based on a least restrictive alternative standard. *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983).

80. *Mills v. Rogers*, 457 U.S. 291 (1982). The Supreme Court discussed the complexities of the right to refuse treatment issue, but did not decide the case before it. *Id.* at 298-300. See *infra* notes 82-87 and accompanying text.

81. *In re Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981). The Supreme Judicial Court of Massachusetts held that a mentally incompetent person, through his

Court admitted in *Mills v. Rogers*⁸² that the right to refuse psychotropic drugs entailed both "substantive and procedural aspects."⁸³ The substantive issue involves first, a definition of the constitutional interest protected, and second, an identification of the competing state interest that would outweigh the patient's right to refuse.⁸⁴ The procedural issue concerns the constitutionally permissible, minimum procedures that are necessary to determine whether the competing interests do, in fact, outweigh the patient's interests.⁸⁵ These two components of the problem are not strictly matters of federal constitutional law but are intimately connected with questions of state law.⁸⁶ Conceding that state law may grant rights "more extensive" than the federal Constitution, the Supreme Court declined to address the merits until Massachusetts had the opportunity to decide the matter.⁸⁷ The Court did provide a model, however, for states to use in analyzing the guarantees it provides for psychiatric patients.

THE RIGHT TO REFUSE TREATMENT IN ILLINOIS

Following the Supreme Court's guidance, this section now turns to the right to refuse treatment in Illinois. Recognizing that the rights afforded by Illinois may be greater than those given by the federal Constitution, this section first explores the substantive nature of the right to refuse. A full understanding of this right necessarily requires a brief examination of the Bill of Rights of the Mental Health and Developmental Disabilities Code (Code). Next, the limits of the right are explored, with special attention given to the state's interest in protecting the patient and others from harm. Similarly, this section discusses the procedural guarantees that may be required in the decision to override the patient's refusal.

The Code

One of the principal additions to the Mental Health and Devel-

guardian, had a constitutional and common law right to refuse antipsychotic drugs. *Id.* at 425 n. 9, 421 N.E.2d at 51 n. 9. The Supreme Court found that this decision, based on state law, may have altered the First Circuit's decision in *Rogers. Mills*, 457 U.S. at 304. Accordingly, it remanded *Rogers* for further consideration in view of *Roe. Id.* at 306.

82. 457 U.S. at 299.

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.* at 300. The Illinois Supreme Court has found that the rights of institutionalized patients granted under the Illinois Constitution and the Mental Health and Developmental Disabilities Code are greater than those granted by the Supreme Court in *Youngberg v. Romeo*. Dixon Ass'n for Retarded Citizens v. Thompson, 91 Ill. 2d 518, 523, 440 N.E.2d 117, 121 (1982).

87. *Mills v. Rogers*, 457 U.S. 291, 298-300 (1982).

opmental Disabilities Code was the creation of a bill of rights⁸⁸ which is contained in the first article of the new Code.⁸⁹ It outlines those rights deemed essential to the maintenance of a humane and progressive mental health system.⁹⁰ The bill of rights begins with a general proviso that all rights guaranteed to non-institutionalized persons by law may not be denied to institutionalized patients solely on account of being institutionalized.⁹¹ This general guarantee demonstrates the policy, reflected elsewhere in the Code,⁹² that

88. The Mental Health Code of 1967 did not contain a separate bill of rights. *See generally* ILL. REV. STAT. ch. 91 1/2, § 1-1 (1977) (repealed 1979). The Governor's Commission recommended the creation of a bill of rights because it "believe[d] it necessary to statutorily articulate the rights of mentally disabled persons. The present Mental Health Code makes certain references to patient rights, but they are vague and ill-defined." *Commission Report, supra* note 3, at 1. In response, the Commission recommended that the first article of the new code spell out "in considerable detail what amounts to a bill of rights for mentally disabled persons." *Id.*

89. *See generally* article I of the Mental Health and Developmental Disabilities Code, ILL. REV. STAT. ch. 91 1/2, §§ 2-100 to 2-111 (1983).

90. There are numerous rights and principles advanced in the new Code. The focus of this comment is section 2-107 (the right to refuse treatment). This right cannot be adequately viewed in isolation. Other rights and principles bear directly on that right. For example, the right not to be subjected to unnecessary restraints (§ 2-108) or seclusion (§ 2-109), and the right to deny treatment on religious grounds (§ 2-102(b)) directly impact on the scope and meaning of § 2-107. Furthermore, the right not to be exposed to shock therapy, psychosurgery, or other experimental therapy (§ 2-110), absent the patient's informed consent, demonstrates the Code's increased concern for patient rights when faced with particularly drastic treatment modalities.

Moreover, two other principles, critical to the right to refuse treatment issue, are also adopted by the Code. The first is the express negation of any presumption of incompetence in section 2-101. *See infra* text accompanying notes 150-58. The second is the adoption of a least restrictive alternative standard in the selection and formulation of treatment plans. *See infra* note 96. *See also Commission Report, supra* note 3, at 23. Section 2-107 cannot be fully understood without reference to these underlying principles.

91. ILL. REV. STAT. ch. 91 1/2, § 2-100 (1983). This section states:

No recipient of service shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services.

Underscoring this provision is the policy that a mentally disabled person may not be discriminated against solely on the basis of receiving mental health services or because he suffers from a mental disability. *See Commission Report, supra* note 3, at 21.

92. Thus, the Code establishes standards that must be met before treatment modalities may be applied. These standards vary depending on the importance of both the state's and the individual's interests and the intrusiveness of the treatment. *See* ILL. REV. STAT. ch. 91 1/2, §§ 2-103(c) (patients entitled to unimpeded and uncensored mail and telephone communication); 2-104 (patient may possess personal property unless in so possessing it others are harmed); 2-106 (patient shall be fairly compensated for labor he performs); 2-108 (restraints may only be imposed to prevent patient from causing physical harm to self or others); 2-109 (patient may be secluded only to prevent him from causing harm to self or others); 2-110 (no shock therapy or psychosurgery without patient's informed consent) (1983). This survey illustrates that the rights of the mentally

the rights of inpatients must only be infringed upon grudgingly, and in each instance, based on independent grounds.⁹³ Many sections of the Code must be interpreted in this manner in order to have meaning and to justify their presence in the Code.⁹⁴

Sections 2-101⁹⁵ and 2-102⁹⁶ reflect this policy. Section 2-101 expressly negates any presumption that a committed patient is in-

disabled are closely guarded under the Code and that they may not be summarily discarded merely because the patient is institutionalized.

93. See *infra* notes 96 & 107 and accompanying text.

94. See *infra* notes 95 & 96.

95. ILL. REV. STAT. ch. 91 1/2, § 2-101 (1983) states:

No recipient of services shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court. Such determination shall be separate from a judicial proceeding held to determine whether a person is subject to involuntary admission or meets the standard for judicial admission.

96. ILL. REV. STAT. ch. 91 1/2, § 2-102(a) (1983) states:

A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan, which shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and, where appropriate, such recipient's nearest of kin or guardian. A qualified professional shall be responsible for overseeing the implementation of such plan.

In constitutional terms, the least restrictive alternative requires that the means adopted to pursue a valid state purpose infringes on a citizen's rights in the least intrusive possible way. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) ("even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle personal liberties when the end can be more narrowly achieved.") In the right to refuse treatment context, the least restrictive alternative means that the recommended treatment modality must be the least intrusive way of achieving the desired end. *Cf. Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969). For example, if a patient can be restrained to effectively calm the patient or prevent him from harming others, then it would be improper for a hospital to perform shock therapy or administer an excessive dosage of a psychotropic drug. In *Rennie*, Rennie had objected to the administering of a psychotropic drug. Since such treatment was the only effective way of treating Rennie, the hospital had chosen the least intrusive means. *Rennie*, 462 F. Supp. at 1154.

While several lower federal courts have readily adopted the least restrictive alternative as the appropriate standard in adjudging whether psychotropic drugs may be forcibly administered, see *Rennie v. Klein*, 653 F.2d 836, 847 (3d Cir. 1981), *vacated and remanded*, 102 S. Ct. 3506 (1982), *reinstated on remand*, 720 F.2d 266 (1983); *Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. 1980), *vacated and remanded on procedural grounds subs nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974); *Welsch v. Likins*, 373 F. Supp. 487, 502 (D. Minn. 1974), the Supreme Court has been reluctant to adopt the standard. In its decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982), the Court did not decide to adopt or reject the least restrictive alternative theory even though the lower court had squarely adopted it. See *Romeo v. Youngberg*, 644 F.2d 147, 165-66, *vacated and remanded*, 457 U.S. 307 (1982). The Court also remanded *Rennie* and refused to decide *Rogers* even though both courts had adopted the least restrictive alternative. See *supra* notes 71 & 76. Furthermore, the Court's holding in *Youngberg*, that due process required at least "the exercise of professional judgment," *Youngberg*, 457 U.S. at 322, has been interpreted by the

competent to make important decisions affecting his welfare.⁹⁷ In fact, section 2-101 requires a separate judicial proceeding to determine a patient's incompetency.⁹⁸ Section 2-102 establishes a least restrictive alternative standard in the formulation of individualized treatment plans.⁹⁹ The least intrusive treatment plan, from the perspective of the patient, must be chosen before any more intrusive plan is adopted.¹⁰⁰ Both of these sections illustrate the general policy of a vigorous advocacy for the rights of mental patients.

Recently, the Illinois Supreme Court has decided its first case interpreting the provisions of the new Code. In *In re Hays*,¹⁰¹ the court ruled that a mental hospital could not involuntarily commit a voluntarily committed patient absent the patient's request to be released. The court's conclusion was not surprising given that three lower Illinois courts had reached the same result.¹⁰² Moreover, the court gave the statutory provision in question¹⁰³ its literal meaning and interpreted the Code precisely as the legislative history indicated it should be interpreted.¹⁰⁴

Third Circuit as an implicit rejection of the least restrictive alternative. *Rennie*, 720 F.2d at 269.

The Court's remand of *Rennie* need not be seen as a rejection of the least restrictive alternative. See *Rennie v. Klein*, 720 F.2d 266, 276-77 (Weis, J., concurring). The exercise of professional judgment require a consideration of all alternatives. "The state, which knows or has the means of knowing the available alternatives, must bear the burden of proving what alternatives are available, what alternatives were investigated, and why the investigated alternatives were not deemed suitable." *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974) "Professionally, a doctor owes [a mental patient] a careful canvas of alternatives to drastic treatments." *Covington v. Harris*, 419 F.2d 617, 625 (D.C. Cir. 1969). The *Youngberg* standard, rather than being inconsistent with a least restrictive alternative, seems to support such a standard.

In Illinois, the least restrictive alternative must always be considered even if it is not the final choice of treatment administered. *In re Ottolini*, 73 Ill. App. 3d 971, 977, 392 N.E.2d 736, 740 (1979). The difficulty in implementing this standard is that a paradigm of treatment modalities arranged according to intrusiveness is required. This calls for the medical opinion of the particular physician, a layman's assessment from the patient, and an institutional assessment from the hospital. These are not likely to be similar; for example, a patient may prefer one drug, the physician may prefer another, and the institution may prefer still another. The least restrictive alternative requires that the exercise of professional judgment be utilized to choose the least intrusive, *effective* treatment of the three. Clearly, it need not be the choice of the patient, but in many situations it will be. See *infra* note 174.

97. ILL. REV. STAT. ch. 91 1/2, § 2-101 (1983).

98. *Id.* See *infra* text accompanying notes 150-58.

99. ILL. REV. STAT. ch. 91 1/2, § 2-102(a) (1983).

100. See *supra* note 96.

101. 102 Ill. 2d 314, 465 N.E.2d 98 (1984).

102. See *In re Meyer*, 107 Ill. App. 3d 871, 438 N.E.2d 639 (1982); *People v. Hill*, 72 Ill. App. 3d 638, 391 N.E.2d 51 (1979); *In re Clement*, 34 Ill. App. 3d 574, 340 N.E.2d 217 (1975).

103. See ILL. REV. STAT. ch. 91 1/2, § 3-403 (1983).

104. See *In re Hays*, 102 Ill. 2d 314, 319-20, 465 N.E.2d 98, 100-01 (1984).

The significance of the decision then, other than being the first case to analyze the new Code,¹⁰⁵ lies in this literal reading of the Code's provisions and the court's willingness to defer to the legislative judgment. The right involved in *In re Hays* was a technical, procedural one, and minor in comparison to other provisions in the Code's bill of rights.¹⁰⁶ That the supreme court read this minor right literally, and faithfully adhered to the ascertained legislative intent in enacting the statute, reflects well on how the court will approach and analyze more difficult or controversial provisions of the new Code.¹⁰⁷ More significantly, the court's deference to the careful balancing done by the legislature, and the court's unwillingness to hastily disturb that balance are indicative of a judicial understanding of the difficulty in balancing the competing interests of the psychiatric patient and the state. The court's analysis demonstrates a judicial tolerance of the legislative determination that in many instances the rights of mental patients are paramount to the interests of the mental health facility,¹⁰⁸ and that a patient's due process rights continue beyond commitment to a mental health facility. In this sense, the tenor of the Code echoes the philosophy that "[a]dditional restrictions beyond those necessarily entailed by hospitalization are as much in need of justification as any other deprivation of liberty."¹⁰⁹

The Substantive Right

The right to refuse generally accepted treatment also demonstrates this philosophy. A commitment alone cannot deny a patient

105. See *supra* text accompanying notes 101-103.

106. Compare ILL. REV. STAT. ch. 91 1/2 § 3-403 with *id.* at §§ 2-107, 2-108, 2-109, & 2-110. The rights in article I of the code provide substantive protections of the patient's individual liberties.

107. Of course, the opposite argument may be advanced that because the right in *In re Hays* was a minor one, the court will look differently upon rights that are more significant. Additionally, the right in *Hays* caused minimal administrative burdens upon the state. The court may look upon rights that create greater administrative burdens on the state more favorably for the state's interest than it did in *Hays*. See *supra* note 70. Finally, the right in *Hays* was not very controversial. It had previously been interpreted by lower courts and had a clear legislative history supporting it. Faced with a more controversial right, such as section 2-107, the court may find a literal reading of the provision less acceptable and will be less likely to defer to the legislative determination of the appropriate balancing of competing interests, particularly if the right in question involves great expense to the state or a significant detriment to the state's interest. The tenor of the opinion, with its emphasis on deference to the legislature and its adoption of the plain meaning of the statute, suggests, however, that, absent special circumstances, the Illinois Supreme Court is unwilling to interfere with the careful balancing of the competing interests done by the legislature.

108. See article I of the Mental Health and Developmental Disabilities Code, ILL. REV. STAT. ch. 91 1/2, §§ 1-100 to 1-200 (1983).

109. *Covington v. Harris*, 419 F.2d 617, 624 (D.C. Cir. 1969).

of all his rights; it plainly should not expose a patient to needless restraint, psychosurgery, or the major, disruptive side effects of psychotropic drugs.¹¹⁰ The effect of section 2-107, which provides that an adult recipient of services "shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication" is that psychiatric patients may refuse psychotropic drugs.¹¹¹ If such services are refused, they shall not be given. Although seemingly straightforward, this section raises several issues. Most prominent among these are who may exercise this right and what underlying principles support the right to refuse?

First, the statute excludes minors; only adults may exercise the right of refuse.¹¹² While the statute does not expressly state that incompetent patients may not refuse, the language clearly suggests that only competent patients may do so.¹¹³ An incompetent's guardian, however, may refuse on behalf of the patient based on a "best interests" standard. Furthermore, the statute makes no distinction between voluntarily and involuntarily committed pa-

110. See *Vitek v. Jones*, 445 U.S. 480, 491-94 (1980). In *Vitek*, the Supreme Court held that a prisoner may not be involuntarily transferred to a mental hospital without a due process hearing. *Id.* at 488. Implicit in the holding was that prisoners had greater liberty interests than mental patients. As the Court noted, "[the prisoners] retained a residuum of liberty that would be infringed by a transfer to a mental hospital." *Id.* at 491. The Court placed great emphasis on the "stigma" that attends commitment to a mental institution and identified it as one of the primary increased deprivations of institutional life in a mental facility. *Id.* at 492; *O'Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975) (constitutional deprivations encountered during commitment); *In re Stephenson*, 67 Ill. 2d 544, 553-55, 367 N.E.2d 1273, 1278-79 (1977) (loss of liberty and stigmatizing effect of civil commitment). See also *Jones v. United States*, 103 S. Ct. 3043, 3060-61 (1983) (Brennan, J., dissenting) (confinement in mental institution is more intrusive than confinement in prison primarily because of exposure to wide variety of treatment modalities). *Olsen v. Karwoski*, 68 Ill. App. 3d 1031, 1035, 386 N.E.2d 444, 448 (1979) (commitment affects one's reputation and business life and should not be done casually).

111. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983). Section 2-107 states in full:

An adult recipient of services, or, if the recipient is under guardianship, the recipient's guardian, shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication, unless such services are necessary to prevent the recipient from causing serious harm to himself or others. If such services are refused, they shall not be given. The facility director shall inform a recipient or guardian who refuses such services of alternate services available and the risks of such alternative services, as well as the possible consequences to the recipient of refusal of such services.

112. *Id.*

113. Section 2-107 provides for refusal by a recipient or his guardian. The only time a guardian is appointed for an adult patient is when the patient is incompetent. Illinois Probate Act of 1975, ILL. REV. STAT. ch. 110 1/2, § 11a-3 (1983). Therefore, a patient must be competent to personally refuse treatment. See *infra* notes 150-58 and accompanying text.

tients;¹¹⁴ it simply refers to any "recipient of services."¹¹⁵ Thus, both voluntarily and involuntarily committed patients may refuse treatment, even though some theoretical problems may be raised about the propriety of voluntary patients refusing treatment.¹¹⁶ Therefore, any adult, competent psychiatric patient may exercise his section 2-107 right to refuse treatment during his commitment at a mental hospital.

The remaining substantive question concerns what rationale supports an adult mental patient's right to refuse medication: what right is being protected by section 2-107? An examination of Illinois case law, the general public policy of Illinois, and the language of the statutory provision itself reveals that the right to refuse is based on an aspect of the patient's privacy interests,¹¹⁷ namely that aspect

114. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983). The Governor's Commission proposed that the distinction between voluntary and involuntary committees be removed from the new Code. "As the law evolves, there is a growing trend to erase the distinction between the rights of voluntary or involuntary patients who receive services. Care and treatment must be based on individual needs and not upon legal status." *Commission Report, supra* note 3, at vii.

115. *See supra* note 111.

116. The major problem arises when voluntary patients refuse to take treatment and the state hospital is unable to have the patient involuntarily committed. A voluntary patient is free to leave, but he may be in need of treatment. Often the state hospital is forced to threaten the patient with involuntary commitment so that the patient will either acquiesce or discharge himself. The inappropriateness of this solution is self-evident. Private mental hospitals do not face this problem because they are free to expel uncooperative patients. *See Weiner, Mental Health Code, REPRESENTING MENTAL HEALTH CARE INSTITUTIONS AND PROFESSIONALS (IICLE) § 11.31 (1980)*. One innovative solution to this problem is for voluntary patients to contract for services and treatment prior to institutionalization. Thus, if the patient then refuses treatment, the contract to provide treatment will be binding despite the patient's protestations otherwise. For a discussion of the voluntary commitment contract and some of its failings, see Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R. — C.L. L. REV 777 (1982).

117. The concept of a right to privacy was first raised in a law review article. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). It found expression in Justice Brandeis's famous dissenting opinion in *Olmstead v. United States* 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (cited with approval in *In re Estate of Brooks*, 32 Ill. 2d 361, 374, 205 N.E.2d 435, 442 (1965)):

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.

The Supreme Court did not formally recognize the right to privacy, however, until *Griswold v. Connecticut*, 381 U.S. 479 (1965). In *Griswold*, the Court ruled that a married couple had a constitutional right to privacy which encompassed the use of contraceptives. The Court extended this right to unmarried couples in *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972). In *Roe v. Wade*, 410 U.S. 113, 155 (1973), the Court held that the right to privacy was broad enough to

of the fourteenth amendment liberty interest that allows a person to make autonomous decisions regarding his personal life, unrestrained by governmental interference.¹¹⁸ Illinois has recognized the right of noninstitutionalized patients to refuse medications on religious, privacy, and liberty grounds.¹¹⁹

In *In re Estate of Brooks*,¹²⁰ the Illinois Supreme Court ruled that a Jehovah's Witness could refuse a life-saving blood transfusion on religious grounds. The plaintiff's first amendment right to freedom in the exercise of his religious belief was subject only to government action where such exercise "endangers clearly and presently" the public health.¹²¹ The state argued that society had a compelling interest in protecting the lives of its citizens, and therefore, could forcibly medicate the plaintiff. The court flatly rejected this argument because the appellant had done "no overt or affirmative act" that endangered society.¹²² Forcibly administering a blood transfusion was a violation of the appellant's privacy and first amendment rights.

In *Pratt v. Davis*,¹²³ the Illinois Supreme Court affirmed the appellate court's holding that performing an unconsented and un-

cover a woman's right to have an abortion. The Court further stated that an individual has an "interest in independence in making certain kinds of important decisions" relating to his life without governmental interference. *Whalen v. Roe*, 429 U.S. 589, 599-600 (1974). See generally L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 893-98 (1978).

The Illinois Supreme Court has viewed these decisions as affirming the right of citizens to make decisions concerning "the most intimate areas of personal and marital privacy." *In re Roger B.*, 84 Ill. 2d 323, 327, 418 N.E.2d 751, 755 (1981). The court refused to extend that line of cases to allow an adoptee to seek his genealogical origin through sealed adoption records. *Id.* The court has held, however, that the state may not regulate matters pertinent to one's choice of lifestyle. *City of Chicago v. Wilson*, 75 Ill. 2d 525, 531, 389 N.E.2d 522, 527 (1978). As the court has stated: "The citizen has always been supposed to be free to determine the style of architecture of his house, the color of the paint he puts thereon, the number of trees he will plant, the style and quality of the clothes that he and his family will wear." *Haller Sign Works v. Physical Culture Training School*, 249 Ill. 439, 443, 94 N.E. 920, 926 (1911). The government may not regulate these affairs or any others that are basic to the "values of privacy, self-identity, autonomy, and personal integrity." *City of Chicago v. Wilson*, 75 Ill. 2d 525, 531-32, 389 N.E.2d 522, 527 (1978) (quoting *Kelly v. Johnson*, 425 U.S. 238, 251 (1976) (Marshall, J., dissenting)). These cases and others, see *infra* notes 119-127 and accompanying text, demonstrate Illinois' longstanding commitment to protect a person's right to privacy, whether it be bodily integrity, self-identity, or personal autonomy.

118. See *supra* note 117.

119. *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (religion and privacy); *In re Reliford*, 65 Ill. App. 3d 177, 382 N.E.2d 72 (1978) (liberty); *Pratt v. Davis*, 118 Ill. App. 161 (1905), *aff'd*, 244 Ill. 300, 79 N.E. 562 (1906) (liberty and privacy).

120. 32 Ill. 2d 356, 205 N.E.2d 435 (1965).

121. *Id.* at 372-73, 205 N.E.2d at 440.

122. *Id.* at 373, 205 N.E.2d at 440.

123. 244 Ill. 300, 79 N.E. 562 (1906), *aff'g* 118 Ill. App. 161 (1905).

authorized surgical removal of the plaintiff's uterus violated her bodily integrity and her right to privacy. The plaintiff suffered from epilepsy, and the defendant argued that the plaintiff was not competent to give her consent to the surgery and that the surgery was in the patient's best interests. The appellate court rejected this contention stating that the patient was able to make decisions "affecting the important concerns of life."¹²⁴ Therefore, while the surgeon may have exercised professional judgment and skill, he could not violate, without the patient's permission, his patient's bodily integrity.¹²⁵

In *In re Reliford*,¹²⁶ the Illinois Appellate Court for the First District discussed the constitutionality of involuntary hospitalization of a mentally disabled patient. The court stated that the state may only infringe upon a patient's privacy rights when the state's interest demonstrates an acceptable and narrow purpose.¹²⁷ Furthermore, the court stated that, to the "fullest extent possible, mentally retarded individuals possess the same rights as other individuals."¹²⁸

Additionally, Illinois has recently passed the Illinois Living Will Act.¹²⁹ Its provisions grant terminally ill, competent, adult patients the right to refuse life-supporting techniques. The terms of the statute seek to ensure that competent adults understand the choice that they are making and that they fully contemplate the consequences of refusing life-supporting treatment. If the patient has decided not to extend his life by artificial means, then that decision will be honored. The public policy of the act is stated clearly and unequivocally in its statement of purpose: "The legislature finds that persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedure withheld or withdrawn in instances of a terminal condition."¹³⁰

The impact of *Brooks*, *Pratt*, and the Living Will Act is clear. In Illinois, competent patients have the right to make fundamental decisions about the medical treatment they receive. This right extends even to the most drastic situations. The public policy of Illinois, then, must also encompass a competent mental patient's right to refuse psychotropic drugs. Moreover, the finding in *Reliford*, that institutionalized mental patients retain the rights of noninsti-

124. *Pratt*, 118 Ill. App. at 175.

125. *Id.* at 166.

126. 65 Ill. App. 3d 177, 382 N.E.2d 72 (1978).

127. *Id.* at 182, 382 N.E.2d at 76.

128. *Id.* at 181, 382 N.E.2d at 76.

129. ILL. REV. STAT. ch. 110 1/2, § 701 *et seq.* (1983).

130. *Id.* at § 701.

tutionalized patients "to the fullest extent possible" compels the same result.

A literal reading of section 2-100 of the Code would also lead to the conclusion that mental patients have the right to refuse treatment.¹³¹ Its impact is that the same rights accorded noninstitutionalized patients must be granted to institutionalized patients. The two compelling interests which the state may assert are the protection of an incompetent and the prevention of harm to others. An examination of the relevant case law reveals that these are precisely the overriding state interests that the courts are concerned with. The search in those cases, however, was unavailing.¹³² The courts have held that, absent such a compelling, overriding purpose, the individual's interest in preserving the " 'inviolability of his person' from unendorsed intrusion"¹³³ by medical treatment and the patient's right "to be left alone"¹³⁴ outweighed the state's desire to forcibly medicate the patient. Today, these are clearly recognized as privacy interests, "the free citizen's first and greatest right,"¹³⁵ and can only be overcome by a compelling state purpose.

Furthermore, the right to refuse treatment found in section 2-107 is intertwined with the doctrine of informed consent.¹³⁶ The

131. ILL. REV. STAT. ch. 91 1/2, § 2-100 (1983). *See supra* note 91.

132. In *Brooks*, the court's decision may have turned on the absence of a minor child. Had Brooks had a minor child for whom the state would have been responsible, the court would probably have ordered the life saving transfusion. *Brooks*, 32 Ill. 2d at 369, 205 N.E.2d at 440. The Living Will Act does not have any effect during the course of a woman's pregnancy. Her life will be sustained as long as she remains pregnant because the state has a compelling interest in preserving the fetus. ILL. REV. STAT. ch. 110 1/2, § 3(c) (1983). In *Pratt*, the court's decision turned on the competency of Davis. Though suffering from epilepsy, which caused occasional lapses in rationality, Davis was at all times competent to decide whether to be treated. *Pratt*, 118 Ill. App. at 175. If Brooks had left a minor child, or if a qualified patient under the Living Will Act had been pregnant, or if Davis had been incompetent, the state would have had an overriding interest to assert, and the patient's decisions would not have been honored. Absent such an overriding interest, however, the wishes of the patient must be followed.

133. *In re Reliford*, 65 Ill. App. 3d 177, 182, 382 N.E.2d 72, 76 (1978) (quoting *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905), *aff'd*, 244 Ill. 300, 79 N.E. 562 (1906)).

134. *In re Estate of Brooks*, 32 Ill. 2d 361, 374, 205 N.E.2d 435, 442 (1965).

135. *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905), *aff'd*, 244 Ill. 300, 79 N.E. 562 (1906).

136. Informed consent is a doctrine that is widely used and an issue that is much litigated in medical malpractice. Foster, *Informed Consent of Mental Patients*, in *LAW AND THE MENTAL HEALTH PROFESSIONS* 71, 71 (W. Barton & C. Sanborn, eds. 1978). It may arise in the admission, treatment, or release of patients. *Id.* Generally, it calls for a patient to be informed of the benefits and risks of undergoing certain medical treatment. C. LIDZ, A. MEISEL, E. ZERABAVEL, M. CARTER, R. SESTAK, L. ROTH, *INFORMED CONSENT, A STUDY OF DECISIONMAKING IN PSYCHIATRY* 10-12 (1984) [hereinafter cited as C. LIDZ & A. MEISEL, *INFORMED CONSENT*]; Symonds, *supra* note 5, at 711. To be valid, the consent must be knowledgeable, voluntary, and competent. C. LIDZ & A. MEISEL, *INFORMED CONSENT*, *supra*, at 10-12. These three requirements often be-

Illinois statute requires that the patient be made aware of alternative services.¹³⁷ The risks incident to both the recommended treatment and the alternatives must be fully explained to the patient, as well as the effects of not taking the prescribed medication or treatment. Inherent in the concept of informed consent is that the patient will be competent to weigh the risks against the benefits and make a choice based on that weighing. Frequently, the patient will agree with the psychiatrist's recommendation. At other times, the patient will disagree and will refuse the treatment. In either situation, it is the right of the patient to balance the risks, to consider the alternatives, and to make the decision that is protected by section 2-107.

Since section 2-107 is couched in language of informed consent, it is clear that the interest it is protecting is that of making a fundamental decision about what is done to and with one's own body. The person's right to expose his body to risk or protect it from harm underlies this choice. When a hospital forcibly medicates a patient, that freedom to decide is indisputably lost. Before the state may deprive the patient from making that choice, it must have an overriding purpose.

There is even greater concern for the bodily integrity and privacy interests of institutionalized patients. The defenselessness of the patient arising out of the involuntariness of his confinement,¹³⁸ the unequal influence and control that the physician has over the patient,¹³⁹ and the peculiarly insidious intrusiveness of psychotropic

come suspect when the patient suffers from a mental disability. Whether the patient is truly informed of *all* the risks, whether his consent can ever truly be voluntary from inside an institution, and whether the patient can competently assess the risks and benefits if he is told them are all critical informed consent issues which must be resolved. See *Kaimowitz v. Department of Mental Health*, Civ. No. 73-19434 AW (Cir. Ct. Wayne Cty. Mich. July 10, 1973), reported in, A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 902 (1974); Symonds, *supra* note 5, at 711-14. Although informed consent may be difficult to obtain in a mental hospital, it is not impossible. See C. LIDZ & A. MEISEL, INFORMED CONSENT, *supra*, at 212, 276-79; see generally Comment, *Informed Consent and the Mental Patient: California Recognizes a Mental Patient's Right to Refuse Psychosurgery and Shock Treatment*, 15 SANTA CLARA L. REV. 723 (1975).

137. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983).

138. The involuntarily committed patient is not free to leave the hospital, escape the watchful eye of the hospital staff, or freely disregard the institution's rules. His life is clearly more controlled than an ordinary patient's life is, see *Developments*, *supra* note 3, at 1194, and the mental patient is more likely to succumb to institutional pressures either out of helplessness or tiresome acquiescence. See C. LIDZ & A. MEISEL, INFORMED CONSENT, *supra* note 136, at 119, 222-24.

139. The influence that physicians have over noninstitutionalized patients pales in comparison with the extraordinary influence they have over institutionalized patients. "Involuntarily confined patients cannot reason as equals with the doctors and administrators over whether they should [be subject to treatment]." *Kaimowitz v. Michigan Dept. of Mental Health*, No. 73-101434-AW

drugs and other psychiatric treatment all expose the institutionalized patient to a greater risk of invasion on his privacy interests.¹⁴⁰ Each of these factors magnifies the necessity of protecting the vital interests of the patient, and makes more imperious his need to be able to refuse treatment. Equally so, these factors demand increased sensitivity to the motives behind forcible medication and require a compelling state interest in overriding the patient's request not to be treated.

THE LIMITS OF THE RIGHT TO REFUSE

Even though the right to refuse psychotropic drugs is fundamentally rooted in a person's privacy interest, it is a qualified right. There are times when the state can assert interests that will override a patient's refusal. Two such situations, found in the case law of other jurisdictions, although not expressly mentioned in the Code, arise when there is a medical emergency and when the patient is incompetent. Section 2-107 expressly provides for another, more common situation. The statute provides that the patient's right to refuse services will be honored "unless such services are necessary to prevent the recipient from causing serious harm to himself and others."¹⁴¹ While the general import of section 2-107 is clear, its precise meaning is not. Terms such as "necessary," "serious harm," and "others," directly qualifying the recipients' right, are unclear, undefined, and in need of interpretation. The follow-

(Cir. Ct. of Wayne County, Mich. July 10, 1973), reported in A BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 902, 915 (1974). See also Dresser, *supra* note 101, at 836-41. See generally C. LIDZ & A. MEISEL, INFORMED CONSENT, *supra* note 136, at 110, 178 (for a variety of reasons, patient feels the decision should be made by doctor).

140. See generally *Jones v. United States*, 103 S. Ct. 3043 (1983). In *Jones*, the plaintiff, an insanity acquittee, challenged his continued commitment. At the time of his release hearing, he was receiving 1000 milligrams of Thorazine. *Id.* at 3061 n. 19 (Brennan, J., dissenting). Justice Brennan spoke eloquently about the undue exposure of mental patients to psychotropic drugs. He noted that patients often do not have a right to refuse drugs and that they are often administered more for the hospital's reasons than for the patient's well-being. *Id.* at 3060-61. Finally, he noted that drugs may lead to permanent institutionalization because

extended institutionalization may effectively make it impossible for an individual to prove that he is no longer mentally ill and dangerous, both because it deprives him of the economic wherewithal to obtain independent medical judgments and because the treatment he receives may make it difficult to demonstrate recovery. The current emphasis on using psychotropic drugs to eliminate the characteristic signs and symptoms of mental illness, especially schizophrenia, may render mental patients docile and unlikely to engage in violent or bizarre behaviors while they are institutionalized, but it does not "cure" them or allow them to demonstrate that they would remain non-violent if they were not drugged.

Id. at 3508 n. 16.

141. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983). See *supra* note 111.

ing sections of this segment discuss this express exception to the right to refuse and other implicit exceptions.

The Emergency Exception

An exception to the patient's right to refuse psychiatric drugs, recognized in the Code¹⁴² and in every case that has found a right to refuse treatment,¹⁴³ is a medical emergency. The emergency exception is not so much a reflection of the diminution of the patient's right to refuse as it is a reflection of an enlargement in the state's interest to override that refusal. Emergencies inherently bring forth an urgency that often stills the reflective consideration of competing interests. The patient's decision making power becomes suspect and the hospital's concern for saving lives becomes paramount. Few courts should have any theoretical difficulties in overriding a patient's persistent refusal in the face of a life-threatening situation. The real problem is one of defining when an emergency is present and when the new decision making hierarchy takes over.

The nature of hospitalization, placing the patient at an extraordinary disadvantage,¹⁴⁴ suggests that in most cases it is the patient's right that will give way first. Furthermore, in every case, it is the patient's decision that is overridden and the patient who stands to lose the most. For these reasons, an emergency situation must be narrowly defined and limited in order to protect the patient's interests. A narrow reading of an emergency would be more consistent with a mental health code oriented toward patients' rights given the likely consequence of hospital domination.

Section 2-111 of the Code defines an emergency as a situation where the delay in obtaining consent "would endanger the life or adversely and substantially affect the health of a recipient of services."¹⁴⁵ When such a situation is present, only "essential medical" procedures may be performed.¹⁴⁶ On its face, this is a stricter definition of emergency than those that were adopted in *Rennie* and *Rogers*. The *Rennie* court defined an emergency as a "sudden, sig-

142. ILL. REV. STAT. ch. 91 1/2, § 3-608 (1983).

143. *E.g.*, *Jamison v. Farabee*, No. C 780445 WHO (N.D. Cal. April 26, 1983) (consent decree), *reprinted in*, 7 MENTAL DISABILITY L. REP. 436, 438 (1983) (an emergency arises when there is a "sudden, marked change in the patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to others," and is grounds for an override of patient's refusal); *Osgood v. District of Columbia*, 567 F. Supp. 1026, 1037 (D.D.C. 1983) (emergency provides compelling state purpose to override refusal); *Davis v. Hubbard*, 506 F. Supp. 915, 934 (N.D. Ohio 1980) (danger must be grave and imminent to be emergency).

144. *See supra* notes 136-140.

145. ILL. REV. STAT. ch. 91 1/2, § 2-111 (1983).

146. *Id.*

nificant change in the patient's condition that causes danger."¹⁴⁷ The *Rogers* court, which adopted a definition closer to Illinois', defined emergency as a situation where "failure to [forcibly medicate] would result in a substantial likelihood of physical harm" to other patients.¹⁴⁸

The Illinois standard is stricter than one or both of these standards in four ways. First, the Illinois standard concerns only dangers to the patient and not others, as do the *Rennie* and *Rogers* definitions. Second, the danger required is specifically danger to life that substantially and adversely affects the patient's health. Third, section 2-111 deals with a specific, imminent threat, unlike the *Rogers* "likelihood" test. Finally, it requires the administration of only those procedures that are essential to ameliorate the emergency situation. Thus, before an institutionalized patient may be forcibly medicated in Illinois on an emergency basis, there should be an imminent, actual threat of serious danger to the patient.¹⁴⁹ This definition will protect psychiatric patients' rights without impeding a hospital's moral imperative to save lives. Additionally, it recognizes the fragile nature of the institutionalized patient's independence and requires the hospital to meet a difficult, but reasonable standard.

The Incompetency Exception

Underlying the doctrines of informed consent and the right to refuse is a basic supposition, often unstated, but always present: a mental patient must be competent to refuse treatment. It must be remembered that a person may be mentally ill and remain competent; "[t]here is simply no necessary relationship between mental illness and incompetency."¹⁵⁰ This seemingly contradictory situation is largely the result of the interaction of the medical and legal systems. Mental illness is a medical term describing a medical condition; its determination is left to expert medical opinion. The Code does not define mental disability largely because of the difficulty of adequately defining it in narrow enough terms to be effective.¹⁵¹ Incompetency is a legal term most prominently used in probate court; its determination is made by a judge. Defining incompetency and keeping it distinct from mental illness have caused some courts problems.

The real difficulty has not been one of confusion. Courts understand the differences between mental illness and incompetency.

147. *Rennie*, 653 F.2d at 847.

148. *Rogers*, 478 F. Supp. at 1365.

149. See *Commission Report*, *supra* note 3, at 54.

150. *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980).

151. See *Commission Report*, *supra* note 3, at 14.

The problem arises when the court presumes that the broader concept, mental illness, encompasses the narrower concept of incompetency; more precisely, courts rule that commitment to an institution presumes incompetence.¹⁵² If a person is unable to live safely outside an institution, so goes the argument, then that person should not be able to dictate to the hospital what treatment is best for him. What this generalized presumption fails to grasp is that commitment too is a legal standard. Commitment may not properly be used as giving medical support to a separate legal finding, that of incompetency.

Courts that have recognized the right to refuse treatment have made this distinction and have kept mental illness and incompetency apart.¹⁵³ This has also been the approach of the new Code. The Code requires a finding of incompetency to be made by a court in a separate judicial hearing from the finding of involuntary commitment.¹⁵⁴ The Governor's Commission noted that when both issues are adjudicated together, the distinctions become blurred and testimony describing the mental illness becomes testimony of incompetency.¹⁵⁵ To prevent this, the Commission mandated separate hearings on both issues.

At the incompetency hearing, the focus is whether the patient has the "capability to take care and intelligently" provide for all of his needs.¹⁵⁶ The proper inquiry is whether the patient's "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 [treatment]" has been undermined.¹⁵⁷ Only if the answer to this question is yes, will the issue be foreclosed and the patient be forcibly medicated. The decision must be made by a court, however, and not by medical authorities because a legal determination is being made and not a medical one.¹⁵⁸ If the patient is competent, then further inquiries become relevant. Prominent among these are whether the patient's right to refuse treatment remains intact in an emergency or when his re-

152. See generally Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 578-81, 646-49 (1978).

153. E.g., *Davis*, 506 F. Supp. at 915; *Rogers*, 478 F. Supp. at 1364; *Rennie*, 462 F. Supp. at 1146-47.

154. See *supra* note 95 (incompetency statute).

155. *Commission Report*, *supra* note 3, at 21-22.

156. *Matter of McPeak's Estate*, 53 Ill. App. 3d 133, 135, 368 N.E.2d 957, 959 (1979). See ILL. REV. STAT. ch. 110 1/2, § 11a-3(A)(1) (1983) (standard in appointing guardian is whether parent has "sufficient understanding or capacity to make or communicate responsible decision" concerning the care of his person).

157. Morse, *supra* note 152, at 632-33.

158. Some type of quasi-judicial hearing may be substituted for a formal court hearing. All that is constitutionally required is an independent hearing overseen by a neutral factfinder. See *Parham v. J.R.*, 442 U.S. 584, 606 (1979).

fusal results in serious harm to others. If the patient has made a choice based on all the relevant information, such a choice must be respected out of recognition of his privacy interest, unless in so respecting it, serious harm will result to the patient or others.

Serious Harm to Others Exception

The emergency and incompetency exceptions are narrowly drawn, and few courts will have difficulty in applying them.¹⁵⁹ A more ambiguous standard, provided in the express language of section 2-107, may prove to be more difficult to adequately define. Section 2-107 provides for the right to refuse treatment unless such services are "necessary to prevent the recipient from causing serious harm to himself or others."¹⁶⁰ The protection of others is a clear aspect of the state's police power. Since the state's power under section 2-107 is coextensive with the state's police power, the reach of one cannot exceed the reach of the other. Thus, the extent of the state's police power becomes highly relevant.

The state's police power is the inherent "attribute of sovereignty in every government by which it may protect lives, health, morals and general welfare."¹⁶¹ This "paramount obligation" of the state, however, is not without limits.¹⁶² To be a valid exercise of the police power, legislation must be designed to protect the public health and safety, or provide for the general welfare. Legislation may not proscribe an innocent activity, harmless in itself, under the guise of the police power.¹⁶³

In the right to refuse treatment context, both public health and general welfare are inappropriate justifications for governmental action. Public health generally pertains to the prevention of pestilence, pollution, or disease.¹⁶⁴ General welfare addresses issues

159. The emergency exception only requires a good faith determination by the physician that an emergency is present. ILL. REV. STAT. ch. 91 1/2 at § 2-111. The incompetency exception requires a separate judicial determination. *Id.* at § 2-101.

160. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983).

161. *Sherman Reynolds, Inc. v. Mahin*, 47 Ill. 2d 323, 326, 265 N.E.2d 640, 642 (1970); *see also* *Memorial Gardens Ass'n v. Smith*, 16 Ill. 2d 116, 156 N.E.2d 857, *appeal dismissed*, 361 U.S. 31 (1959).

162. *Sinclair Refining Co. v. City of Chicago*, 178 F.2d 214, 218 (7th Cir. 1950).

163. *Pacesetter Homes, Inc. v. Village of South Holland*, 18 Ill. 2d 247, 250, 163 N.E.2d 464, 467 (1960); *People v. City of Chicago*, 413 Ill. 83, 89, 108 N.E.2d 6, 20 (1952); *see generally* Comment, *Police Power in Illinois: The Regulation of Private Conduct*, 1972 U. ILL. L.F. 158.

164. *See, e.g.*, *Chicago Title & Trust Co. v. Village of Lombard*, 19 Ill. 2d 98, 166 N.E.2d 41 (1960) (prevention of hazards of too many gas stations in close proximity); *City of West Frankfort v. Fullop*, 6 Ill. 2d 609, 129 N.E.2d 682 (1955) (protecting public water supply from pollution); *Spalding v. Granite City*, 415 Ill. 274, 113 N.E.2d 567 (1953) (police power proper to extend sewage system to dispose wastes properly and prevent outbreak of disease).

such as poverty, illiteracy, and the betterment of society.¹⁶⁵ Only with respect to safety can the police power justify forcibly medicating a patient. Because the prevention of harm to others is a valid exercise of the state's police power, the state may forcibly medicate when it becomes necessary to prevent harm to others.

There are two particularly troublesome aspects of this standard: when is forcible medication "necessary," and whom does the term "others" incorporate? The Illinois Supreme Court has held that the legislature may not proscribe an activity that may cause harm only to oneself.¹⁶⁶ If the sole purpose of a legislative act is to prevent a person from causing harm to himself, the statute becomes an invalid exercise of the state's police power. From this perspective, the patient may only be forcibly medicated when he causes serious harm to others. The statute provides for an override, however, when it is "necessary to prevent the recipient from causing serious harm to *himself* or others."¹⁶⁷ Under a pure police power analysis, this statutory provision is unacceptable. While the provision may be supported on other grounds,¹⁶⁸ as an exercise of the state's police power, it is too expansive.

This does not mean that the state is powerless to help a patient whose condition is deteriorating, or is suicidal. In these cases, the state's powers under the emergency exception will support intervention.¹⁶⁹ Alternatively, if the patient is declared incompetent, the state's *parens patriae* powers may fill the void.¹⁷⁰

What these illustrations demonstrate is that the decision to override can be placed on a continuum. At one end, where the state's interest is greatest, lies the emergency situation and the pro-

165. See, e.g., *Finish Line Exp., Inc. v. City of Chicago*, 72 Ill. 2d 131, 379 N.E.2d 290 (1978) (police power extends to off-track betting on horse races); *Brotherhood of R.R. Trainmen v. Terminal R.R. Ass'n of St. Louis*, 379 Ill. 403, 41 N.E.2d 481 (laws "promoting peace and good order" of society are valid under police power), *aff'd*, 318 U.S. 1 (1942).

166. *People v. Fries*, 42 Ill. 2d 441, 250 N.E.2d 149 (1969); *Pacesetter Homes, Inc. v. Village of South Holland*, 18 Ill. 2d 247, 163 N.E.2d 464 (1960). In *Fries*, a statute which required a motorcyclist and his passengers to wear helmets was struck down as an invalid extension of the state's police power. *Fries*, 42 Ill. 2d at 450, 250 N.E.2d at 155. The purpose of the statute was to protect the operator and passengers from serious head injuries. *Id.* The Illinois Supreme Court declared that such a statute could not be justified by the state's police power. *Id.* While the state may have had a worthy purpose, "[s]uch a laudable purpose . . . cannot justify the regulation of what is essentially a matter of personal safety." *Id.*

167. ILL. REV. STAT. ch. 91 1/2, § 2-107 (1983) (emphasis added). See *supra* note 111. See also *Rennie*, 462 F. Supp. at 1145 (while the police power may give the power to confine, "standing alone it does not give the power to treat involuntarily").

168. See *supra* note 68.

169. See *supra* notes 142-49 and accompanying text.

170. See *supra* notes 150-58.

tection of others from harm. At the opposite end, where the state's interest is most suspect, lies the punishment and coercion situations. There is little dispute with the power of the state to forcibly medicate in an emergency, or the power of the patient to refuse when the state's purpose is solely punishment or coercion. The difficulty lies in making the determination in all those situations which arise between the polar extremes—in making the close call between necessity and mere convenience.

The decision to override a patient's refusal, then, breaks down to a consideration of four factors: the competency of the patient, the seriousness of the harm the patient causes to himself and others, the intrusiveness of the chosen treatment, and the available alternatives.¹⁷¹ The importance of any one of the factors will depend on the particular facts of the case. These are fact-based decisions that must be made on a case-by-case basis. The decision of a physician must be accorded great weight because it is presumptively the product of professional judgment made in the best interests of the patient.¹⁷² The patient's decision must also be particularly scrutinized because of his inferior position in the treatment decision.¹⁷³

Both decisions, of course, entail value-laden concerns manifesting themselves in personal priorities and preferences, as well as opinions regarding the effectiveness and intrusiveness of certain drugs.¹⁷⁴ Nevertheless, these concerns are amenable to standards;

171. All of these factors are either explicitly or implicitly built into the Code. See ILL. REV. STAT. ch. 91 1/2, §§ 2-100 (competency), 2-107 (serious harm to others and informed consent), 1-119(b) (least restrictive alternative), and 2-111 & 3-608 (emergency) (1983). See also ILL. REV. STAT. ch. 110 1/2, § 11a-3 (1983) (competency standard). These sections carry out the Governor's Commission's policy that in right to refuse treatment decisions "a balance is sought to be reached between the needs of clinicians to provide adequate and necessary treatment and the rights of recipients who may object to such forms of treatment." *Commission Report, supra* note 3, at 1. These are the same four factors that the *Rennie* court found essential to making a fair decision that adequately considered the interests of all parties. *Rennie*, 476 F. Supp. at 1297; see *supra* note 58.

172. *Youngberg v. Romeo*, 457 U.S. 307, 329 (1982); *Parham v. J.R.*, 442 U.S. 584, 607-613 (1979).

173. See *supra* notes 138-140.

174. There are a number of factors that the courts should examine in determining the intrusiveness of a particular treatment. One commentator has suggested six such factors:

- (1) The extent to which the effects of therapy . . . are reversible;
- (2) The extent to which the resulting psychic state is . . . 'abnormal' or 'unnatural' for the person in question;
- (3) The rapidity with which the effects occur;
- (4) The scope of the change in the . . . mind's functions;
- (5) The extent to which one can resist *acting* in ways impelled by the psychic effects of the drug;
- (6) The duration of the change. (Minor, long-lasting changes are more serious than profound, temporary ones).

standards which are flexible enough to protect vital interests without impugning the parties' judgment, and rigid enough to provide uniformity in application and responsible, accountable action.¹⁷⁵ The Illinois Mental Health and Developmental Disabilities Code has provided a scale upon which these decisions must be weighed. Faced with an override dispute, the courts should read the statute faithfully, weigh the interests of the parties fairly, and decide accordingly.

CONCLUSION

Section 2-107 of the Code confers a basic right to refuse treatment to all institutionalized mental patients. This right is based on the patient's fundamental privacy interest in making autonomous decisions about one's own health without interference from the state. The capacity to make this decision does not automatically expire once the patient is institutionalized; adjudication of incompetency must precede a denial of the right to refuse. Recognition of this fundamental interest has been denied too long, and the Illinois courts must vehemently and faithfully enforce the legislative grant of this right to mental patients.

The patient is not the only party that carries an important interest to the treatment decision. The Code recognizes that the patient's physician, other patients, the hospital, and its staff also have vital interests that must be considered. Guided by legal norms, courts must strive to reach the proper balance between these competing interests, and courts must not hesitate to protect lives in an emergency, prevent serious harm to others when it is clearly present, and inexorably confront the abuses of patient's rights wherever it finds them.

This is not an easy task, but it is one which inevitably calls for a judicial solution. The courts must be careful to view each party as

Shapiro, *Legislating the Control of Behavior Control: Autonomy in the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237, 262-69 (1974). A hospital may establish a paradigm based on the degree of intrusiveness of certain treatment modalities. Such a paradigm may only be used as a guide, however, as the factors will vary from case to case and patient to patient. *See supra* note 89.

175. The accountability of mental hospitals is also one of the primary objectives of the new Code. The Governor's Commission, in its recommendations, stated the goals of the new Code in this regard:

The prevailing mood of our country today is to require openness, honesty, and greater accountability. The Commission's recommendations include provisions not only for improved treatment and habilitation services, but also for improved techniques to monitor government provided services . . . Our recommendations will strengthen the monitoring of care and services and require greater accountability to insure not only that funds are properly expended, but that people receive all the services to which they are entitled.

Commission Report, supra note 3, at vii.

advancing worthwhile positions which merit serious consideration. The hospital cannot be portrayed as a leviathan swallowing up helpless victims without regard for their rights. Neither can the patient be seen as an amorphous laboratory animal passively receiving the newest medical craze. The right to refuse issue is a complex situation calling for human understanding and compassion. The realization that there are human beings on both sides of the treatment decision, each demanding respect and dignity, each possessing human frailties, will carry us far into resolving this complex problem.

Steven Shobat

