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Mental Hospital Drugs, Professionalism, and the Constitution

SHELDON GELMAN*

Until 1953, a social, medical, and legal consensus favored confinement of the mentally ill in state hospitals as the preferred means of dealing with serious mental illness.¹ State policy toward serious mental illness was premised on the principle that, when necessary, the mentally ill should be held in public custody, in state psychiatric hospitals, where physical and mechanical restraints were liberally used.²

Life in a mid-twentieth century state mental hospital was regimented, degrading, and hopeless.³ Hospitals housed patients in bleak, dangerous, and overcrowded wards; disordered behavior within the psychiatric institutions was controlled through seclusion techniques and, as already noted, close physical restraints.⁴ The duration of hospitalization was normally measured in years, with many patients living out their lives in state hospitals.⁵ The medications used in the state facilities were addictive sedatives, which had no specific effect on serious mental illness.⁶ Electroshock and insulin shock treatments were freely employed, and other patients were lobotomized; these treatments did nothing, however, to reduce the burgeoning state hospital population.⁷

In 1953, the advent of a new family of psychiatric drugs⁸ revolutionized state mental health systems.⁹ The drugs immediately were recognized as a

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1. For a view of state psychiatry just prior to the drug regime, see A. DEUTSCH, SHAME OF THE STATES (1948).
5. Id. at 350 (more than half of patients in state mental hospital remained in institution for 5 years, and more than one-third of patients had been institutionalized for more than 10 years).
6. Id. at 344.
8. These drugs, as a class, are called “major tranquilizers,” “neuroleptics,” or “antipsychotics.” The word “drug” is used in this article to refer to these agents, unless the context indicates otherwise.
9. For reviews of the changes in state hospital psychiatry since 1950, see Bassuk & Gerson, Deinstitutionalization and Mental Health Services, Sci. Am., Feb. 1978 at 46; Becker & Schulberg, Phasing Out
powerful addition to the psychiatric treatment arsenal. Their first generic name, "major tranquilizer," suggested as much, as did the trade names of certain new drugs: "Thorazine," "Largactil," and "Prolixin." State institutions across the country quickly adopted the drugs because of their psychiatric promise. Before the end of the decade, the new drugs had become the state hospitals' primary measure for dealing with serious mental illness, supplanting the older measures; by the middle of the next decade, drugs had displaced state hospitals themselves as the centerpiece of public mental health systems.

Inside state hospitals, insulin shock, lobotomy, and in many instances, electroshock treatment, have yielded to the use of drugs. Similarly, seclusion and physical restraints are much less in evidence, since high drug doses usually accomplish the same ends. Average hospitalizations are measured now in days and weeks—not in years and lives. Indeed, when the mentally ill wish to be hospitalized, they may find it difficult to gain admission and more diffic-


10. J. TALBOTT, supra note 7, at 26 (discussing dramatic effects of introduction of autopsychotic medications on institutional psychiatry); see generally J. SWAZEY, CHLORPROMAZINE IN PSYCHIATRY: A STUDY OF THERAPEUTIC INNOVATION (1974).

11. "Thorazine," the first of the major tranquilizers, seems to have been named for Thor, the mythological god of thunder. The relation between god and drug was, I believe, as follows: At the time of Thorazine's introduction electroshock therapy was widely used and constituted the drugs' most formidable competition. The name "Thorazine" suggested that the new drug was related to electroshock therapy in the way that thunder was related to lightning: a different but equally powerful manifestation of the same phenomenon despite the absence of any visible electric flash. Interestingly, drug recipients sometimes drew the same connection, calling the drugs "liquid shock therapy." Sitnick, Major Tranquilizers in Prison: Drug Therapy and the Unconsenting Inmate, 11 WILLAMETTE L.J. 378, 379 n.10 (1975). The names "Largactil" and "Prolixin," with their obvious overtones of power, speak for themselves.

12. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 39 (1961) ("These [tranquilizing] drugs have revolutionized the management of psychotic patients in American mental hospitals . . . ."). J. SWAZEY, supra note 10, at 207-24, describes the remarkable inroads that drugs had made as early as 1956, less than three years after their introduction.

13. The rate of psychiatric hospitalization in the United States began to decline in 1955 and dropped even more sharply after 1965. Bassuk & Gerson, supra note 9, at 47-48.

14. Sterling, Ethics and Effectiveness of Psychosurgery, in CONTROVERSY IN PSYCHIATRY 126 (J. Brady & H. Brodie eds. 1978); see Constitutional Rights of the Mentally Ill, Hearings Before the Subcommittee on Constitutional Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess. at 37 (1961) (statement of Dr. Overholser) (lobotomy had all but disappeared from hospitals because, according to Dr. Overholser, "[s]ince the tranquilizers came in you can get pretty much the same effect by giving them these drugs. . . .);

15. For discussion of the widely noted decline in physical restraint and seclusion, see Goldman, The Snow Phenomenon: Tranquilizing the Assaultive, 28 PSYCHIATRY 88, 89 (1965) (massive doses of major tranquilizers given to eight percent of all drug recipients to control assaultive behavior). In the late 1970s many New Jersey mental hospital wards with which I am familiar, including some wards for highly disturbed patients, had no seclusion rooms at all. The hospitals' reliance on drugs thus was reflected in its architectural arrangements.

The introduction of drugs has had a profound effect on the state institutions themselves. Private settings such as boarding or nursing homes have replaced state hospitals as the preferred housing for the mentally ill.\textsuperscript{18} There has been a vast reduction in the number of patients at state mental hospitals.\textsuperscript{19} A primary function of the hospitals is the institution of drug regimens,\textsuperscript{20} which will make the patients acceptable to private custodians.\textsuperscript{21} Hospitalization generally lasts no longer than is necessary to accomplish that goal.\textsuperscript{22} Meanwhile, the mentally ill live a drugged existence in these private settings.\textsuperscript{23}

Despite suggestions to the contrary, the drug regime in psychiatry is not self-evidently preferable to the custodial regime it supplanted. Indeed, despite the revolution that drugs have wrought in public mental health care, custody—defined as close supervision of the patient and restraints on the patient’s freedom of movement—remains the central part of the state psychiatric regime. Today, custody is different only in the sense that private settings have replaced public ones, and the restraints used are biological rather than physical.\textsuperscript{24}

The effects of involuntary drugging go beyond mere custody, however. Potential drug side effects are among the most serious harms that states impose upon persons protected by the Constitution. Patients forced to take drugs—as most are\textsuperscript{25}—can be mentally tormented or physically debilitated by the medi-

\begin{itemize}
  \item \textsuperscript{17} Reich & Siegel, The Chronically Mentally Ill Shuffle to Oblivion, in Psychiatrists and the Legal Process: Diagnosis and Debate 264, 266 (R. Bonnie ed. 1977) (as state mental institutions close, only acutely mentally ill admitted; others turned back to community).
  \item \textsuperscript{18} “Community” treatment and housing of the mentally ill are currently widely preferred to all forms of hospitalization. Moreover, the resulting “community” treatment settings and residences are, in general, privately rather than state operated. See generally Joint Commission on Mental Illness & Health, Action for Mental Health (1981); A. Scull, Decarceration: Community Treatment and the Deviant—A Radical View (1977); J. Talbott, The Death of the Asylum (1978); Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Mich. L. Rev. 1108 (1972); Rhoden, The Limits of Liberty: Deinstitutionalization, Homelessness and Libertarian Theory, 31 Emory L.J. 375 (1982).
  \item \textsuperscript{19} The number of patients in American state mental hospitals has decreased from a high of 559,000 patients in 1955 to 138,000 in 1980. Goldman, Taube, Regier & Witkin, The Multiple Functions of the State Mental Hospital, 140 Am. J. Psychiatry 296, 298 (1983).
  \item \textsuperscript{20} See Crane, Clinical Psychopharmacology in Its Twentieth Year, 181 Science 124, 125 (1973) (one study reported that 85% of hospitalized schizophrenics receive drugs at any given time); Geller, State Hospital Patients and Their Medication—Do They Know What They Take, 139 Am. J. Psychiatry 611, 612-13 (1982) (a study of state mental hospital housing 281 patients showed 262 were receiving drugs; four more were refusing drugs that had been prescribed); Mason, Nerviano & DeBurger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 Diseases of the Nervous System 541, 541 (1977) (drugs prescribed for more than 93% of patients at four state hospitals).
  \item \textsuperscript{21} Reich & Seigel, supra note 17, at 270 (patients in nursing homes placed under “chemical restraint” by giving them large doses of tranquilizing drugs).
  \item \textsuperscript{22} Id. at 266, 268-70 (patients discharged from hospital into nursing homes, foster homes, shelters, and proprietary homes).
  \item \textsuperscript{23} Drugging of the seriously mentally ill in the “community” is all but universal. See, e.g., P. Lerman, Deinstitutionalization: A Cross Problem Analysis 61-62, 64-68 (1981) (76% of former hospital patients in boarding homes being drugged); Leaf & Holt, How Wyatt Affected Patients, in Wyatt v. Stickney, Retrospect and Prospect 49, 96 (1981) (approximately 80% of former mental patients recently discharged from Alabama mental hospital in wake of right to treatment class action decree were being drugged); see also S. Estroff, Making It Crazy: An Ethnography of Psychiatric Clients in an American Community 68-69 (1981) (of 43 chronically mentally ill persons in “community” program, 35 received drugs on a constant basis).
  \item \textsuperscript{24} See infra text accompanying notes 112 to 130 (discussing question of whether drugs also cure mental illness).
  \item \textsuperscript{25} See supra note 20 (describing percentage of patients taking drugs).
\end{itemize}
cations, yet remain mentally ill even with the treatment. 26

As this revolution unfolded, drugs received remarkably little attention from outside of medical circles. In particular, serious judicial scrutiny of the drugs came surprisingly late. It was not until the mid- to late-1970s that patients began filing lawsuits claiming that forced medication was unconstitutional. 27 No federal court of appeals reached the merits of a drug refusal lawsuit until 1980 28—almost thirty years after the drugs' American debut and almost a decade after landmark federal court decisions recognizing a “right to [state mental hospital] treatment” and the right to trial-like hearings in connection with involuntary state hospital commitment. 29

The drugging plaintiffs' rhetoric portrayed state mental patients as ordinary medical clients who had the right to decline medical intervention, 30 but the

26. See infra note 75 to 104 and accompanying text (discussing certain side effects of drugs).
28. Earlier cases raising constitutional challenges to involuntary civil commitment involved drugs tangentially. See Bell v. Wayne County Gen. Hosp. at Eloise, 384 F. Supp. 1085, 1100 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1978, 1103 (E.D. Wis. 1972), vacated and remanded, 414 U.S. 473 (1974); see also A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 53 (1975) (discussing Lessard and permissible limits of pre-commitment hearing medication). Because the issue in these cases was whether any nontrivial treatment could be forced on patients in advance of a commitment hearing, no serious inquiry into the drugs' attributes was required or made in these cases. A still earlier case, Winters v. Miller, 446 F.2d 65 (2d Cir. 1971) cert. denied, 404 U.S. 985 (1971), upheld the right of a nondangerous, involuntarily committed woman to refuse drugs on religious grounds when she had had no judicial hearing of any kind in connection with her confinement. Although the Winters opinion included some fairly sweeping language, it is unclear whether the decision protected patients (1) who refuse drugs on nonreligious grounds, or (2) who are dangerous, or (3) who receive a prior commitment hearing.
30. Describing the litigation situation as of 1981, one commentator remarked that "the [judge-made] law regarding the right to refuse treatment generally, when measured by judicial decisions rather than articles in legal journals, still remains rather sparse." D. WEXLER, MENTAL HEALTH AND LAW: MAJOR ISSUES 244 (1981). Since the Supreme Court has never reached the merits of a "right-to-refuse-medication" claim, see Mills v. Rogers, 457 U.S. 291 (1982), and Rennie v. Klein, 457 U.S. 298 (1982), the issue remains open.
real import of these cases lay elsewhere. Unlike ordinary medical patients who can reject any and all medical treatment, state mental patients can be involuntarily confined or restrained if they refuse drug treatments. Thus, drug-refusal litigants invite the state not to treat them as ordinary patients, but rather to manage them with custodial rather than biological means. Patients who refuse drug treatment in effect reject the new state psychiatric order, and their right to do so is the central issue in “right to refuse drugs” cases.

Drug refusal therefore runs counter to the basic programmatic tenets of contemporary state psychiatry in every way. Since private boarding facilities are unlikely to accept someone who is not being drugged, the patient who refuses drugs will remain a public charge. The patient must remain in a secure hospital setting, despite state psychiatry’s presumption against prolonged hospitalization. In addition, when drugs cannot be used to manage threatening behavior, the disfavored techniques of physical restraint and seclusion must be employed.

Confronted by drug lawsuits, with their implied challenge to the current drug regime, courts generally have agreed that mental patients enjoy a constitutionally protected right to refuse drugs and that states can override this right under certain conditions. The difficult question has been whether to characterize those conditions, and thus to delineate the scope of the patients’ rights, by using medical or legal constructs. A medical characterization, for example, would allow the state to override drug refusals whenever such action was medically necessary in the state’s “professional” judgment. A legal characterization, by contrast, would employ no medical standards. Involuntary drugging might be barred, for example, unless the state had a “compelling reason” and no “less restrictive alternative” to drugging—familiar legal concepts foreign to medical decision-making. Similarly, patients’ procedural entitlements in drug matters could be determined by medical constructs, such as the right to talk with the treating doctor, or legal constructs, such as the right to an administrative hearing before a lay judge, with attorneys, witnesses, rules of evidence, and the like.

This article explores the medical and legal characterizations of the “right to refuse drugs.” The implications that these characterizations hold for present-day state psychiatry and judicially mandated change also will be explored.

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31. See, e.g., Rogers, 634 F.2d at 656 (state may override right to refuse drugs when likelihood of violence outweighs potential harm to patient or when drugging needed to prevent patients’ deterioration); Renne, 462 F. Supp. at 1145 and 476 F. Supp. at 1308 (when patient dangerous to others, when refusal caused by underlying mental condition, when drugs are component of full treatment plan, or when no alternate treatment available important factors in deciding when state can override right to refuse drugs); see also infra text accompanying notes 246 to 258.

32. E.g., Renne v. Klein, 653 F.2d 836, 855 (3d Cir. 1981) (en banc) (Seitz, C.J., concurring) (only “substantial departure from accepted professional judgment” justifies court review).


34. E.g., Renne, 653 F.2d at 849.

35. E.g., Renne, 462 F. Supp. at 1147-48; see Shavill, supra note 30, at 590.
Part I argues that the legitimacy of state drugging must be based on a choice between "professional" and "political" charters. Both the outcome of constitutional "interest weighing" and the subsequent fashioning of a remedy depend upon this choice. Part II then examines state drugging in light of the considerations enumerated in Part I. Without suggesting that either choice is compelled, the article argues that there is unprecedented strength in the case for a political charter, rather than a professional one, in state drugging matters.

Part III turns to the judicial decisions concerning the right to refuse drugs and examines the seemingly unworkable combinations of legalistic substantive standards and medical procedures that have appealed to thoughtful courts. Part IV takes issue with the courts' basic orientation and concludes with a plea for judicial candor about state drugging of the mentally ill.

I. STATE PROFESSIONALISM AND THE CONSTITUTION

When a state acts in a professional capacity, providing medical, legal, or medical,36 legal,38 or

36. My approach to this subject differs from others. In general, commentary about the "right to refuse drugs" has had two aspects. First, either explicitly or implicitly, drugging is allocated to the medical or political (legal) realms of action, see infra notes 40 to 45 and accompanying text; no matter which realm is chosen, the choice is usually taken to be self-evident. Second, there is a principled discussion of the constitutional rights and interests at stake and an analysis of how these should be balanced or adjusted to accommodate drugging's medical or political nature (depending on which realm was chosen). See, e.g., Rhoden, supra note 30, at 375 (right to refuse medication founded on constitutional right to privacy); Comment, Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 1980 Wis. L. REV. 497, 500, 542 (various autonomy interests may be asserted in right-to-refuse-drug cases).

I believe that the question of whether drugging is "medical" or "legal" is, in fact, the primary issue. In my view, however, the answer is not self-evident; rather, the question is arguable, and it deserves all the analytical care and attention usually devoted to the legal issues. As I argue in Part I, the outcome of constitutional "balancing" in fact turns on the characterization of drugs as "medical" or "legal."

This approach has its own antecedents and tradition. It is influenced by work on the place of legal structures and values in nominally medical realms. See, e.g., A. Brooks, Law, Psychiatry and the Mental Health System (1974); A. Stone, Mental Health and Law: A System in Transition (1975); Dershowitz, Psychiatry in the Legal Process: "A Knife That Cuts Both Ways", TRIAL, Feb.-Mar. 1968 at 29. Second, it owes a debt to the view of constitutional law decisions as choices "among alternative allocations of [social] decisionmaking authority . . . [the] allocation of competences." Tribe, Foreword- Toward a Model of Roles in the Due Process of Life and Law, 87 HARv. L. REV. 1, 11, 13 (1973) (internal emphasis and quotation marks omitted); see generally M. Walzer, Spheres of Justice (1983). I also am influenced by the linkage of constitutional analysis to painstaking attention to facts about drugging. See DuBose, Of The Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?, 60 MINN. L. REV. 1149 (1976). While DuBose analyzed drugs' benefits under experimental conditions and deemed the attitude of a reasonable man toward that experimental data as decisive, I believe that a broader base of facts is necessary and that DuBose's "reasonable man" apparatus is not strong enough to do the issue justice. Finally, commentators outside of the law and psychiatry domains have argued, as I shall, that the "professionalization" of constitutional standards is inexplicable as the outcome of judicial "interest balancing" and that it reflects something deeper. See Note, Due Process, Due Politics and Due Respect: Three Models of Legitimate School Governance, 94 HARv. L. REV. 1106 (1981).

I devote only passing attention to questions of remedy. Brooks, supra note 30, provides a careful discussion of remedies.


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Forced state hospital drugging, a classic case of state professionalism, illustrates these problems. To recognize a right to refuse drugs is to acknowledge legal limits on a state's power to impose potentially harmful biological interventions on its citizens. The kind of substantive and procedural constraints imposed on politically chartered activities, however, simply do not comport with the professional aspects of state hospital drugging. When mental patients avail themselves of trial-type hearings in drug matters or refuse drugs altogether, the nature of the psychiatrist-patient relation changes. That relation must be affected when doctors and patients stand as equals and dispute therapeutic issues before third-party judges—as a political charter would mandate. Moreover, if drug refusal is permitted, the doctor-patient relationship is not dissolved, as it would be in most medical settings. Instead, the patient, whose lack of judgment about psychiatric care presumably contributed to his involuntary commitment, is empowered to dictate to the doctor charged with his


40. The use of the word "charter" in this article is a loose adaptation of a usage in social anthropology, which itself is probably derived from legal concepts like "corporate charter." See generally B. Malinowski, A SCIENTIFIC THEORY OF CULTURE AND OTHER ESSAYS 48, 52-53 (1944).

41. For discussion of the diversity of goals in political realms, see generally J. Rawls, A THEORY OF JUSTICE (1971).
care. The doctor, in turn, must abandon what he or she regards as the preferred treatment—drugs—in favor of what are deemed to be less effective treatments or primitive custodial measures. The basic organization of the public mental health system is threatened and, in theory at least, state hospitals face the prospect of being overwhelmed with undruggable, unmanageable patients.42

At the same time, the license granted by a professional charter cannot comport with any view of forced drugging as a political instrument that advances a legitimate public purpose, subject to constraints designed to protect individual rights. For example, some judges override the patient's right to refuse drugs whenever the hospital's decision is recognizably "professional" in nature;43 the same judges reduce procedural due process to an opportunity for the patient to speak with a doctor.44 As a result, the right to refuse treatment is transformed into a right to receive "professional" treatment;45 a substantive constitutional liberty right becomes no more than an entitlement to a professional judgment concerning one's biological or medical well-being; and the constitutional guarantee of due process is deemed satisfied by whatever medical judgment happens to be recognized in the psychiatric science of the day.

This conflict is not necessarily between purity of constitutional reasoning on the one hand and drug refusers' health on the other. Mental patients, like others, have an interest not only in fair treatment, but also in avoiding harmful biological impositions. Moreover, incremental improvements in mental health may not be the patients' primary life goal, especially if the improvement is slight and the cost in individual dignity and physical integrity is high. Nor can one assume that state psychiatry's judgments about individual well-being—about therapeutic benefit and risk—are inevitably sound or deserving of social acquiescence.

Either professional or political values must be sacrificed in such a controversy over state professionalism. One can attempt to minimize the sacrifice, but given the incompatibility of professional and political charters, some substantial sacrifice is generally unavoidable. The difficult task is choosing which principal values to sacrifice.

B. STATE PROFESSIONALISM AND BALANCING OF INTERESTS

1. Characterization is Determinative of the Balancing Process

Courts do not resolve the conflicts posed by state professionalism simply by

42. See Shavill, supra note 30, at 602-04 (right to refuse drugs will result in sicker patients, longer hospitalizations, and demoralized doctors); Stone, Recent Mental Health Litigation: A Critical Perspective, 134 AM. J. PSYCHIATRY 273, 278 (1977) (right to refuse drugs will cause "serious harm to both patients and staff... reversing 200 years of progress and transforming the 20th century dream of the mental health center into the 18th century nightmare of bedlam.")

43. See supra note 32 and accompanying text.

44. See, e.g., Rennie v. Klein, 653 F.2d at 850-52 (judges' role limited to reviewing hospital regulations to ensure they satisfy constitutional standards); Rogers v. Okin, 634 F.2d at 657 (court's role limited to designing procedures which ensure that qualified physician considers patients' interests).

weighing and balancing individual and public interests. Before balancing these interests, courts either consciously or, more often, unconsciously characterize the challenged state action in political or professional terms; that is, they choose the appropriate charter for that activity.  

The Supreme Court has wrestled with this problem in a variety of related contexts. In *Parham v. J.R.*, 47 for example, minors challenged a state mental hospital's practice of committing children, based on their parents' signatures and consent, without a prior hearing. Should the court have politically characterized the plaintiffs as people held involuntarily by the state for treatment they did not want, or should the court have characterized the plaintiffs in a professional light—as underage medical clients, no different than children admitted to general hospitals for tonsillectomies by their parents? While both descriptions are appropriate, the children could not be characterized in both ways simultaneously, since the question was whether to require an adversarial hearing before their involuntary admission to the hospital, and the two characterizations lead to contrary conclusions. Similarly, in *Ingraham v. Wright*, 48 public school students attacked their teachers' practice of paddling as constitutionally impermissible corporal punishment. Should the physical beating have been judged politically, as a constitutionally constrained means for states to pursue legitimate public purposes, or should the paddling have been considered professionally, as a disciplinary tool of educators who just happen to work in public schools? As these two cases suggest, the characterization of the state's activity analytically precedes the weighing of constitutionally protected interests.

To determine what constitutes due process under the fourteenth amendment, courts generally state that they weigh the interests of the affected individual and the government along with the likelihood that enhanced procedures can contribute to accuracy in fact-finding. 49 The outcome of this process, however, actually will depend on whether the state's activity has been characterized as political or professional.

When the court characterizes an activity such as drugging in professional terms, the due process balancing formula will reveal a high and benign state interest (treating mental illness), an individual interest tempered by the affected person's own substantial stake in the realization of professional goals (medical cure), and a small likelihood that additional procedures invented by lay judges will improve upon the profession's own methods for achieving suc-

46. For a similar observation, though somewhat critical and confined to Supreme Court decisions about schooling, see Note, supra note 36, at 1106-07 ("[T]he standard instrumental approach [i.e. balancing of interests] is effectively abandoned [in the school cases]; reliance . . . [being] placed instead on intuitive judgments concerning the legitimacy of school governance . . . [T]he instrumental analysis . . . is not so much flawed by erroneous valuations of the relevant interests as it is simply not applied"). Unlike the author of the note, I regard the abandonment (or, at least, postponement) of balancing as inevitable, rather than remarkable or deplorable. It also is not obvious that the balancing of interests is any less "intuitive"—in that author's words—than what I have called the process of characterization.  
47. 442 U.S. 584 (1979).  
cess. The same state action, characterized politically, will produce a dramatically different outcome, although the formula for due process analysis remains unchanged. Judged in nonprofessional, political terms, the state's action of forced biological containment will be viewed as an extraordinary measure. Individuals will be viewed as having a substantial interest in resisting such measures, the government's interest in avoiding less extreme alternatives probably will not be seen as overwhelming, and the necessity for enhanced fact-finding will be great. The same analysis of characterization applies to the extent that courts approach issues of substantive constitutional rights by a similar "weighing" of competing interests.\footnote{50}

The weight of the public and private interests remains relevant, of course. A mental patient forced to endure group therapy once a week and a mental patient forced to accept immobilizing drug injections administered weekly do not have the same interest in resisting the hospital's actions. In addition, their respective claims to freedom present different due process issues. The difficult state professionalism cases, however, pit substantial individual interests against important state concerns. In these cases—Ingraham, Parham, and the forced drugging lawsuits, for example—characterization, or the choice of a social charter, carries decisive importance.

2. Why Balancing is Secondary To Characterization

While characterization is determinative of the balancing process, in our law, as a matter of social theory or logic, that need not have been so. To the contrary, the choice between professional and political characterization could have depended on a weighing process in which the court assayed individual and public interests in political and profession-neutral terms. Were that the case, characterization and constitutional weighing would remain linked: characterization would then follow from, rather than precede, the court’s analysis of individual and public “interests.” Several considerations, however, compel the conclusion that courts first characterize an activity and only afterwards weigh the interests involved.

The Supreme Court's recent state-professionalism opinions suggest the primacy of characterization.\footnote{51} The Justices do not identify or address this precise question, but they have described the state action being challenged as "medical"\footnote{52} or "educational"\footnote{53} in nature and have attached significance to such de-
scriptions. At the same time, the opinions do not suggest that these descriptions were arrived at through even a preliminary analysis or weighing of social and individual interests.\footnote{4. On the other hand, Supreme Court opinions do consider the effects of constitutional decision-making on day-to-day professional functioning. To this extent, the Court's characterizations turn on a form of institutional analysis. See, e.g., Youngberg v. Romeo, 457 U.S. at 322 (“courts must show deference to the judgment exercised by a qualified professional [at state mental retardation facility] and thereby minimize “interference by the federal judiciary with the internal operations of these institutions”); Ingraham v. Wright, 430 U.S. at 682 (“additional administrative safeguards [in connection with public school corporal punishment] . . . . would . . . . entail a significant intrusion into an area of primary educational responsibility”); Goss v. Lopez, 419 U.S. at 583 (formal due process procedures eschewed because they would destroy “effectiveness” of public school suspensions viewed “as a part of the teaching process”). This type of analysis does not flow from weighing or balancing individual and social interests. In terms of the framework adopted in this article, however, the analysis is incomplete because it does not explain why the impact of a political characterization on professional values and institutions counts for more than the potential impact of a professional characterization on political concerns and institutions. In his opinion, Justice Holmes declined to characterize sterilization as a medical activity subject to a professional charter. \textit{Id.} at 203-05. Rather, Justice Holmes accepted biological alteration as a legitimate political device, and thereby implied that judges and legislatures could make legal judgments in such extraordinary realms as compulsory sterilization without recourse to professional norms or considerations. Sterilization arguably is an acceptable measure under a professional charter, yet it is an unfathomable anomaly under a political one. Holmes refused to recognize the distinction.

Indeed, Virginia’s arguments for a professional characterization of compulsory sterilization—that the woman was incompetent and the operation would speed her release from the institution, \textit{Id.} at 203-05—
C. "DISCOVERING" CHARACTERIZATIONS

Political and professional characterizations are not easy to make, describe, or defend. Perhaps as a result, courts usually construct state-professionalism opinions as though no choice at all were involved.

When a court describes some exercise of state psychiatric power as a "medical decision" for example, it may style its pronouncement as a factual discovery rather than a legal decision—as though "medicalness" inhered in the situation itself. Courts that "discover" characterization in this manner ignore the alternative characterization. They also ignore the fact that, depending on the context, the very same exercise of state power may be characterized in one case as legal or political and, in another case, as medical.

Much of the medical and legal debate over forced drugging stalls at the point of characterization. One side insists that forced drugging is a self-evident "medical" prerogative, while the other side just as confidently contends it is a self-evident political measure, which should be subjected to legal rules. The proponents of a medical charter base their characterization upon a portrayal of drugs as medical therapy and of state hospitals as medical settings. Proponents of a political charter, on the other hand, picture drugs as instruments of state action and draw the appropriate conclusions. These views are mirror images are echoed in today's forced drugging cases. See, e.g., Brief of the American Psychiatric Association at 25-26, Rennie v. Klein, 653 F.2d 836 (2d. Cir. 1982) (failure to impose treatment "irresponsible" when patients' objections "senseless"); Shavill, supra note 30, at 602 (failure to impose drug treatment over patients' refusals results in increased length of hospitalization due to ineffectiveness of other treatments).

Buck v. Bell probably would be decided—or rationalized—differently today. See, e.g., In re Grady, 85 N.J. 225, 262 n.8, 426 A.2d 467, 481 n.8 (1981) (decision to allow sterilization of mentally retarded adult based only on best interests of incompetent, not convenience of society).

38. See Parham v. J.R., 442 U.S. at 609, 613 (questions essentially medical in character; independent medical decision-making process appropriate to make necessary decisions); cf. Chappell v. Wallace, 103 S. Ct. 2362, 2367 (1983) (courts should defer to professional military judgments).

59. See supra note 52 to 53 (discussing Supreme Court cases describing state action as medical or educational in nature).

60. Compare Parham v. J.R., 442 U.S. 584, 609 (1979) (parent's decision to place child in a state hospital medical in nature and demands only careful medical examination) and Addington v. Texas, 441 U.S. 418, 453 (1979) ("clear and convincing" evidence required in proceeding to commit an adult to state mental hospital) with Vitek v. Jones, 445 U.S. 480, 495 (1980) (adversary hearings required before prison inmate transferred to state psychiatric facility, although question "essentially medical"). See also Chappell v. Wallace, 103 S. Ct. 2362, 2366 (1983) ("The complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force are essentially professional military judgments, subject always to civilian control of the Legislative and Executive Branches") (quoting Gilligan v. Morgan, 413 U.S. 1, 10 (1973)) (emphasis in original). Thus, in Chappell, the judgments were "professional" for purposes of judicial scrutiny and "political" for purposes of executive and legislative control.

61. See, e.g., Appelbaum & Gutheil, "Rotting with Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal By Psychiatric Patients, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306, 315 (1979) (legal arguments supporting right to refuse medication do not fit with clinical reality); Armstrong, The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision?, 29 HOSP. & COMMUNITY PSYCHIATRY 118, 118 (legal constraints have "usurped" physicians' authority to make medical decisions); Comey, Patients' Rights: Too Much Courting, Not Enough Carrying, in REFUSING TREATMENT, supra note 7, at 49, 50 (psychiatric treatment essential ingredient in hospitalization; decision to commit patient involuntarily should overcome any right to refuse medication).

62. See, e.g., Cole, Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?, in REFUSING TREATMENT, supra note 7, at 56, 67 ("right to refuse treatment" cases must be analyzed within context of constitutional and common law principles concerning individual's privacy rights); Plotkin, supra note 30, at 463 (as long as public not endangered, individual retains ultimate power to make health decisions).
of each other, equally rigid and doctrinaire. Neither side acknowledges that both the medical and political characterizations are plausible and that what is needed is a principled way of choosing between the two.

D. CHOOSING BETWEEN THE PROFESSIONAL AND POLITICAL CHARACTERIZATION: SIX FACTORS

Since the political and professional realms cannot be reduced to a single universe of interest, an intricate, comparative analysis is unavoidable in state-professionalism cases. The professional characterization’s cost to political values must be measured against the political characterization’s cost of professional accomplishment. As courts approach the question of characterization, they must consider a number of factors in determining whether to choose one characterization over the other. No single factor is determinative; rather, as will be seen in the following discussion, the factors’ relation to each other varies with the particular practice considered.

1. Utilitarian and Means Considerations

When characterizing a practice, two important considerations are its overall contribution to human well-being (whether for good or ill) and the way it

63. The very language judicial opinions use to describe drugs has become stylized. Opinions adopting a political characterization describe drug actions using nonmedical terminology that emphasizes the chemicals’ similarity to classical deprivations of liberty. These courts write of the drugs’ “behavior modifying capacity,” Goedecke v. State Dept. of Inst., 198 Colo. 407, 603 P.2d 123, 126 (1979) (en banc); term them “chemical restraints,” Haldeman v. Pennhurst State School and Hosp., 612 F.2d 84, 108 (3d Cir. 1979) (en banc), rev’d and remanded, 451 U.S. 1 (1981), on remand, 673 F.2d 647 (3d Cir. 1982), rev’d on other grounds, 104 S. Ct. 900 (1984); and either attach the label “major tranquilizer,” In re K.K.B., 609 F.2d 747, 748 (Okla. 1980); or use other nonmedical expressions, such as “powerful,” Romeo v. Youngberg, 644 F.2d 147, 166 n.43 (3d Cir. 1980) (en banc), rev’d, 457 U.S. 307 (1982), to underscore the drugs’ potential for drastic action.

Opinions adopting a professional characterization take the opposite approach. Using language overladen with medical and curative connotations, these opinions describe the drugs as “treatment,” Rennie, 653 F.2d at 844; and label them “antipsychotics,” id. at 839 n.2, a term that underscores their medical, putatively curative nature.

Rhetorical stylization is not objectionable in itself: drugs have to be described in some way. Stylization, however, cannot substitute for a considered choice between the political and professional charters for forced drugging. The problem will not be moved closer to a solution if drugs are pictured as self-evident instruments of cure or depicted as obvious behavior-modifying biological restraints.

The first Rennie district court opinion, 462 F. Supp. 1131, is a notable exception to these generalizations. It described drugs as curative, id. at 1136-37, but nonetheless characterized them politically. Interestingly, the judge used the terms “major tranquilizer,” id. at 1136, and “antipsychotic,” id. at 1138, but generally settled on a neutral term—“psychotropic”—to describe the drugs. Id. at 1137.

64. Of course, there is sizable literature presuming that one solution will advance medical and political (or constitutional) values alike and thus that neither set of values need be sacrificed. Indeed, one argues for that unique solution by pointing out how alternative measures impair either legal or political concerns. The possibility of such a uniquely satisfactory solution appears, however, to be small—particularly in the drug cases. See infra notes 75 to 121 and accompanying text (discussing effects of drugs). For an example of this viewpoint, see Brotman, Behind the Bench in Rennie v. Klein, in REFUSING TREATMENT, supra note 7, at 31, 40-41 (District Court Judge Brotman, reflecting on decision in Rennie, noted that ruling was compromise that would hopefully satisfy patient advocates and medical profession alike; and hoped that decision would “spur the reforms that are so badly needed” and would produce “better patient care to satisfy the demands of society”). For further discussion of Judge Brotman’s ruling, see infra text accompanying notes 275 to 293. See also Brooks, supra note 30, at 216 (“The medications refusal dialogue between psychiatrists and lawyers should . . . concentrate . . . on ways in which the two professions can join forces to solve the intricate and complex problems that confront both.”)

65. The term “utilitarian” is used loosely; for example, it does not imply that large numbers of
makes its contribution. Difficult questions arise, since the issues involved are often technical and the determination of the amount of "good" accomplished can be intertwined with professional judgment.

There is a strong temptation to accept a professional characterization when considering the contribution of a particular practice. It is natural to assume that professionals would not prescribe treatments that generally are harmful. Moreover, the treatment's very adoption would make it prima facie professional. Nonetheless, where the practice promises to accomplish little, or if the treatment requires no professional judgment or expertise, the case for a professional characterization is weakened considerably.

2. Self-Characterization

The institution's own performance can serve to characterize itself. Some missteps bespeak political overreaching, while others are the result of unintentional carelessness, human fallibility, or lack of knowledge. An institution's attempts to correct its errors and its relations with the people subject to it are elements of self-characterization. If single institutional episodes are hard to characterize in these terms, institutions—like people—can also reveal their true nature over the course of years; thus, history is important.

A mismatch between judicial characterization of an institution and the institution's self-characterization can reduce court decrees to futility—or worse. Political characterization by judges leads to the fashioning of constitutional rights in a way calculated to remedy and deter state overreaching. If the institution's mistakes do not have that character, judicial decisions will be heavy-handed and needlessly destructive of the good accomplished by the institution. Similarly, professional characterization by the courts produces a version of constitutional rights that is deferential in the face of scientific uncertainty and that is designed to address only occasional, flagrant lapses in institutional performance. Thus, if an institution is following the classical forms of state overreaching, the professional characterization will not respond to the wrong. As a result, the characterization can accomplish nothing, or it may exacerbate the wrong by lending constitutional sanction to the action.

3. The Relevant Profession's Performance

Looking beyond a particular professional practice, a third consideration turns on the status and performance of the relevant profession itself. When the profession's promise of social benefit is in question, whether the profession is

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66. While these two related factors are obviously relevant, I do not believe they are decisive in any class of cases. Other factors can outweigh them. Compare DuBose, supra note 36, at 1153-57 (determinative factors are likelihood of improvement, scope of improvement, and dangers involved in treating or not treating). For further discussion of this point, see infra text accompanying notes 75 to 130.

67. See In re Gault, 387 U.S. 1 (1967) (failure of national juvenile justice system's discretionary components to rehabilitate youngsters and system's weak claim on professional status led Supreme Court to impose political charter, in form of procedural regularity mandated by due process, on state juvenile courts.)

68. For further discussion of self-characterization, see infra text accompanying notes 131 to 187.
usually as good as its word becomes important.  

4. Traditional Allocations of Social Power

The fourth consideration is the traditional allocation of social power between professionalism and politics with respect to the practice or institution in question. Each culture and era will have made a decision on this question and the courts must either reckon with or defer to that decision.  

5. Appropriateness

A fifth factor concerns the ability of the practice or institution to operate under legal (or professional) rules and procedures. While the utilitarian and means consideration calls upon courts to weigh the institution's contributions to well-being under present arrangements, this fifth consideration requires judges to estimate how judicially decreed changes would affect the balance of good and harm. This allows for recognition of social inertia. Moreover, certain matters that a profession handles badly can be handled in an even worse fashion if treated as a political problem, for example. In that case, despite a relatively harmful state professional practice, the courts nonetheless might defer and choose a professional characterization.  

6. Judicial Limitations

The last two factors mentioned are closely related to the sixth factor: the limited ability of courts to impose a legal charter on a recalcitrant social arena. For example, if doctors, legislators, and the public at large regard a practice as medical in nature, and if it has been traditionally allocated to the medical domain, a court's contrary conclusion will meet with resistance and could prove impossible to enforce at any acceptable cost.  

E. HOW THE SIX CONSIDERATIONS RELATE TO EACH OTHER

As already noted, none of the six considerations is singularly decisive, and each has the potential to override the others. For example, a court might defer to lackluster professionalism, overriding the first (and third) considerations, if the problem seemed intractable and social acceptance of a political characterization was doubtful (factors four, five, and six). Yet neither the intractability of the problem nor the popular feeling that courts should stay their hand should prevent political characterizations when the institution's overreaching is serious.

69. For further discussion, see infra text accompanying notes 190 to 199.
70. For further discussion, see infra text accompanying notes 200 to 206.
71. See infra text accompanying notes 207 to 210 (discussing problems associated with judicial intervention); see also Fletcher, The Discretionary Constitution: Institutional Remedies and Judicial Legitimacy, 91 YALE L.J. 635, 691 (1982) ("Because of the intractable nature of questions concerning treatment for mental patients, the Court may conclude that constitutional rules of liability are ill-suited to define and protect whatever non-procedural interests the mentally ill and retarded may have . . . . [T]he importance the Court attaches to mental patients' needs does not outweigh the cost to the legitimacy of the judicial process necessarily entailed in enforcing such a right.")
72. See infra text accompanying notes 211 to 216 (discussing costs of political characterization as constraint of judicial power).
The fourth factor, consideration of tradition, can be powerful, but allocation of functions between the professional and political realms change over time. Thus, the traditional allocation, standing alone, can hardly be decisive. Indeed, the advent of state mental hospitals was the culmination of a movement to allocate insanity to the professional rather than the political domain. The second factor, self-characterization, also is not decisive. The underlying social problem can prove resistant to any kind of realistic remedy. As a result, there would be no pressing need to match the true character of the wrong (self-characterization) with an appropriate remedy. Moreover, an institution’s self-characterization, as discerned by judges, can vary radically from consensus views—a circumstance that should give courts pause. Courts can draw the wrong conclusions about self-characterization if they are exposed to inaccurate, incomplete, or misleading trial presentations of the relevant facts. Even judges confident about their conclusions must consider whether any judicial remedy can be effective in the face of a social and institutional resistance; thus, the sixth factor can override the second.

II. THE PROPER CONSTITUTIONAL CHARACTERIZATION OF FORCED DRUGGING

A. UTILITARIAN AND MEANS CONSIDERATIONS

Have major tranquilizers proved to be a valuable contribution to the treatment of mental illness? If one answers positively, the case for a professional characterization seems strong. A negative response, on the other hand, calls into question our reliance on professional judgments about the drugs. The first inquiry then must be the utility of the drugs themselves, and the method by which that utility—or disutility—is achieved.

The question of the drugs’ contribution raises three issues. First, whether and to what extent the drugs increase the patients’ well-being? Given the potential for serious drug side effects, a null or minimal contribution substantially weakens the case for a professional characterization.

Second, if the drugs do contribute to patient well-being, is that contribution peculiarly medical? Some measures, such as regular diet, absence of physical abuse, clean surroundings, and simple human kindness, may be therapeutic but may not be properly considered as a uniquely medical treatment. While the professional characterization of drugging is enhanced if drugs are truly medical or “antipsychotic” measures, the argument is diminished if drugs are simply chemical restraints, their therapeutic value deriving from their power to restrain or benumb.

Third, what role do the drugs play in state psychiatry? If the drugs are truly antipsychotic, the consequent reduction in mental illness would explain why

74. See infra notes 85 to 104 and accompanying text.
the number of state-institutionalized, physically restrained patients has decreased. If, however, the drugs are simply a means by which patients can be transferred from state institutions to private custodial care, no antipsychotic effects are necessarily achieved, and the need to defer to medical judgment is considerably weakened. The near-universal use of drugs in state psychiatry raises a presumption that they are beneficial. The true therapeutic effect of the drugs can indicate, however, that the benefits accrue less to the patients themselves than to those who care for them.

1. Positive Drug Effects

Drug treatment clearly benefits many patients by minimizing or even eliminating psychotic symptoms such as hallucination or catatonic posturing. Patients who used to hear voices no longer hear them, for example, or the urgency of the voices diminishes. This benefit lasts only as long as the patients continue to take the drugs, and the drugs on occasion can actually induce hallucinations. Even so, drugs minimize psychotic symptoms often enough that they are called "antipsychotics." Drugging can also lengthen the interval between psychotic relapses, so that drugged patients are hospitalized, on average, less frequently than are those who are drug-free. Moreover, drugging can reduce the duration of psychotic episodes, as measured by the length of hospitalization.

According to empirical studies, the effect of the drugs on the length and frequency of hospitalization is statistically significant. One study, for example, found that over a three-year period, drugged patients were hospitalized on average about 200 days while drug-free patients were hospitalized on average 300 days. It is estimated that eighty percent of undrugged schizophrenics and fifty percent of drugged schizophrenics will suffer relapses and require rehospitalization within two years. These figures demonstrate that drugs, though far from being a panacea, are effective.

It is easy, however, to read too much into studies that document the drugs' effectiveness. The numbers, figures, and comparisons largely concern rehospitalization rates, but do not measure the drugs' effectiveness against the

75. See Comment, supra note 36, at 512 (psychotropic drugs used to counter delusions and hallucinations).
76. Id.
77. See Van Putten, Mutalipassi & Malkin, Phenothiazine Induced Decompensation, 30 ARCHIVES GEN. PSYCHIATRY 102, 102 (1974) (describing drug-induced hallucinations).
78. American Psychiatric Association, Tardive Dyskinesia: Report of the Task Force on Late Neurological Effects of Antipsychotic Drugs 2 (1979) (while these drugs do calm agitated or manic behavior, they are not simply sedatives, and older term "tranquilizers" is misnomer).
79. May, Tuma, Yale, Potepan & Dixon, Schizophrenia—A Follow-up Study of Results of Treatment, 33 ARCHIVES GEN. PSYCHIATRY 481, 482 (1976).
81. Carpenter, Heinrichs & Hanlon, Methodologic Standards for Treatment Outcome Research in
most persistent aspects of mental illness: mental deterioration, inability to work, and the loss of capacity for human relationships. Moreover, the drugs' overall contribution to declining relapse rates does not mean that each patient's chance of relapse is diminished. A substantial minority of patients seem to suffer relapses more frequently because of drugs, and leading drug researchers suggest that, in practice, fifty percent of schizophrenics can derive no actual benefit from continued medication.

2. Irreversible Side Effects of Drugs

"Side effects" are on the opposite side of the drug equation: the unpleasant, unwanted sequelae of drug taking. Many of these effects disappear when drugs are discontinued or shortly thereafter; some can persist for some time, however, and can become permanent.

_Tardive Dyskinesia._ In recent years, one side effect known as "tardive dyskinesia," has aroused the most legal interest and medical concern because of its "irreversible" nature. The tongue, mouth, and chin are common sites of tardive dyskinesia: the tongue sweeps from side to side, the mouth opens and closes, and the jaw moves in all directions. Fingers, arms, and legs may display comparable movements; swallowing, speech, or breathing can be affected as well. The movements are uncontrollable, although their intensity varies from case to case. In severe cases, the involuntary movements impede walking and even digestion. Health can be endangered, and often the victim's appearance becomes grotesque. Tardive dyskinesia is common: estimates of the disorder's prevalence rates (the proportion of patients with tardive dys-

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82. Carpenter, McGlashon, & Strauss, _The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions_, 134 AM. J. PSYCHIATRY 14, 15 (1977); (rehospitalization rates do not adequately reflect social functioning); Rifkin, Quitkin, Rabiner & Klein, _Fluphenazine Decanoate, Fluphenazine Hydrochloride Given Orally and Placebo in Remitted Schizophrenics: Relapse Rates After One Year_, 34 ARCHIVES GEN. PSYCHIATRY 43, 44 (1977) (drugs have only proven effective in preventing severe psychotic symptoms, such as delusions and hallucinations; the quality of patients' lives can remain miserable despite drugging).


84. Gardos & Cole, _Maintenance Antipsychotic Therapy: Is the Cure Worse Than the Disease?_, 133 AM. J. PSYCHIATRY 32, 34 (1976); see also Kurucz & Fallon, _Dose Reduction and Discontinuation of Antipsychotic Medication_, 31 HOSP. & COMMUNITY PSYCHIATRY 117, 119 (1980) (7% of schizophrenic in-patients whose drug therapy discontinued showed improvement within 90 days); Marder, von Komnen, Doherty, Rainer & Bunney, _Predicting Drug Free Improvement in Schizophrenic Psychosis_, 36 ARCHIVES GEN PSYCHIATRY 1080, 1080 (1979) (8 of 22 psychotic schizophrenic patients improved substantially during 30-day drug-free period); May, Van Putten & Yale, _Predicting Outcome of Antipsychotic Drug Treatment From Early Response_, 137 AM. J. PSYCHIATRY 1088, 1088 (substantial number of schizophrenics do just as well after drug therapy discontinued).

85. See, e.g., Rennie, 653 F.2d at 843 (referring to tardive dyskinesia as drug treatments' "most serious" side effect); Brooks, _supra_ note 30, at 185 (incidence of tardive dyskinesia clearly high enough to warrant legal, protective action).

86. See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, _supra_ note 78, at 2 (tardive dyskinesia now recognized as general public health problem of major proportions); Gardos & Cole, _Overview: Public Health Issues in Tardive Dyskinesia_, 137 AM. J. PSYCHIATRY 776, 776 (1980) (response of medical profession to tardive dyskinesia has shifted from "mild concern" to "panic").

kinesia at any particular time) range as high as sixty-five percent; fifteen to twenty percent is a widely accepted estimate. It can develop after prolonged drug exposure, normally six months or longer, and usually persists throughout the patient's lifetime. There generally is no cure.

3. Reversible Side Effects

Reversible drug side effects generate much less concern than does tardive dyskinesia. The distinction between reversible and irreversible side effects, however, is academic to patients who are constantly maintained on drugs, since many suffer as long as the drugs are administered and it is irrelevant that their suffering would abate if they could stop taking the drugs.

_Akathisia._ One common "reversible" side effect, for example, that is persistent and very hard to live with is called "akathisia," which is a subjective state and refers not to any particular type or pattern of movement, but rather to a subjective need or desire to move. This urge to move is always accompanied by affective distress and, objectively, is usually manifested by restless pacing, inability to sit still, fidgetiness and continuous alternations in posture. With the subtle akathisias, the patient may not pace or use the word 'restless,' and complain instead of 'nervousness,' 'irritability,' 'impatience,' "feeling keyed up," or of an 'inability to feel comfortable.'

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88. See e.g., AMERICAN PSYCHIATRIC ASSOCIATION, supra note 78, at 43-44; Gardos & Cole, supra note 86, at 776.

There are reports of irreversible drug side effects other than tardive dyskinesia. For example, one study has found that prolonged drug administration induces a permanent, paranoid form of psychosis, which is associated with tardive dyskinesia-like physical symptoms. Chouinard & Jones, Neuroleptic-Induced Supersensitivity Psychosis: Clinical and Pharmacologic Characteristics, 137 AM. J. PSYCHIATRY 16, 16 (1980). Another has found that drug-induced Parkinsonism, which symptoms include tremor and a masked facial expression, becomes permanent as well. Transcript of Testimony, Vol. XVII at 19-20, Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979) (testimony of Dr. George Crane).

89. Jeste & Wyatt, Tardive Dyskinesia: A Review of the Treatment Possibilities, 10 PSYCHIATRIC ANNALS 26, 37 (1980). This study noted, however, that perhaps a third of the cases might reverse themselves if the drugs were withdrawn.

90. AMERICAN PSYCHIATRIC ASSOCIATION, supra note 78, at 137-53 (no therapies for tardive dyskinesia have been proven safe and effective).

91. Many "reversible" side effects persist for weeks—and even months—after drug discontinuation. Hall, Jackson & Swain, Neurotoxic Reactions Resulting From Chlorpromazine Administration, 161 J. A.M.A. 214, 218 (1956) (6 of 90 patients receiving drug therapy showed Parkinson-like neurological disorders for 60 days or more after drug therapy ceased). It is commonly said that most reversible drug side effects either abate spontaneously or respond well to anti-Parkinsonian medication. See, e.g., Rennie, 462 F. Supp. at 1135. Many patients find, however, that these side effects persist throughout drug administration and do not respond to measures short of dose reduction or drug discontinuation. See Estroff, supra note 23, at 110 ("For our group [of about 40 outpatients] taking meds always meant developing visible side effects. The shakes, stiffness, blank expression, gait, leg jiggling, eye rolling, and facial grimacing, were physical markers to others and were badges of patienthood to themselves"); Chouinard, Annable & Ross-Chouinard, Fluphenazine Enanthate and Fluphenazine Decanoate in the Treatment of Schizophrenic Outpatients: Extrapyrimidal Symptoms and Therapeutic Effect, 139 AM. J. PSYCHIATRY 312, 314 (1982) (despite receiving anti-side effect drugs, about 75% of the patients studied complained of "reversible" side effects); Shapiro, Shapiro & Wayne, Treatment of Tourett's Syndrome, 28 ARCHIVES GEN. PSYCHIATRY 92, 96 (1973) (virtually all patients treated with Haloperidol, a common antipsychotic, develop akinesia); see also Groves & Mandel, The Long Acting Phenothiazines, 32 ARCHIVES GEN. PSYCHIATRY 893 (1975).

Although "anxiety" and "pacing" can seem a small price to pay for freedom from acute, serious mental illness—a trade, in effect, of psychotic symptoms for neurotic ones—many patients dislike akathesia intensely and feel they cannot get on with their lives while it rules them. While drug recipients often find the symptoms of their own mental illnesses to be "normal" and part of themselves, they usually perceive akathesia and other side effects as foreign and objectionable. Moreover, akathesia's symptoms appear odd and pathological, even in the mental hospital context where odd behavior is not unusual.

**Akinesia.** Another common, reversible drug side effect is "akinesia," the behavioral and psychological opposite of akathesia. It is manifested by a reduced capacity for physical or mental spontaneity. Patients display "few gestures, unsportunate speech, and particularly, apathy and difficulty initiating usual activities." It is accompanied by a mental state resembling demoralization. Patients speak of being "in a stupor," acting like a "zombie," and walking around with a "shuffle, head hung down, looking . . . like [you're] not seeing anything."

**Distress, Disphoria, and Drug-Induced Psychosis.** Some patients endure drug-induced mental states far worse than the demoralization of akinesia. For these people, drugs are the most painful, distressing ordeal they have ever experienced—in a different class than prolonged solitary confinement or physical deprivation.  

93. Id; Van Putten, Mutalipassi & Malkin, Phenothiazine-Induced Decompensation, supra note 77, at 105 (1974).

94. One mental patient, being deposed in the Rennie lawsuit, recalled that patients:

"march back and forth in the coldest weather . . . you see people out there in State clothes with odd shoes or . . . sock, just socks . . ."

Q. These people march back and forth?
A. "They pace back and forth as if in a cell."
Q. You think that has to do with the drugs?
A. "It certainly does because why would they do it unless—it's not normal."


95. Rifkin, Quitkin & Klein, Akinesia: A Poorly Recognized Drug-Induced Extrapyramidal Behavioral Disorder, 32 ARCHIVES GEN. PSYCHIATRY 672, 672 (1975).

96. Joint Appendix, supra note 94, at 66b.

97. See, e.g., Opton, Psychiatric Violence Against Prisoners: When Therapy is Punishment, 45 Miss. L.J. 605, 641 (1974), quoting an interview with a drug recipient:

"There is no other feeling like it. Nothing to relate to, no experience anyone would normally go through in their life. It affects you mentally and physically and you feel suicidal. The physical effects are so bad you can't stand it. You get muscle spasms . . . you get lockjaw; you can't control your tongue; you get leg cramps; you get so tired (as if you've been up three days in a row) you lie down. But you can't stay down for more than three or four minutes because your knees begin to ache . . . . Your thoughts are broken, incoherent; you can't hold a train of thought for even one minute. You're talking about one subject and suddenly you're talking about another. You start to roll a cigarette, drop it, pick up a book, take a shit, forget to wipe your ass. Your mind is like a slot machine, every wheel spinning a different thought.

Q. What do you mean, you feel suicidal?
A. " . . . The thought of suicide keeps recurring in order to alleviate, once and for all, the tortuous effects of the drugs."

See also N. MAILER, THE EXECUTIONER'S SONG 328 (1979):

"And they shot me with that foul drug Prolixin and made a zombie out of me for four months. I was virtually paralyzed. I couldn't stand up without help and when I was raised to my feet
MENTAL ILLNESS AND DRUGS

Such severe distress, like other serious side effects of the drugs, is not uncommon. One study found that ten percent of the mentally ill respond to drugs with deep dysphoria—depression or profound unhappiness—while another forty percent endure a less intense but similar reaction.98

There are also reports of drug-induced psychotic episodes, although no psychiatric consensus exists on the extent of this problem. Researchers have described a group of patients—eleven percent of one sample and in another sample thirty-five percent of patients taking a particular drug—who underwent “a sudden and dramatic exacerbation of psychosis, an experience of abject terror” that was drug induced.99 These episodes, although intense, are regarded as reversible.100

Pseudo-Parkinsonism. The drugs commonly cause a form of pseudo-Parkinsonism, which is marked by retarded muscle movements, “masked” facial expression, body rigidity, and tremor. It causes the shuffling gait that has become almost the hallmark of drugged patients, although the symptoms are generally regarded as reversible.101

Physical Complications. Reversible, physical complications are well documented. Muscle spasms, blurred vision, and dry mouth are common, as is drug-caused interference with sexual functioning and inhibition of sexual interest.102 More serious physical complications exist, but are comparatively

I'd wonder what the fuck I wanted to stand up for and I'd sit back down. When it was driving me the worst I went for three weeks without sleep. I just sat on the corner of the bed—I hallucinated to the edge of insanity . . . . I lost about 50 pounds. I just couldn’t get the food to my mouth. Getting up to take a piss was a major effort, I dreaded it, it would take me about 15 to 20 minutes—I couldn’t get the pants buttoned. . . .

Id. at 405.


A number of prominent research psychiatrists report that drugs impel some patients to attempt suicide, and mental patients have drawn the same conclusion. See, e.g., Alarcon & Carney, Severe Depressive Mood Changes Following Slow Release Intramuscular Fluphenazine Injection, BRIT. MED. J. Sept. 6, 1969 at 564 (10 of 124 patients developed severe depression, and 5 patients committed suicide); Joint Appendix, supra note 94, at 393a (John Rennie testified that the drug Prolixin “increases your depression . . . it makes you want to kill yourself”); see also S. Estroff, supra note 23, at 105 (side effects of Prolixin treatment included anxiety, self-doubt, distress, and suicidal thoughts). Other psychiatrists remain unpersuaded, however, and there are few relevant studies on the relationship between antipsychotic treatment and suicide. It is clear, though, that drugs induce demoralization and extremely unpleasant subjective states, whether or not patients actually are driven to suicide.


100. The drugs can, however, cause a permanent psychotic condition. See supra note 97.

101. American College of Neuropsychopharmacology—Food and Drug Administration Task Force, Neurological Syndromes Associated with Anti-Psychotic Drug Use, A Special Report, 28 ARCHIVES GEN. PSYCHIATRY 463, 464 (1973); see supra note 91 (discussing reversibility of pseudo-Parkinsonism).

102. Scott v. Plante, 532 F.2d at 945 n.8; Rennie v. Klein, 462 F. Supp. at 1138. See also Mitchell &
A very small number of patients are apparently inflicted with a drug-
induced sudden death syndrome, in which the patient becomes dramatically
more psychotic and then, for no apparent reason, dies.104

4. Drug Effects Compared to Effects of Other State Professional Measures

Although the drugs' potential for harm is widely acknowledged, few appreciate that the magnitude and incidence of harm place drug treatment in a class apart from other coercive, extraordinary state measures (with the exception of the death penalty for crime and the possibility of a military conscriptee's death in combat) that have been upheld by the Supreme Court.

In Jacobson v. Massachusetts,105 a case sometimes cited to demonstrate that state psychiatry's interventions are not unprecedentedly severe,106 the Supreme Court upheld a statute punishing as a crime the refusal to submit to smallpox vaccination. Vaccination, however, involves minimal harms when compared to the harms caused by forced state drugging. Moreover, one could legally avoid the harms imposed by the Massachusetts statute,107 and the state did not seek to impose the treatment by direct force.108 Even so, Jacobson upheld the statute only as applied to someone unable to demonstrate that the vaccination would harm him.109 By contrast, many mental patients face demonstrable, serious drug-caused harms, and brute force—or the threat of it—is routinely brought to bear to compel submission.

The early twentieth-century case law upholding compulsory sterilization of retarded people110 provides another example of state-coerced, biological inter-

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103. Shavill, supra note 30, at 584-85 (other serious side effects of antipsychotic drugs include eye and skin damage, liver disorders, and agranulocytosis).
107. Jacobson could have left Massachusetts for a jurisdiction that had no compulsory vaccination law. Jacobson, 197 U.S. at 36.
108. Jacobson was punished by a fine and imprisonment for not accepting a vaccination, but he was not physically compelled or even ordered to submit to an injection. Id. at 14.
109. Id. at 38-39.
110. See supra note 57 (discussing Buck v. Bell, 274 U.S. 200 (1926)).
vention. Despite harsh edicts, pro-sterilization decisions emphasized the safety of medical procedures involved, which the courts said carried with them no appreciable danger of side effects or harm, other than the intended one of incapacitating the reproductive system. By comparison, modern psychiatric drugs cause much more serious harms, and their effects range far beyond the states' avowed purpose in using them. If sterilization or vaccination routinely made jaws, arms, legs, and hands twitch interminably, or caused demoralization or produced incessant pacing, it is not obvious that those measures would have been allowed. No matter how one measures drug benefits, the potential harms of drugs are constitutionally remarkable.

5. How Drugs Work

Although the drugs' harms can be assessed apart from any other consideration, their contribution to a patient's well-being is related to the issue of their putative "antipsychotic" action. Certain harms can be tolerable if the drugs promise a net positive benefit by curing mental illness. If the drugs are used only for custodial purposes, however, these harms are less acceptable. Clearly, physical restraint and chemical sedation are not acceptable when their use results in physical deformity and mental torment. If drugs produce benefits merely by tranquilizing or restraining patients, the risks of side effects can be intolerable. If, on the other hand, drugs are "antipsychotic," then they belong to the family of medical measures, such as chemotherapy, whose severe side effects are sometimes an acceptable cost of their beneficial effect.

Drugs are not the first treatment in psychiatry to be described as curative or "antipsychotic." Indeed, claims for an "antipsychotic" effect have been made on behalf of every era's commanding psychiatric therapy. Lobotomy, insulin shock, and, in earlier times, bleeding and purging have all been said to possess curative effects beyond their immediate result, which was the weakening or mutilating of the patient until no energy was available for psychotic behavior. Benjamin Rush presented his nineteenth century invention of the "tranquilizer"—a chair with straps and other gadgets—as a truly medical invention, possessing curative properties beyond those of simple restraint. State mental hospitals themselves also were thought to be uniquely curative. At least in theory, the hospitals' location, administrative structure, and architecture supplied an environment replete with social and personal ordering, the absence of which was deemed to be the cause of mental illness.

It is difficult to evaluate such claims, or to distinguish, except in crude intuitive ways, between true "antipsychotic" measures and mere palliatives or adjuncts to custody. The physiological causes and concomitants of mental illness

111. See e.g., Buck v. Bell, 274 U.S. at 305 (sterilization involves no medical danger to patient); State v. Feilen, 70 Wash. 65, 126 P. 75, 77 (1912) (vasectomy less serious than tooth extraction).
112. Cf. DuBose, supra note 36, at 1182-83 (no legitimate state interest in involuntary, forced drugging if purpose only to control internal, nondangerous aspects of patient's condition).
113. See generally Sterling, supra note 14, at 98 (discussing prior procedures thought at time to be curative, while in fact only debilitative).
114. G. Grob, supra note 2, at 20; A. Deutsch, supra note 2, at 79-80 ("tranquilizer" believed to have curative effect by reducing pulse).
remain matters for speculation.\textsuperscript{116} Physiologically, antipsychotic effects cannot be confidently distinguished from crude measures—such as bleeding, purging, and, in all probability, lobotomy—which render individuals too weak or preoccupied to attend to their psychotic urgings. On the other hand, it is conceivable that simple physical restraint and undaunted psychiatric hospitalization do set off brain reactions no less “antipsychotic” in nature than the reaction to drugs. However, if every such measure—crude restraint, simple housing arrangements, and brain surgery alike—qualifies as “antipsychotic,” then that concept is almost meaningless. In this regard, the fact that psychiatric intervention comes in drug form does not enhance its claim;\textsuperscript{117} as a class, drugs are not inherently more plausible pretenders to antipsychotic status than brain surgery, physical manipulation, or therapeutic “talk.”\textsuperscript{118}

\textsuperscript{116} A widely held theory states that the drugs block the effects of a brain neurotransmitter and in that way attack the very causes of mental illness. See Comment, supra note 36, at 498 n.6 (citing authorities). Recent work, however, has challenged this theory. See Van Kammen, Docherty, Marder, Rayner & Bunney, Long Term Phenothiazide Pretreatment Differentially Affects Behavioral Responses to Dextroamphetamine in Schizophrenia: Further Exploration of the Dopamine Hypothesis of Schizophrenia, 39 ARCHIVES GEN. PSYCHIATRY 275, 280 (1982) (research findings seriously question hypothesis of simple pathogenic involvement of single neurotransmitter). Because it now appears schizophrenia is not a function of any one brain neurotransmitter, id., it can no longer be said that drugs act on the “cause” of schizophrenia. Cf AMERICAN PSYCHIATRIC ASSOCIATION, supra note 78, at 2 (while drugs have “real and selective antipsychotic effects” in schizophrenia, they are “rarely, if ever, curative”).

\textsuperscript{117} From at least the 17th century onward, mental illness has been “treated” by drugs such as hellebore, camphor, asafoetida, opium, hemlock, bromides, and sodium amytal. 1955 SYMPOSIUM, supra note 116, the relationship between drugs and schizophrenia was always speculative. Moreover, the effects of the drugs themselves do not necessarily bespeak peculiarly antipsychotic action.

Indeed, in the drugs’ early years, many drug enthusiasts, who were closely evaluating the chemicals’ effects on patients, concluded that beneficial drug effects resulted from brain damage, a process rather like that of lobotomy. See, e.g., 1955 SYMPOSIUM, supra note 15, at 72 (discussing and criticizing current theory that drugs represented “chemical lobotomies”), id. at 51 (remarking that drugged patients develop signs of “basal ganglion dysfunction” which appear to increase along with drugs’ psychiatric effectiveness); see also Deniker, Experimental Neurological Syndromes and the New Drug Therapies in Psychiatry, 1 COMPREHENSIVE PSYCHIATRY 92, 100 (1960) (co-discoverer of Thorazine suggests that drugs’ side effects resemble symptoms and sequelae of various forms of brain encephalitis and that “the somatic disease may be necessary to cure the mental illness”). Apart from such theorizing, many observers were convinced by careful examination of drug-treated patients that these drugs did not affect the basic symptomatology of schizophrenia:

We have had cases in which there has been a remarkable social improvement [because of drugs], but our findings are that underneath this the [pathological] ideation and often the affect, is not fundamentally changed. . . . [T]here is . . . less overt verbalization of the psychotic delusions when the patient is on the drug.

1955 SYMPOSIUM, supra note 15, at 94.

Other observers noted that:

There is no question that the patients on phenothiazines changed dramatically in relation to the on/off drug condition. However, it should be emphasized that the observed changes did not suggest that the patient was any less schizophrenic. For the most part, it merely meant that the group exhibited less florid symptomatology. For example, patient R.M. still heard voices while receiving thioridazine, but he no longer shouted at them or did cartwheels in response to their commands. In consequence, he appeared to be more “normal,” and people were able to relate to him in a more reasonable fashion. In fact, in R.M.’s case, the drug plateau was such that he could go out and work for short periods of time while he was on the drug. Had the drugs been a bit more effective, they might have reduced his bizarre behavior to a point below the critical threshold, making it possible for his family and the community to accept him again. The drug enables some patients to function independently of the hospital, while the bizarre behavior of others is not sufficiently reduced, and they must remain. A third
The effects of the drugs appear “antipsychotic,” but the overall picture is mixed. Their prophylactic effect against future mental illness, although not overwhelming statistically, can be impressive. Nonetheless, most acute psychotic episodes abate with or without drugs. Drugs appear to be ineffective against the progressive mental and social deterioration of schizophrenics. Many patients seem to derive no benefit from drugging, and the drugs are often no more than modestly effective at what they do. Moreover, the drugs have effects—notably akinesia, which renders patients subdued, compliant, and unspontaneous—that hardly qualify as antipsychotic, which could explain the drugs’ effectiveness. Arguably, the drugs diminish psychotic symptomatology and delay relapse not by acting on the causes of mental illness, but simply by slowing the patient’s mental processes. Without a convincing theory to justify drugs’ special claims, and with more prosaic explanations of drug “success” available, it would appear that drugs should be deemed, at best, a limited “antipsychotic” measure.

6. Drug Effects and the New State Psychiatric Regime

Powerful, benevolent, antipsychotic properties cannot be inferred from the wide use of drugs by state psychiatry. The drugs undeniably have custody-enhancing effects which alone can account for every distinctive feature of the modern state psychiatric system. Indeed, it would appear that much the same system would have evolved based on drugging even if the drugs had no claim at all to antipsychotic effects.

Despite the drugs’ warm reception into state psychiatry, it was not assumed in 1953 that Thorazine and other drugs would have revolutionary consequences for the mental health system. For decades the building blocks of state mental health policy had remained hospitalization, public custody, and physical restraint. State psychiatry had accommodated new therapies as they group of patients improve enough with drugs to function part-time on their own. Nevertheless, all of these patients are still schizophrenic, and there is no evidence that any enduring and fundamental change has been achieved by medication.


119. See supra note 80 and accompanying text (discussing relapse rates of patients).
120. See supra notes 81 to 84 and accompanying text (discussing effectiveness of drugs).
121. See supra note 118; see also 1955 SYMPOSIUM. supra note 15, at 73 (“In some, this drug induced reduction in drive, motility and impulsivity may be so pronounced that it assumes Parkinsonian proportions. Far from constituting complications, however, these actions are held to be closely related to the drug’s psychiatric effectiveness”); Deniker, supra note 118, at 92 (noting that Thorazine characteristically "produces a very unique syndrome of psychomotor indifference").
122. See generally 1955 SYMPOSIUM, supra note 15. The drugs’ potential for changing the nature of state hospitals—making them calmer, more treatment-oriented places—was the object of much symposium discussion. Id. at 83-84. Increased discharge rates were anticipated, but the disappearance of mental hospitals as such generally was not. Rather, a calmer and reduced patient population was expected to permit hospitals to be more effective therapeutically. Id. at 88-89, 145. A few symposium participants, however, did see the potential for a dramatic shift to nonhospital care. See, e.g., id. at 166-67 (drugs would enable most patients to be cared for at home or at “travelling clinics”); see also Swazey, supra note 10, at 216-19 (noting dramatic shift away from custodial care in “disturbed wards” since advent of drugs).
were developed without the system undergoing any fundamental structural change.

To comprehend why drugs proved to be so different from predecessor therapies (without supposing drugs to be miraculous cures), the reasons behind the resilience of the old psychiatric regime must be understood. Earlier therapies were used too rarely to have much impact. For example, only a minority of patients underwent lobotomy operations. In addition, a therapy such as lobotomy could be so debilitating that administering it actually diminished the patient's chance of hospital discharge. Moreover, even when a therapy, such as electroshock, enjoyed wide use and was not permanently debilitating, its effects could be too short-lived or modest and too dependent on a hospital setting to appreciably reduce the institutional census. Thus, long-term hospitalization remained indispensable; physical restraints continued, and states kept operating the mental hospitals.

**Why Drugs Are Different.** Drugs differ from previous forms of treatment in each of these respects. Drugs subdue psychotic behavior but do not generally debilitate patients in the process. Moreover, administering the drugs does not require a medical setting. No machines are involved, no elaborate medical precautions are necessary, and no specially trained medical staff is required. Patients must only be persuaded to swallow a pill or to submit to an injection, both of which can be done anywhere. Thus, drugs promise long-lasting effects outside of a hospital setting.

**Drugs and Deinstitutionalization.** Drugs make custody possible without its traditional physical trappings. To house a drugged population, the thick walls, physical barriers, geographical isolation, and staff supervision of state mental hospitals are generally unnecessary.

Any custodian, particularly one of the mentally ill, must keep his or her charges' behavior within limits that the institution can accommodate. He or she must be able to issue commands with confidence that they will be followed, or else he or she must be able to subdue the patients by force—a task generally requiring a large staff, a secure building, and a willingness on the staff's part to inflict and to endure physical insults. Drugs, however, allow patients to be confined in marginally staffed, minimally secure, and fragilely constructed community settings, as opposed to physically secure hospitals.

**Drugs and the Decline of Physical Restraint.** Drugs are remarkably effective restraining devices and are easier than physical restraint to adminis-
ter and maintain, but restraint is not their most important custody-enhancing effect. Drugs also possess a remarkable potential for undermining individual will and self-direction, thereby producing a psychological state of unusual receptiveness to the directions of custodians. When this condition progresses too far, it is deemed akinesia, but in its milder forms, the phenomenon, which renders confinees submissive and compliant,\textsuperscript{127} is almost certainly an intended result of state drugging.

Drugs also ease the burden of the custodian’s remaining tasks, such as keeping his charges nourished and clean. Physical restraints and seclusion made every requirement of confinee life an onerous staff task. Physically restrained patients were individually fed by staff, or by mechanical means. Similarly, staff accompanied every restrained or secluded patient to the bathroom; if patients could not leave their rooms, staff had to clean up after patients who soiled themselves. Simple tranquilization or chemical sedation involved the same problems: patients too tranquilized to walk or follow instructions might just as well be physically restrained, from the staff’s point of view. By contrast, drugged patients are generally ambulatory and, as just noted, unusually sensitive to direction from their custodians. They can walk to the dining area \textit{en masse}, feed themselves, return to their quarters, and relieve themselves. This condition entails minimal staff effort.\textsuperscript{128}

\textbf{Drugs and the Shift to Private Forms of Custody.} Drugs thus supplanted physical restraint because they are more effective restraints. They reduce the role of the psychiatric hospital by making a secure form of custody possible without the hospital’s large staff, protective architecture, and geographical isolation. The connection between drugs and state psychiatry’s third distinctive feature—the shift to private custody of the mentally ill—is, however, more subtle. Drugs, in theory, could coexist with a system of small, publicly operated custodial arrangements, such as a network of state-operated boarding homes. What, if anything, ties drugs to the system of private custody for the mentally ill?


Two doctors who ingested one of these drugs as an experiment described this effect:

\[\text{It was marked and very similar in both of us: within ten minutes a marked slowing of thinking and movement developed, along with profound inner restlessness. Neither subject could continue work, and each left work for over 36 hours. Each subject complained of a paralysis of volition, a lack of physical and psychic energy. The subjects felt unable to read, telephone or perform household tasks of their own will, but could perform these tasks if demanded to do so [sic]. There was no sleepiness or sedation; on the contrary, both subjects complained of severe anxiety.}\]

Belmaker & Wald, \textit{Haloperidol in Normals}, 131 \textit{BRIT. J. PSYCHIATRY} 222 (1977). This psychological state, induced in confinees, must be every overweening jailer’s ideal.

128. It is hardly surprising that a participant at the 1955 Symposium on Thorazine commented that “every day at least one or two ward people mention how much easier their job is since we started putting Thorazine to such wide use.” \textit{1955 SYMPOSIUM, supra} note 15, at 98.
The connection is built upon a cultural attitude toward drugs and physical restraint, respectively. Were it not for drugs, physical restraint, confinement, and crude somatic measures for subduing confinees would have remained the primary means of dealing with serious mental illness. Private facilities that routinely bound, shackled, restrained, benumbed, or secluded the mentally ill would be intolerable today, because the state jealously guards its monopoly on physical force. Thus, shifting custody from public to private institutions depended on the invention of a treatment form that made private management of mental illness consistent with evolving general norms about physical force and restraint. What private custodians cannot be allowed to accomplish with physical restraint, they can do even more efficiently by drugging—without serious objection from any quarter. It is simply taken for granted that drugs are a medical measure unconnected to police or custodial purposes.

Thus, every distinctive feature of the new public mental health regime is paralleled by the chemical properties of the drugs, none of which is curative in nature or necessarily benevolent in effect. A society motivated by desires to phase out state hospitals to save money, to transfer the mentally ill into private custody to free the state from official responsibility, and to employ restraints more powerful and effective than leather straps or straitjackets, would embrace drugs even if the mentally ill suffered more as a result. At the very least, one cannot conclude that state psychiatry's wide adoption of the drugs is evidence of the chemicals' benevolence or "antipsychotic" mode of action.

B. SELF-CARACTERIZATION

Given the drugs' double-edged promise as medical and custody-enhancing measures, and given the plausible picture of state psychiatry using drugs primarily for their custody-enhancing effects, the next factor in state-professional analysis takes on added weight. By the mistakes it has made and by its response to those mistakes over the past thirty years, state psychiatry may have marked itself as a professional (or political) undertaking. In other words, state drugging may have characterized itself.

1. The Psychiatric Response to Tardive Dyskinesia

One drug side effect, tardive dyskinesia, is an important test of self-characterization. Because of its irreversible and often grotesque symptoms, tardive dyskinesia is widely considered to be the most serious potential consequence of drugging. Did state psychiatry's posture toward tardive dyskinesia bespeak the high traditions of medical science, with doctors paying it close attention? Or did state psychiatry approach tardive dyskinesia with the attitude of custodians, determined to protect their most effective means of control at almost any


130. See infra note 201 and accompanying text (discussing drugs' cultural status as medical prerogative).

131. See supra text accompanying note 68.

132. See supra notes 85 to 90 and accompanying text (discussing tardive dyskinesia).
cost? Precisely because of tardive dyskinesia’s seriousness, which would attract public attention, custodians would ignore the disorder.

State psychiatry adopted the second posture. Tardive dyskinesia was slow to be acknowledged by academic psychiatrists and slower still to enter the calculations of ward physicians, who, throughout the 1970s, virtually ignored it.

Academic Psychiatrists. In the late 1950s and early 1960s, a few reports, usually involving individual patients, appeared on tardive dyskinesia. The condition had no agreed-upon name and was thought to be rare. Indeed, the evidence of its very existence was not overwhelming.

A breakthrough, and an omen of research psychiatry’s attitude, came in 1967. Dr. George Crane, a National Institute of Mental Health researcher, had examined patients in randomly selected mental hospital wards and reported that nearly thirty percent of them—at the time, an unheard of percentage—manifested tardive dyskinesia’s symptoms. Crane’s findings, however, met with disbelief, derision, and admonition not to invent a side effect without any “clinical or scientific evidence” to back it up.

Crane’s report threatened to change prevailing patterns of drug use. Tardive dyskinesia recalled the disgraced lobotomy operation whose permanent side effects had proven to be its downfall.

Dr. Crane’s paper and the response to it constitute, I believe, two pivotal events in 20th century psychiatry. Crane’s findings challenged the prevailing view that drugs, unlike lobotomies, had no widespread, permanent side effects. Moreover, Crane depicted tardive dyskinesia as a potentially disfiguring rather than trivial condition.

Dr. Crane delivered his report orally before an audience that included two pre-eminent psychiatrists: the American, Dr. Nathan Kline, and the Frenchman, Dr. Pierre Denber. An “emergency discussion” ensued. Dr. Kline disagreed with Crane completely. Since the introduction of neuroleptics, he said, there had been “no great change in the appearance of the patients” in mental hospitals. “Let us not produce an epidemic of side-effects and papers,” Kline admonished Crane, “unless there is real evidence of it, either clinically or scientifically.”

Furthermore, Kline noted that only 83 cases of tardive dyskinesia had been reported, including 50 patients who were brain-damaged. In his view, “[s]chizophrenics are notorious lovers of stereotypic movements so that the condition tends to perpetuate itself. In a sense it is a kind of conditioning.”

Dr. Crane replied:

Dr. Kline quoted figures as to the rarity of the disease. The disease is rare because it is not reported. For instance, no patient included in my presentation was reported in the literature. The difference between schizophrenic stereotypics and this neurological syndrome is very marked; as one becomes familiar with the syndrome there is no difficulty in distinguishing the two types of clinical manifestations.

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tion to Crane's works bespoke an awareness of the high stakes involved.139

According to Crane, who continued to publish papers and who pressed his views at the Food and Drug Administration (FDA), there was "strong opposition on the part of the medical profession, industry and also government agencies [to] . . . accept[ing]" tardive dyskinesia as a serious medical problem.140 Until 1972, Crane "had many discussions with prominent clinicians in academic circles . . . [but] for the first few years, [and] until 1971, '72, they denied the existence [of tardive dyskinesia] as a disorder or felt the disorder was unimportant."141

In 1972 the barriers fell. The package inserts accompanying the drugs were amended to include tardive dyskinesia as a possible side effect,142 and academic psychiatry finally acknowledged the condition.143 The Archives of General Psychiatry published a "special report" about tardive dyskinesia, announcing that "patients [who clearly show this syndrome] are not uncommon."144 An accompanying essay hailed this report as proof "that there indeed are resources in American psychiatry exercising medical accountability and equipped to exert scientific scrutiny over issues which affect the welfare of the mentally ill"145—reflecting psychiatry's awareness that tardive dyskinesia tested its professional and moral credibility. Whether the test was passed, however, entirely is another matter.

The enormity of psychiatry's default in the late 1960s and early 1970s should not be underestimated. Patients must have suffered tardive dyskinesia at roughly the same rate as they do now,146 yet in psychiatric circles, this grotesque disease was widely said not to exist at all. Almost no one noticed the obvious symptoms that were everywhere in mental hospitals—a development all the more striking due to the obviousness of the symptoms and the ease with which confined mental patients can be studied and observed.147

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139. Dr. Denber stated that "sweeping conclusions" like Crane's threatened to "undo the past 15-years of work," id. at 218, apparently referring to Thorazine's 15-year tenure in psychiatry.

140. Joint Appendix, supra note 94, at 1087a-88a (testimony of Dr. George Crane); see also Crane, supra note 20, at 127-28 (government and drug companies failed to show serious interest in tardive dyskinesia despite considerable evidence about problem).

141. Joint Appendix, supra note 94, at 1088a.

142. Id.

143. See id.; see also American College of Neuropsychopharmacology—Food and Drug Administration Task Force, supra note 101, at 463 (American College of Neuropsychopharmacology and FDA “have recognized the seriousness of these complications and established a task force”).

144. American College of Neuropsychopharmacology—Food and Drug Administration Task Force, supra note 101, at 463.

145. Id. at 467.

146. See supra note 88 and accompanying text.

147. In the latter part of the 1970s, psychiatric journals overflowed with studies of tardive dyskinesia. See Jeste & Wyatt, Changing Epidemiology of Tardive Dyskinesia: An Overview, 138 AM. J. PSYCHIATRY 297, 300-01, 307-09 (1981) (citing published studies). No attention, however, is paid to why psychiatrists had ignored the disorder before. Indeed, Jeste and Wyatt reason that the increasing reports of the disease in medical journals mean that its incidence is on the rise. Id. at 300-01. Even legal commentators take this approach. See, e.g., Plotkin, supra note 30, at 476 (tardive dyskinesia “went unrecognized for years because its symptoms are often not manifested until late in the course of treatment”). Of course, this approach fails to explain why Dr. Crane found high incidences of tardive dyskinesia in the late 1960s.
MENTAL ILLNESS AND DRUGS

State Psychiatry's Response. Although academic psychiatry's disregard for tardive dyskinesia ended in the early 1970s, clinical state psychiatry's calculated ignorance of it had just begun. Despite the condition's notoriety, state doctors almost never diagnosed it and never took serious steps to minimize, manage, or prevent the condition during the next decade. State mental hospitals simply ignored tardive dyskinesia, as academic psychiatrists had the decade before.

Though no systematic study of state psychiatry's practice toward tardive dyskinesia exists, a clear picture emerges from the available information. The published psychiatric literature of the early 1980s makes it clear that, until that time, tardive dyskinesia had received little clinical attention. Moreover, when Dr. Crane surveyed state mental hospital systems in the 1970s, he consistently found that physicians neither diagnosed tardive dyskinesia nor even acknowledged the existence of its symptoms.

Clinical disregard of the condition was profound enough to leave other traces in the historical record. A mid-1970s General Accounting Office survey of Veterans' Administration hospital drugging concerned itself with side effects, but the study did not even mention tardive dyskinesia. A more recent similar study of New York mental hospitals, one of the largest state mental health systems, likewise ignored the disorder. Public hospitals did not rec-

149. Dr. Crane testified in Rennie that there was "no precedent" in modern medicine for doctors ignoring a psychiatric problem as serious as tardive dyskinesia for such long period of time. Joint Appendix, supra note 94, at 1093a.

I believe that Dr. Crane's moral genius and devotion to the truth were largely responsible for tardive dyskinesia's recognition in 1972. But for Crane, organized psychiatry would have continued to ignore the disease for several more years. Nevertheless, organized psychiatry did confront tardive dyskinesia; thus one can argue that research psychiatry has behaved professionally—rather than politically—toward this condition since 1972.

I will not pursue this question any further, since it is state, and not academic, psychiatry that is being characterized. For my purposes, it is enough to say that a strong disinclination to acknowledge that tardive dyskinesia was already apparent before the arguably overworked and undertrained state hospital staffs confronted the issue. Moreover, since the themes and rationalizations of the academic debate reappear unchanged in the clinical setting, see infra notes 149 to 161 and accompanying text, it is instructive to confront them for the first time in another context.

149. Of course, research in academic psychiatry focuses on the disorder and its incidence—not on whether state doctors actually ignored it. As several researchers have noted, "Despite the voluminous literature on psychotropic drugs, very little information is available on the actual prescription practices in mental hospitals." Mason, Nerviano, & DeBurger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 Diseases of the Nervous System 541, 541 (1977).

150. See, e.g., Gardos & Cole, supra note 86, at 776 ("A quarter of a century into the neuroleptic era, drug-induced tardive dyskinesia has emerged as a significant public health problem"); Opler, Katz, Kobayashi & Ruiz, Tardive Dyskinesia and Institutional Practice: Current Issues and Guidelines, 31 Hosp. & Community Psychiatry 239, 239 (1980) ("Many recent reviews document that [sic] tardive dyskinesia is a very real, most often late complication of long-term neuroleptic treatment, and they end by cautioning the clinician to take this factor into account as one more consideration in the treatment of chronic psychosis. Unfortunately these cautions have had little impact on individual and institutional practice"); Task Force on Late Neurological Effects of Antipsychotic Drugs, Tardive Dyskinesia: Summary of a Task Force Report of the American Psychiatric Association, 137 Am. J. Psychiatry 1163, 1163 (1980) (generally regarding problem as recently discovered and of increasing concern).

151. Joint Appendix, supra note 94, at 1087a (Testimony of Dr. Crane).


ognize tardive dyskinesia as a clinical entity worth any attention.

The most complete picture of a state mental hospital system's attitude toward tardive dyskinesia in the late 1970s appears in the *Rennie v. Klein* trial record. According to the hospital medical directors, the four New Jersey hospitals involved in the case had never, as of 1978, diagnosed the syndrome.154 When Dr. Crane, as the *Rennie* plaintiffs' expert witness, surveyed selected New Jersey mental hospital wards, however, he found that approximately twenty percent of the patients had tardive dyskinesia.155 Not a single patient chart contained the diagnosis, however, and the charts almost never noted tardive dyskinesia's obvious symptoms: twitches, movements, and grotesque postures.156 No datum or observation that suggested tardive dyskinesia's existence received official recognition from the hospitals.

The hospitals could control the contents of their patient records, but how did they explain tardive dyskinesia's grotesque movements to those afflicted, their families, and interested outsiders? Since severely regressed patients do not ask questions or demand explanations, in many cases the hospital need say nothing. When pressed, however, the hospitals in New Jersey adopted one or more of three different expedients. Staff branded symptoms as faking.157 They attributed grotesque movements to mental illness or "nerves,"158 just as prominent researchers in 1967 had dismissed reports of widespread dyskinetic movements.159 In addition, as Dr. Crane's survey in *Rennie* found, hospital staffs denied that obvious grotesque movements existed at all,160 just as academic psychiatrists earlier had failed to notice symptoms.161 Other state hospitals must have resorted to similar expedients to explain away tardive dyskinesia's grotesque manifestations.

State psychiatry's approach to tardive dyskinesia bears the earmarks of state overreaching, not medical error. Its missteps defy explanation in terms of professional carelessness, lack of medical knowledge (indeed, physicians had to know which grotesque movements to ignore), or shortages of medical staff. Hospitals developed an official—and inherently incredible—version of the truth to serve their narrow custodial interests. There was widespread lying to patients about the grotesque, drug-caused movements that led the victims to blame themselves for their deformity. Physical distress was visited on patients, with a nonchalance suggesting that the harms—and the patients—counted for nothing at all. Patients were treated as fungible objects, with no regard paid to their individual response to drugs. More remarkably, this approach produced virtually no dissent in state psychiatric circles. Indeed, the only vocal dissenter

157. *Id.* at 1301.
158. Joint Appendix, *supra* note 94, at 1343a, 2307a (hospital staff attributed John Rennie's tardive dyskinesia to "psychological difficulties").
159. See *supra* note 136 (describing discussion between Dr. Crane and Dr. Kline).
160. See *supra* note 155; see also Shavill, *supra* note 30, at 595 n.279 (in connection with court hearing on hospital's petition to forcibly medicate patient, attorney noticed lip and tongue movements symptomatic of tardive dyskinesia, which hospital doctors had not mentioned in court report).
in the 1970s among academicians, researchers, and National Institute of Health officials was Dr. Crane.

2. Self-Characterization and Other Drug Side Effects

The track record on tardive dyskinesia is not the sole reason for warranting a political characterization of state drugging. State psychiatry's decision to drug nearly every patient and to downplay other adverse, reversible drug reactions also is relevant.

There is a palpable feeling in state hospitals that drug-taking is the duty of everyone subject to the institution's power.\textsuperscript{1} This appears, on its face, more a political than a medical obligation of patients.\textsuperscript{2} Other side effects and drug consequences that might interfere with this duty are ignored, as was (and still is) tardive dyskinesia. Thus, although state psychiatry's goal is to alleviate mental suffering, it has been observed that physicians almost never ask patients how drugs make them feel.\textsuperscript{3} If the doctors did ask, it appears they would not like the answers—up to forty percent of patients react to drugs with discomfort or depression that generally is overlooked.\textsuperscript{4} Similarly, state physicians usually interpret drug withdrawal symptoms—which have no connection to naturally occurring disease—as signs of resurgent psychosis, and their remedy for this kind of drug-caused distress is to prescribe more drugs.\textsuperscript{5}

Moreover, state psychiatry's general view toward reversible side effects has resembled its stand toward tardive dyskinesia, albeit without the stark pattern of nonacknowledgement.\textsuperscript{6} Researchers were quick to note reversible side effects in the 1950s,\textsuperscript{7} and state hospitals did not hesitate to acknowledge their existence in principle. Indeed, during the 1950s and 1960s, many psychiatrists, making a virtue out of the inevitable, viewed side effects as signs of drug effect-

\textsuperscript{1} See, e.g., Davis, \textit{Recent Developments in Drug Treatment of Schizophrenia}, 133 Am. J. Psychiatry 208, 210 (1976) (although "a substantial number of patients improve considerably on placebo . . . most schizophrenic patients do receive neuroleptics, so the implicit assumption of many psychiatrists may be that neuroleptics are indicated for all cases of schizophrenia, a somewhat undifferentiated treatment strategy"); Gardos & Cole, \textit{supra} note 84, at 36 (perhaps 50% of stabilized schizophrenics would do just as well drug-free); see also Rennie, 476 F. Supp. at 1298 (trial record reflected that many patients treated with psychotropics could improve with smaller doses, or no drugs at all). See generally Carpenter, McGlashan & Strauss, \textit{supra} note 82; May, Van Putten & Yale, \textit{supra} note 84.

\textsuperscript{2} See, e.g., Shavill, \textit{supra} note 30, at 591 (drug refusal per se disrupts "therapeutic milieu" because it "undermines the good will of other patients on the ward"); moreover, structure of therapeutic milieu is derived from authority of therapist and drug refusal "undermine[s]" that structure, thereby "contributing to anxiety on the part of other patients"). Based on this view, one's duties to the ward itself and to fellow patients require acquiescence in drugging, no matter what the consequences to the individual. Compare \textit{Buck v. Bell}, 274 U.S. 200 (1926). Such views, I believe, are common in state psychiatry.\textsuperscript{165}


\textsuperscript{4} Since reversible side effects received some acknowledgement, generalizations about how state hospitals handled them cannot be made with the same confidence as generalizations about tardive dyskinesia, which was completely ignored in word and deed.

\textsuperscript{5} See, e.g., 1955 SYMPOSIUM, \textit{supra} note 15, at 37, 58-61 (discussion by symposium participants on drugs' effects). See generally Ayd, \textit{A Survey of Drug Induced Extrapyramidal Reactions}, 175 J. A.M.A. 1054 (1961); Hall, Jackson & Swain, \textit{supra} note 91.
tiveness. Although that idea is now totally discredited, there remains a reluctance in clinical state psychiatry to actually diagnose these side effects—a reluctance that seems to increase in proportion to the side effect’s negative implications for future drug use.

Dr. Crane, perhaps the only research psychiatrist of his generation to seriously study state psychiatry’s diagnostic attitudes toward side effects, once again is an important source. Crane’s New Jersey study included drug-induced, Parkinson-like tremors, generally thought to be reversible and quite common, as well as tardive dyskinesia. He found that the state physicians often ignored obvious drug-caused tremors, neither charting their existence nor diagnosing them as symptoms of drug-induced Parkinsonism. Unlike tardive dyskinesia, however, this Parkinsonism received occasional attention in patient charts, and doctors did not claim this problem to be nonexistent. The Rennie record also depicted several cases in which staff ignored obvious reversible side effects and, when pressed, either branded the patients as “fakers” or invoked one of the other rationalizations that were used in cases of tardive dyskinesia. Accounts abound of state psychiatrists elsewhere similarly ignoring these side effects.

Some drug research literature also suggests the extent to which reversible side effects have been ignored. For example, one study of Prolixin reported that thirty-five percent of the experimental subjects developed serious akinesia and as a result had to be dropped from the study. The high incidence of

169. See, e.g., 1955 SYMPOSIUM, supra note 15, at 51, 55-57, 67 & 73; Deniker, supra note 118, at 92 (side effects may be necessary to cure disease). In his well-informed 1976 study of drug issues, DuBose remarked on the “intuitive notion shared by many psychiatrists that the effective dosage level of a drug is reached only when side effects appear.” DuBose, supra note 36, at 1176 n.70.


171. See supra note 155.

172. Joint Appendix, supra note 94, at 1069a-83a.

173. Id. at 1076a-77a.

174. 476 F.2d at 1300-03.

175. See, e.g., Wexler & Scoville, The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 ARIZ. L. REV. 1, 68, 203 n.10 (1971) (“hospital feels that many of the patients who appear to be heavily sedated are simply very regressed psychologically”); Ferleger, Loosing the Chains: In-Hospital Civil Liberties of Mental Patients, 13 SANTA CLARA L. REV. 447, 448-49 (1973) (nurse refused to respond to patient’s complaints that medication produced adverse side effects); see also Naughton v. Bevilaqua, 458 F. Supp. 610 (D.R.I. 1978), aff’d sub nom. 605 F.2d 586 (1st Cir. 1979) (staff allegedly ignored patient’s extreme reactions to Prolixin).

My own experience representing patients in New Jersey mental hospitals comports with this picture. I never knew a psychiatrist who discontinued drugs because of side effects. Often doctors ignored drug distress that—it seemed to me—easily could have been alleviated. This harsh practice was the rule rather than the exception. On occasion, the doctors did shift to a different member of the same family of drugs in hopes of avoiding drug-caused harms, and doctors routinely prescribed anti-side effect drugs. Patients whose side effects did not abate with these measures—and there were many—simply continued to suffer. No fact that suggested drug discontinuation might be in order was ever acknowledged in patient charts.

Some patients fared even worse. Those who complained, who antagonized staff, or who sought my help in connection with drugs usually received Prolixin, a drug notorious among patients and staff for producing the most severe side effects. In John Rennie’s own case, for example, Prolixin had always caused him great suffering and—in my view—often had driven him to suicide attempts. Yet Prolixin was the one drug staff insisted on giving him when he enlisted my help. See supra note 97 (describing patients’ reaction to drugs); Rennie, 462 F. Supp. at 1138, 1140, 1143 (court faulted hospital staff for ignoring Rennie’s reports of suffering from akinesia while on Prolixin).

176. Rifkin, Quitkin, Rabiner & Klein, supra note 82, at 45.
akinesia surprised the authors, but every one of the research subjects had been treated with Prolixin during the preceding year at a clinic, where physicians apparently had failed to notice akinesia.

In general, the patterns of thought and practice evident in state psychiatry's posture toward tardive dyskinesia are recurring. First, nonbeneficial, reversible drug side effects fail to register with state psychiatrists. A manifest disinclination to look for these drug harms pervades day-to-day practice. As already noted, for example, state psychiatrists generally do not even ask patients how drugs make them feel. At the same time, symptoms of mental illness, like social deterioration, which are unresponsive to drugs, do not appear in calculations of therapeutic success and failure, which are measured, ironically, in terms of the number of days that one is free of inpatient psychiatric hospital treatment. Furthermore, an overwhelming presumption in state psychiatry that all harms are caused by the absence of drugs in the bloodstream mistakenly attributes relapses and the distress that results from drug withdrawal to a lack of drugging, just as drug-caused harms are generally attributed to naturally-occurring disease. Thus, it is not surprising that drug-caused harms, after being well established in the literature, are quickly forgotten in clinical practice. For instance, fifteen years after Thorazine's co-discoverer proclaimed akinesia to be almost a signature of Thorazine's presence in the body, it was described as a "poorly recognized drug-induced . . . behavioral disorder." What psychiatrists refuse to see in their patients directly, they also refuse to learn about from books. The result, in the eyes of many state psychiatrists, is that drugs can do no wrong to any patient at any time. All distinctions among patients collapse into their common responsibility to submit to drug actions.

Of course, intellectual biases prevail in every scientific and professional endeavor. The existence of conceptual presumptions and paradigms, without more, hardly marks an endeavor as unscientific, unprofessional, or political. Clinical state psychiatry's "paradigm"—if that is the appropriate term—is "political," however, in a number of respects. Its disregard of apparent facts and its simple-minded view of drug response are difficult to reconcile with any

177. Id. at 44.
178. Id. at 43-44.
179. See supra note 164.
180. See supra note 164.
181. See Carpenter, Heinrichs & Hanlon, supra note 81.
182. See Hogarty, Schooler, Ulrich, Mussare, Ferro & Herron, Fluphenazine and Social Therapy in the Aftercare of Schizophrenic Patients: Relapse Analyses of a Two-Year Controlled Study of Fluphenazine Decanoate and Fluphenazine Hydrochloride, 36 ARCHIVES GEN. PSYCHIATRY 1283, 1288 (1979) (patients whose drug intake was assured relapsed at same rate as patients free to discontinue drugs); see supra note 162.
183. See generally Rifkin, Quitkin & Klein, supra note 95 (discussing conclusions of some psychiatrists that patients would fare better if drug-free).
184. See generally Rifkin, Quitkin & Klein, supra note 95 (authors show how drug-induced akinesia often confused with depression and residual schizophrenia).
185. Deniker, supra note 118, at 92.
186. Rifkin, Quitkin & Klein, supra note 95, at 672.
187. See Crane, The Prevention of Tardive Dyskinesia, 134 AM. J. PSYCHIATRY 756, 757-58 (1977) ("It is quite obvious that the publication of articles on tardive dyskinesia and the pleas of a few investigators to use neuroleptic drugs with greater discretion have had little impact on the prescribing practices of physicians.")
bona fide scientific or professional view. The apparent motivation is to maximize drugging because of the drugs’ custody-enhancing effects—a political rather than a scientific objective. Its reduction of individuals to fungible entities without distinguishing characteristics, its tolerance for state-induced distress, and its apparent willingness to conceal the truth bespeaks political overreaching more than scientific or professional error. Because of these considerations and because every inference in favor of continued drugging seems to be indulged in the face of “reversible” and “irreversible” side effects alike, state drugging has characterized itself as political in nature.

C. THE PSYCHIATRIC PROFESSION

When Dr. George Crane delivered his 1967 report about the high incidence of tardive dyskinesia, his audience probably thought of lobotomy. Lobotomy’s inventor had received a Nobel Prize in 1949 yet, within a few years, the public and part of the psychiatric community came to regard the surgery as excessive, ill-conceived, and ill-motivated. This harsh judgment was influenced by the severity of the operation’s side effects, its permanence, and the fact that psychiatry—to a remarkable extent—had not noticed or acknowledged the problem. Dr. Crane had now found serious permanent drug side effects, but state psychiatrists would not notice or acknowledge these either, at least for the next decade. These repeated failures raise a question as to the bona fide nature of the state psychiatric profession itself.

Any state-professional controversy requires analysis of the profession in question—its social status, its motivating forces, and its history. The goal of such analysis is not to punish professionals or to make them relinquish professional prerogatives because of past mistakes. Rather, the profession's credibility and past performance are relevant to the overall question of characterization. Indeed, the arguments in favor of a professional characterization are ultimately premised on the profession's standing as such. Society defers to professional judgment because of its source, and if the source has not lived up to expectations, society, including the courts, should adjust its judgments accordingly.

Psychiatry's self-proclaimed missteps are particularly telling when viewed from this perspective. The succession of organic therapies in psychiatry over the past hundred years—bleeding, skull scraping, purging, restraining gadgets, insulin shock, and lobotomy—do not inspire confidence. The fact that therapies succeed one another is hardly worrisome in itself; it could reflect true scientific progress, as well as changing cultural fashions or the simple juggling of custodial measures over time. The manner in which therapies rise and fall in psychiatry, however, is remarkable. With each new therapy's emergence, the

189. Egas Moniz first reported the results of lobotomy in 1939 and was awarded the Nobel Prize in Medicine 10 years later. *9 INT’L. ENCYCLOPEDIA OF PSYCHIATRY, PSYCHOLOGY, PSYCHOANALYSIS AND NEUROLOGY* 306 (B. Wolman ed. 1977).
old form of intervention is not respectfully retired but is repudiated and regarded as excessive or perhaps ill-motivated from the start. Meanwhile, the new therapy is received uncritically and, even after years of use, the harms it causes remain little noticed. The entire cycle then repeats itself. Indeed, the old therapies' repudiation makes the new therapies appear that much better in contrast. In this sense, psychiatry's history is an endless succession of bright, new therapeutic eras, each deemed to be far better than its predecessor, and all destined to be regarded as deplorable.

In any case, there are strong similarities between psychiatry's receptiveness to lobotomy and to drugs. Both were regarded as dramatic advances, both apparently worked via sophisticated biological mechanisms, and in both cases, serious and obvious side effects went unnoticed. Additionally, there is no reason to think that psychiatry's internal processes—its capacity to detect the harms it inflicts and its willingness to deal with those harms meaningfully—have changed in any fundamental way since lobotomy's heyday.

History has demonstrated psychiatry's lack of maturity as a science—a fact upon which courts have repeatedly commented. Accordingly, psychiatry's judgments should carry less weight than the judgments, for example, of other medical professions. It is almost unthinkable that a court would question a

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192. See id.
193. See, e.g., Carpenter, McGlashan & Strauss, supra note 82, at 15 ("[Psychiatry's ignoring of drugs' noxious effects on behavior, adjustment, and mood] . . . results in a situation not entirely dissimilar to past enthusiasm for lobotomies, where attention focused on the positive attributes of the procedure to such a degree that the short-term and long-term hazards were overlooked"); Carpenter, Heinrichs & Hanlon, supra note 81, at 470 ("[research psychiatrists' failure to pay attention to deleterious therapeutic effects] can have serious repercussions as we accept, overgeneralize, and then retreat from therapeutic innovations").
194. See supra notes 149 to 161 and 190 to 191 and accompanying text (discussing state psychiatry's disregard of tardive dyskinesia and lobotomy).
196. Some judges appear to draw the opposite conclusion—pointing out the tentativeness of psychiatric diagnoses and then deciding, partly on that account, to defer to psychiatric judgment. The foremost example is Chief Justice Burger, whose opinions generally note psychiatry's shortcomings and then oppose judicial intrusions into psychiatrists' treatment decisions. See Parham v. J.R., 442 U.S. at 608-69; O'Connor v. Donaldson, 422 U.S. at 579, 584 (Burger, C.J., concurring). The Chief Justice has reasoned that psychiatry's conclusions are tentative because the underlying problems verge on being intractable, and no nonpsychiatric agency could improve on the profession's performance.

These analyses, however, came in contexts quite different from the forced drug cases. In O'Connor v. Donaldson, Chief Justice Burger's concurring opinion attacked the claim that involuntarily confined mental patients enjoyed a right to treatment. "Given the present state of medical knowledge regarding abnormal human behavior and its treatment," he wrote, "few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of such treatment as will give [them] a realistic opportunity to be cured." 422 U.S. at 585-89. Nonetheless one could not argue that the gaps in our knowledge of "abnormal human behavior and its treatment" justify denying patients the right to refuse those treatments. As the Chief Justice noted, "[O]ne of the few areas of agreement among behavioral specialists is that an uncooperative patient cannot benefit from therapy . . . ." Id. at 579. Similarly, in Parham v. J.R., a fourteenth amendment challenge to admitting children to state mental hospitals on the signature of a parent or guardian, Chief Justice Burger stated, "[W]e acknowledge the fallibility of medical and psychiatric diagnosis . . . [but] we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science . . . to an untrained judge or
competent internist’s recommendation that someone’s gall bladder be removed, but a psychiatrist’s Prolixin prescription is an entirely different matter. Individuals and society at large would be foolish to accord equal weight to these two medical judgments.197

Psychiatry is handicapped by its subject matter. Not only has human behavior thus far resisted scientific understanding, but its study is notoriously subject to passing political tides and cultural fashions.198 Moreover, state psychiatry—so directly involved in policing behavior—is apt to abuse that very power, in which case a professional characterization is misplaced and a political one is required to afford protection from such abuse.199

In short, the courts should pause long before according weight to psychiatric consensus opinion. Contrary to the implicit arguments of psychiatrists, their professional endorsement does not guarantee the drugs’ benevolence or moot the history of the drugs’ actual use.

D. THE TRADITIONAL ALLOCATION OF AUTHORITY

Up to this point, every consideration has favored a political characterization of state drugging. However, three factors remain to be considered,200 and each points the opposite way, toward a professional characterization. The first deals with the traditional allocation of authority in drugging matters between politics and professionalism.

When something “belongs” in the medical realm, we are inclined to accept medical decisions about benefit and detriment even if the detriments are great. By the same token, we are disinclined to tolerate any harm at all if it results from outside interference—by a judge, for example—with medical judgment. Who causes the harm is no less relevant than how much harm has been caused; in this sense, the relevant analysis is role oriented as much as it is utilitarian in nature.

Political characterizations of state drugging clash with these cultural conventions regarding the realms of medicine, politics, and law. We allocate insanity

administrative hearing officer after a judicial-type hearing.” 442 U.S. at 609. Here, however, the Court already had characterized the parent’s decision to hospitalize his or her child as a medical decision, id., such as the decision to have a tonsillectomy performed, and it followed that the reasonableness of the decision would be tested by medical (psychiatric) standards as well. In this context, the argument for medical as opposed to trial-type procedures is overwhelming. Nonetheless, it surely does not follow that the “shortcomings” of psychiatric treatment constitute reasons for the courts to defer to psychiatric judgment.

197. Cf. Aden v. Younger, 57 Cal. App. 3d 662, 684, 129 Cal. Rptr. 535, 549 (1976), which either overlooked or declined to make the distinction suggested in the text, and went on to hold that the California legislature was bound to treat electroconvulsive therapy as a nonexperimental medical procedure, which an informed, competent patient could elect to undergo without prior medical board review of the treating physician’s recommendation.

198. See, e.g., ROTHMAN, supra note 2; Blackwell, supra note 7, at 3 (“[the state of psychiatric therapy] has often been more reflective of the social, political and legislative climate than of the state of medical knowledge”).

199. The connection between psychiatry and state activity has another dimension. For many years, state hospitals were preeminent in the care of the seriously mentally ill. Thus, states were important components in the psychiatric enterprise and—to an extent difficult to determine—may have shaped that enterprise along political lines.

200. The three factors are traditional allocations of authority between the political and psychiatric realms, the nature of the problem drugs respond to; and practical constraints on judicial activism—activism being the inevitable result of a political characterization in this field.
to the medical realm and regard the drugs as preeminently medical measures. When courts decide otherwise, even with good reason, they open themselves to the charge of usurping a medical prerogative.201

The Rogers v. Okin202 record is illustrative. The district court had enjoined all forcible drugging in nonemergency situations in two Boston State Hospital wards. After the order had been in force for five years, the case reached the court of appeals.203 There, much was made of a single, drug-refusing patient. Doctors had detected this man's violent tendencies. As they had understood the injunction, the danger this patient presented was not imminent enough to warrant emergency drugging.204 Undrugged, the patient had erupted and harmed others. When this came to the district court judge's attention, he faulted the doctors for not declaring an emergency and for not drugging the patient.205 However, the court of appeals took a different view, regarding the episode as an illustration of the inevitable problems that arise from applying legal tests and standards to state hospital drugging.206

It is remarkable that no one regarded this one violent episode as a predictable, unavoidable, and perhaps acceptable cost of the five-year court injunction—a cost more than justified if the injunction prevented a commensurate amount of drug-caused harm. Since drugs had been implicitly allocated to the medical realm, however, harm from nonmedical interventions was deemed intolerable. No amount of accompanying benefit could redeem the damage non-physicians caused. In short, doctors' drugging decisions are justifiable on the ground that they produce, overall, more good than harm, but nonphysicians' actions are denied the same utilitarian justification. This is what allocating drugging to the realm of medicine means, and this is the convention courts adopting a political characterization must defy.

E. THE INTRACTABILITY OF THE PROBLEM

Were interlopers in the psychiatric realm allowed utilitarian justifications, and they are not, it might not make any difference. The underlying problem—to manage the insane humanely—may resist feasible, rational solution.207
It would be hard to demonstrate that any plausible, judicially mandated alternative to the drug regime would prove to be more beneficial. First, there are the serious practical difficulties inherent in comparing the harms and benefits of the drugs with the personal costs and advantages of remaining undrugged. For example, how many fewer days of hospitalization equal how much freedom from drug-induced anxiety? \(^\text{208}\) Even if such comparisons could be made, the large numbers of people involved and our relative ignorance about actual clinical outcomes present formidable problems. Moreover, such assessments are complicated by the drug revolution’s overwhelming success. Drugs eradicated the old psychiatric regime so thoroughly that nondrug and minimal drug treatment modes are all but forgotten. Neither judges nor other decision-makers can confidently envision, or weigh in the balance, a working, nondrug regime or its benefits.\(^\text{209}\)

Even modest judicial interventions are problematical. For example, a judge who requires careful medical consideration of drug refusers’ complaints would concentrate the hospital’s resources on one group of patients—the refusers—at other patients’ expense. \(^\text{210}\) Moreover, in the absence of a showing that state psychiatry’s drugging practices result from any lack of medical attention, this remedy promises little. Of course, moderate judicial remedies are not necessarily futile. Empirical research might demonstrate that some forms of limited judicial intervention made state psychiatry somewhat more beneficient. This possibility, however, is not a likely one, and it would be surprising if it ever came to pass.

None of this means that judges cannot advance constitutional values by a political characterization of drugging. Doctors lying to patients, their infliction of serious drug harms, and their affronts to patient dignity can be checked by court decree. However, the likely overall effects of judicial intervention in drug matters remain hard to calculate.

F. CONSTRAINTS ON JUDICIAL POWER

1. The Costs of a Political Characterization

The last two factors discussed bear heavily on the final consideration—the implementation problems attendant on a political characterization of state drugging by courts. The traditional allocation of drugs to the medical realm will color the attitudes of the public, as well as that of other branches of government, toward the courts’ efforts. In addition, as just noted, the problem of devising an alternative to drugs in any significant number of cases is daunting. The result is that political characterization of state drugging promises problematical results when there is little initial social tolerance for judicial activity in this area.

There are other obstacles to political characterization, including the near-

\(^{208}\) Brief for the American Psychiatric Ass’n as Amicus Curiae at 23–25, Rennie v. Klein, 653 F.2d 836 (3d Cir. 1982) (en banc) (noting role of drugs in shortening period of hospitalization).

\(^{209}\) But see generally Carpenter, McGlashan & Strauss, supra note 82 (discussing feasibility of treating acute schizophrenia without drugs in research setting).

\(^{210}\) Shavill, supra note 30, at 593 (disruptive patients require inordinate amount of staff time, resulting in less time spent on nondisruptive patients).
universal psychiatric endorsement of drugs. Were the medical profession divided over drugs, or largely opposed to them, court intervention would enjoy some professional support. As it is, however, a political characterization confronts not a debatable psychiatric measure but the profession of psychiatry itself. This makes state psychiatrists even more incredulous about political characterizations of drugging. Moreover, pro-deinstitutionalization physicians and officials will be unsympathetic to court decisions that reinvigorate mental hospital custodial techniques and stall the movement from public to private custodial settings. Additionally, state hospitals will resent any legal checks on their use of drugs to insure against patient-caused harm. The result is that compliance with judicial edicts in drug matters will be grudging at best.

The hospitals' attitude and stance are important. Mental hospital staffs that adamantly oppose a judicial decree are in an excellent position to undermine it. The affected institutions are isolated; the affected patients, many of whom are incompetent or easily provoked, are not in a good position to challenge staff actions, staffs control the records, and patients seem untrustworthy. At some point it must also be acknowledged that staff—if they are to run the institution at all—must have their way.

The major obstacle to a political characterization, however, is that the struc-

211. There is nothing remarkable about justifying a political characterization partly on the ground that it produces results (some) professionals can accept. When a political characterization is consistent with professional viewpoints, the case for judicial intervention is enhanced considerably.


213. Indeed, state hospitals and physicians resist even nonjudicial efforts to regulate drugs. See Armstrong, supra note 212, at 119-20 (describing Michigan and California state physicians' "disgruntled" response to modest internal measures and their resort to "civil service grievances and . . . civil injunctions and restraining orders"); see also Roth & Appelbaum, What We Do and What We Do Not Know About Treatment Refusals in Mental Institutions, in Refusing Drugs in Mental Institutions—Values in Conflict 140 (1984) (in New York, state doctors ignored internal regulations about drugs). Court interventions surely will be received with even less understanding, sympathy, and tolerance. Indeed, when New Jersey state hospitals adopted de minimus internal procedures, doctors at every level—including the Division of Mental Health directorate—ignored and subverted the rules. For a discussion of de minimus nature of the regulations, see infra note 252; Mills, Yesavage & Gutheil, Continuing Case Law Developments in the Right to Refuse Treatment, 140 Am. J. Psychiatry 715, 717 (1983) (co-authored by the defendant in Mills v. Rogers, this article describes New Jersey's system of legal checks as a "minimal" one); for a discussion of compliance with the regulations, see Rennie, 476 F. Supp. at 1303, 1305 (state central office for mental health failed to insure implementation of regulation; some hospitals remained totally unaware of regulation's existence because no one bothered to inform them; some hospitals made no pretense of complying; hospitals that nominally observed regulations in fact failed to acknowledge patients' drug refusals; force, threats of force, and punishment were employed to avert self-imposed, medically oriented procedural opportunities for patients).

214. See infra note 226 (discussing incompetency issue).
ture of state psychiatry is premised on untrammeled drugging. Drugs keep the mental hospital rolls low. At some point, a staff with all the goodwill in the world will not be able to manage more patients without drugs or fundamental changes in hospital staffing, approach, and procedures. Drugs keep order within the hospitals. Different techniques and a new moral consensus about them must be put into place if drugs cannot be used. These changes entail considerable restructuring, rethinking, and expense. Courts hardly would be the ideal supervisors of this process, and no court has attempted to do so. Simply withdrawing drugs by court decree without planning would threaten chaos. Therefore, courts cannot even tinker with drugging without threatening the sine qua non of today's state psychiatry and thus flirting with disaster.

2. The Proper Place for Consent

One might object to this Draconian picture on the ground that the impact of a political characterization would be limited because few patients ever refuse drugs, particularly for any length of time. It is true that the reported incidence of state hospital drug refusal is low. It would be a mistake, however, to judge the drug refusal phenomenon on that limited basis.

The most difficult patients could well turn out to be drug refusers. Moreover, drug refusal, once officially sanctioned, could become contagious, a possibility that worried the doctors in Rennie. Thus, a few undrugged patients could impose significant burdens despite their small numbers.

A still more important consideration is that refusals are significantly underreported by hospitals so the problem's dimensions generally are underestimated. Many patients find drugs objectionable. In Rennie, for example, doctors testified that only a handful of patients refused drugs, yet thousands of patients' charts contained an order for injectible medication, to be given "as needed," and usually the need arose when patients were unwilling to swallow a pill. Indeed, New Jersey patients who refused a pill, but then failed to physically resist the subsequent drug injection, did not—by the hospitals' reason-

215. See Armstrong, supra note 212, at 120 (noting "dramatic decrease in the [state hospital] population after the introduction of psychoactive medications").

216. One successful experiment in low- or no-drug treatment of acute schizophrenia employed a large motivated staff to deal with a small number of patients. Carpenter, McGlashan & Strauss, supra note 82, at 16-17. Nothing in their work suggests that discontinuing drugging on a wide scale, while holding staffing and other organizational features constant, would produce anything short of chaos.

217. See Brief for the New Jersey Dep't of the Public Advocate, Division of Mental Health Advocacy as Amicus Curiae in support of Respondents, Mills v. Rogers, 457 U.S. 291 (1982). The Public Advocate, the plaintiffs' attorney of record in Rennie, argued in Rogers that the medication review decree was viable, based on the "steady decline in the number of hearings requested and conducted in the nearly two years of operation of the system." Id. at 44; see also id. at 54-55 (citing "steady decline" in frequency of hearings requests). Notably, in the last month of the district court Rennie decree, only one hearing on drug refusal was held in the five mental hospitals under the decree. Id at 30. Almost certainly, the hospitals had simply returned to their entrenched practice of refusing to acknowledge drug refusals. See infra text accompanying notes 221 to 224.

218. See, e.g., Rennie, 476 F. Supp. at 1303-04 (noting low refusal ratio at New Jersey mental hospitals); Geller, supra note 20, at 612 (4 out of 281 state patients acknowledged as refusers). See Rennie, 462 F. Supp. at 1152 n.1 (John Rennie's discussion of court opinion encouraged other patients to refuse medication).

219. See Rennie, 462 F. Supp. at 1152 n.1 (John Rennie's discussion of court opinion encouraged other patients to refuse medication).

220. See supra notes 213, 217, and 218.

221. Rennie, 476 F. Supp. at 1304 (citing to trial record).
If a refusing patient ever willingly accepted a pill, New Jersey doctors deemed the rejection recanted. Moreover, patients who refuse drugs do so despite tremendous staff pressures. Without staff pressure, the number of refusers would surely be higher.

The potential extent of drug refusal and the impact of these lawsuits can be explored in another way. It is estimated that nearly one-half of all patients suffer drug-induced dysphoria or depression. These patients should be inclined to refuse. Partially overlapping with this group are patients who face tardive dyskinesia or other serious side effects, along with those who stand to benefit only slightly or not at all from being drugged. If properly informed, many of these patients should refuse as well. Other patients who simply are frightened by the drugs and the prospect of drug harm also would, rightly or wrongly, refuse drugs. Added to this number should be patients who would refuse drugs for irrational reasons, or for no reason at all. It is impossible to arrive at a precise figure, but the number of potential refusers—people who would rationally or irrationally refuse, if given a fair chance—undoubtedly is large.

Moreover, the reach and potential impact of right-to-refuse drug case law extends beyond the number of drug refusers. If drug refusers are constitutionally entitled to “professional medical judgment” or the “least restrictive alternative,” those who accept drugs must not enjoy any smaller entitlement. We cannot deny the Constitution’s solicitude to mental patients who cooperate with the doctors, while providing it to patients who resist, because such an approach would discourage cooperation for no apparent reason. Moreover, these legal standards for drug refusal are framed so as to relate to minimum decencies—albeit that judges disagree on what those minima should be. Under these standards, then, it would be wrong to accord “consenting” patients any less protection than patients who refuse. Indeed, courts that judge forcible drugging by the professional medical judgment test could hardly develop a more lenient, yet still rational standard: would “near-professional judgment” suffice for those who consent to drugs? Thus, the substantive constitutional standards for drug refusal are also applicable to consensual state drugging.

In any event, “consent” is a very thin constitutional reed, considering the debilitated mental condition of many patients, the incessant institutional pressure to accept drugs, and the absence of information in mental hospital

\[\text{See id. ("extensive use" of forced injections when patients refused pill not reflected in statistics).}^{222}\]
\[\text{Id.}^{223}\]
\[\text{See supra note 98 and accompanying text.}^{224}\]
\[\text{See supra note 213; see also A. BROOKS, supra note 190, at 915 (noting inherently coercive atmosphere of mental institutions).}^{227}\]

\[\text{See infra notes 179–187 and accompanying text.}^{226}\]
wards about drug harms. To ignore these differences and presume that mental patients' judgment is by and large unimpaired, that state hospitals are indifferent about patient drug-taking or are powerless to influence patients' choices, or that drug side effects are made known to patients and fairly portrayed by staff, is to base constitutional adjudication on a fiction.

State psychiatrists often claim that, when mental patients withhold consent to treatment, it should count for less than any other medical client's withholding of consent. A mental patient's grant of consent, then, clearly should also count for less. Indeed, the factors that vitiate consent in mental hospitals generally impel patients to accept, rather than reject, drugs. Impaired judgment leads patients to succumb to institutional pressures on drugging when it is unwise to do so.

Patient attitudes about drugs are not irrelevant; to the contrary, it is generally agreed that patient-physician cooperation and trust are extremely important in psychiatry. Moreover, patient drug refusal, whether explained rationally or not, can be a cry of pain about drug side effects. Furthermore, in close cases there is every reason to accept the patients' judgment about drugs. When the arguments about drugs are in balance, we might as well defer to the patient, even if his or her judgment is questionable. Nonetheless, patient consent does not deserve to be the basic organizing principle in drug matters, and, as will be shown, courts have not treated it as such, even when they may pay lip service to it. Just as we as a society should second-guess psychiatrists more than we do other physicians, so should we second-guess state mental patients' judgments more than other medical clients': wrong decisions to accept or refuse Prolixin should receive less deference than misjudgments about one's own gall bladder surgery.

228. See Rennie, 476 F. Supp. at 1309.
229. See Geller, supra note 20, at 615. (“Only express [drug] refusal is addressed. If a patient refuses his medication, the question of competency is raised. If he takes his medication, his competency is never questioned”). The problem of incompetent consent to drugs generally is ignored. Id. But cf. Rennie, 476 F. Supp. at 1314 (judicially mandated procedures for protecting incompetent patients' right to consent).
230. See O'Connor v. Donaldson, 422 U.S. 563, 584 (Burger, C.J., concurring) (recognizing patient cooperation with mental health professionals as fundamental to effective therapy).
231. This point is often overlooked by medical polemists. See, e.g., Appelbaum & Gutheil, supra note 61, at 310-13. The authors tested mental patients' asserted reasons for refusing drugs against constitutional theory, in effect treating the patients' remarks as pro se legal complaints and finding them wanting.
232. Judge Brotman observed in Rennie. “It is . . . difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risk of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risk is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion.” 462 F. Supp. at 1145.
233. See infra Part III (discussing Rennie and Rogers decisions).
234. See supra notes 188 to 199.
235. See id. Compare Wexler's treatment of competency as organizing principle for state psychiatry,
The consent issue, which stands at the forefront in rhetoric about the "right-to-refuse-drugs," in fact is a secondary concern. In the final analysis, the right-to-refuse-drug cases depend upon the Constitution's tolerance for state drugging and the public mental health regime premised on it. It makes no difference whether or not a patient consents to drugging.

III. The Courts' Response: Rennie and Rogers

The dilemmas of state-professionalism take their sharpest form in the controversy over state drugging. On one hand, a political characterization of drugging is more strongly supported for that practice than for other widely accepted forms of professional treatment. As demonstrated earlier, the biological effects of drug use set drugs dramatically apart from corporal punishment and involuntary confinement. These physical effects are far more harmful than compulsory vaccination, forced sterilization, or simple custody.

Moreover, the drug regime bears the marks of state overreaching. The Constitution seemingly was designed to prevent that regime's characteristic indifference to personal dignity and suffering, its unwillingness to draw relevant distinctions between individuals, and its pervasive, indiscriminate application. In addition, the profession of psychiatry's claims to judicial deference are tenuous.

While a professional characterization of state drugging would preserve the status quo, a political characterization could lead courts to challenge current drug policies. The courts' direct involvement with, and responsibility for, mental hospital functioning would increase dramatically, with uncertain results. Some mistaken clinical decisions would be made, and patients who should have drugs might not receive them. The number of institutionalized patients would expand, the risk of violent behavior would increase, and custo-

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D. Wexler, supra note 27, at 202-03, with Plotkin's discussion of the same subject, Plotkin, supra note 30, at 485-90. Both Wexler and Plotkin seem to attach an a priori value to making competence the building block of mental patients' rights. Yet Wexler notes that the competency concept is used as "camouflage when condemning choices the consequences of which are unacceptable." D. Wexler, supra note 27, at 203. I am simply proposing that for mental hospital drugging practices, it would be best to strip away the "camouflage" and see the problem for what it is. Where Wexler was concerned about the adverse consequences to the mentally ill of applying the label "incompetent," I am more worried about the consequences of imputing an ability to decide about and resist drugging where, in fact, no such ability exists.

236. When state professional treatment carries serious consequences and is suspect in professional circles at the same time, see Brooks, supra note 190, at 902 (avowedly experimental psychosurgery), the case is quite different, and the argument for a political characterization is enhanced considerably. If the same measure is designed to inflict suffering, as some "behavior modification" programs are, that argument also becomes almost overwhelming. E.g., Knecht v. Gillman, 488 F.2d 1136 (6th Cir. 1973); Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973). For a discussion of the medical, legal, and moral issues attendant on behavior modification, see Friedman, Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons, 17 Ariz. L. Rev. 39 (1975); Note, Conditioning and Other Technologies Used to "Treat?", "Rehabilitate?", "Demolish?" Prisoners and Mental Patients, 45 S. Calif. L. Rev. 616 (1972). These extreme cases are far easier for a court to deal with; they almost invite a political characterization.

237. See supra text accompanying notes 85 to 104.

238. See supra text accompanying notes 105 to 111.

239. See supra text accompanying notes 131 to 187 (discussing self-characterization of state-dragging).

240. See supra text accompanying notes 189 to 199 (discussing history of psychiatric intervention).
dial measures like physical restraints and seclusion would become more evident.

Political characterization, however, would not require barring drugs. While states can be guilty of overreaching with drugs, there is no reason to think that drugs themselves are a form of overreaching. Indeed, a political characterization would probably continue to allow the drugging of a majority of mentally ill patients in state institutions. A substantial number of the patients, however, would be drug free, and the amount of artificial, state-induced harm would decrease, even as the amount of naturally caused suffering increased. State deception would stop, and terrifying forms of state overreaching would be checked. Yet a court's political characterization of drugging would be widely regarded as judicial usurpation of medical prerogative, an action that might create chaos in mental hospitals and that could entail far-reaching judicial involvement in state psychiatry's affairs—an involvement that could prove futile, or worse. The many patients who benefit from drugs might well suffer as a result of judicial intervention.

A court, however, does not extract itself from the fray simply by characterizing state drugging as either professional or political: much more remains to be decided. A political characterization could result in an absolute right to refuse drugs, a constitutional bar against drugging in the event of certain side effects, a requirement that drugs constitute the "least restrictive alternative," or any number of other substantive rights. Procedurally, it could require anything from a full-fledged trial with counsel to the most informal administrative proceeding. Similarly, a professional characterization might translate substantively into the right to an "adequate," "accepted," or "recognizably professional" judgment. Procedurally, the professional characterization could require the opportunity to speak with the treating doctor, medical director, or nurse, or it might translate practically into no rights whatsoever if the court decides to deny all appeal from professional norms and methods of proceedings.

241. See supra text accompanying notes 200 to 206 (discussing traditional allocation of authority in drugging matters between politics and professionalism).

242. See supra text accompanying notes 207 to 210 (discussing problems associated with judicial intervention).

243. See supra text accompanying notes 211 to 216 (discussing costs of political characterization).

244. Patients suffer different kinds of harms—drug induced, political, and dignitary—because courts have stayed their hands.

245. Cf. Polk County v. Dodson, 454 U.S. 312, 325 (1981) ("[A] public defender does not act under color of state law when performing a lawyer's traditional functions as counsel to a defendant in a criminal proceeding"). Viewed in one light, there is all the difference in the world between recognizing a right which is characterized in professional terms and failing to recognize—as Polk County does—any right at all. The "no right" option, however, lies on the same continuum—and in fact it responds to the same kind of considerations—as does the "professional" right. The court could have applied a "professional judgment" standard to the Polk County problem, but chose to go just one step further. Compare Ingraham v. Wright, 430 U.S. 651 (1977) (public school corporal punishment held to implicate constitutionally protected interests, but as to identity and scope of any enforceable rights that affected school children might enjoy, Court reserves judgment; Court also finds that common law, post-deprivation remedies available in state courts satisfy constitutional right to procedural due process). Ingraham stands halfway between a purely professional version of constitutional right and the "no right at all" option. Moreover, in theory, professional characterizations could produce rules framed in legal terms, and legal characterizations might lead to professional-sounding rights. For example, a judge adopting a political characterization might rule that drugging is constitutionally permissible only when every conceivable doctor would so drug, or when the drugging doctor is a nationally renowned
The basic dilemma remains: the choice of either a political or professional characterization is not compelled. Nonetheless, the choice is particularly difficult because the stakes are high, and both choices carry grave consequences. The courts’ response to the state drugging cases shows judicial dissatisfaction with what are the only available options.

A. THE RENNIE AND ROGERS DECISIONS

It is not surprising that a court confronted with this dilemma tries to endorse both the professional and the political charters. In such cases, one of the two charters takes on a purely symbolic role, as the political charter has in recent appellate decisions. After all, a court cannot have it both ways.

Although some opinions reflect a professional characterization, while others reflect a political one, the most interesting decisions harness legalistic rights to purely medical procedures. When a court harnesses professional procedures to political substantive rights, the combination would appear inconsistent with the necessity of choosing a single characterization in the first place. In Rennie v. Klein, for example, the Third Circuit upheld due process proce-

psychopharmacologist. Such a standard would ensure that few patients received drugs and would check more abuses than some stringent sounding legal standards, like the compelling state interest test. Framing the right in those terms, however, arbitrarily would outlaw most instances of arguably professional intervention without articulating any values that would justify the result.

Similarly, constitutional tests that were highly tolerant of state drugging because the court had chosen a professional characterization could be framed in legal rather than professional terms. For example, holding that drugging was permissible whenever it served a rational state interest would almost allow all drugging of the mentally ill. It would, however, abandon any appeal to professionalism, suggesting instead that powerful biological interventions are a prima facie constitutional way for states to pursue legitimate state interests, a result unacceptable in our jurisprudence. Compare supra text accompanying notes 51 to 57 with Judge Garth’s concurring opinion in Rennie, 653 F.2d at 855.


247. Compare Dershowitz, supra note 36.

248. See Rennie, 653 F.2d at 854 (Seitz, J., concurring) (opting substantively for professional judgment test and procedurally for “reasonable assurances that there will be an opportunity for adequate input by various professionals and the patient”).

249. E.g., Rogers, 478 F. Supp. 1342, 1364 (D. Mass. 1979) (holding nonemergency forced drugging unconstitutional unless patient declared incompetent by state court and a duly appointed guardian-consent); see also In re K.K.B., 609 F.2d 747, 751 (Okla. 1980) (legally competent adult involuntarily committed to state mental hospital has right to refuse consent to administration of antipsychotic drugs).

250. No decision is known to me that does the opposite: tie a medical version of patients’ substantive rights to trial-type, legal procedures. Legal techniques are obviously ill-suited to medical decision making.

251. 653 F.2d 836 (3d Cir. 1981). A still-divided Third Circuit Court of Appeals redecided Rennie after the Supreme Court’s summary remand, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983) (en banc), but the Court of Appeals’ second Rennie opinion turned on the meaning of the Supreme Court’s remand instructions more than on the issue of the “least intrusive means” that had divided the court before. Compare the opinion of Judge Garth (“If we are to reconsider Rennie in
dures that amounted to a purely medical system of peer review and, at the same time, announced the “least intrusive infringement” (or “least drastic means” or “least restrictive alternative”) doctrine—a stringent legal standard—as the substantive constitutional test for forcible drugging. Similarly, in determining the rights of allegedly incompetent mental hospital drug refusers, the First Circuit in Rogers v. Okin combined a legal test—the “substituted judgment” standard, according to which unwanted medical treatment can be administered only after a determination that, but for an incompetent mental state, the patient would have accepted the treatment voluntarily—with a purely medical procedural vehicle (i.e., “some mechanism for periodic review by nontreating physicians of the full treatment history of patients to ensure that the treating physicians are in fact attempting to make treatment decisions as the patients themselves would were they competent”). With respect to dangerous patients, the First Circuit’s approach closely resembles that of the Third Circuit: “[A]ntipsychotics . . . [should not be] forcibly administered,” the Rogers court said, “absent a finding by a qualified physician that . . . [the patients’ constitutional interests in refusing] are outweighed in a particular situation and less restrictive alternatives are unavailable.” Once again, legal-sounding interests are to be enforced through distinctively medical means—in this case, a “finding by a qualified physician” about the “least restrictive alternative” doctrine’s application.

These decisions are anomalous because medical procedures in practice will void legal rights. Doctors, nurses, and hospital attendants hardly will understand that the “least restrictive” test represents a higher level of constitutional scrutiny than the “rational relationship between means and ends” test. In addition, the legalistic standards will not acquire a coherent meaning as they are interpreted in real mental hospital cases. The concepts are not medical, and therefore hospitals will not seriously attempt to clarify them. Medical practice, in the judgment of Belchertown v. Saikewicz, 308 Mass. 415, 421 N.E.2d 417 (1977).

252. 653 F.2d at 848-49. This was a system of patient-staff conferences culminating in a medical review by the hospital director.

253. Id. A majority of the court of appeals, however, repudiated the “least intrusive means” test after the Supreme Court’s summary remand, believing that the remand required such action. What the Supreme Court intended is, however, unclear. See 720 F.2d at 274 (Weis, J., concurring).


256. Rogers, 634 F.2d at 661.

257. Id. at 657.

258. See Romeo, 644 F.2d at 183-85 (Aldisert, J., concurring) (difficult for doctors and other hospital staff to second-guess courts in interpretation of constitutional rights).
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unlike common law adjudication, does not hone concepts in the process of applying them. Doctors can make endless individual determinations, applying their professional preferences to each one, and still not shed light on the meaning of “least restrictive alternative.” Moreover, if a doctor did try to do so, there would be no mechanism equivalent to the reports of legal decisions to institutionalize the attempt and give it weight, influence, or permanence. If the concepts acquired any meaning at all, they would acquire medical meanings unrelated to their legal connotations and traditions. In any case, when medical judgment calls for drugs, doctors are unlikely to believe that any less restrictive alternative to the drugs exists, or that a competent person would reject the doctor’s orders and refuse drugs. Thus, the medical procedures of Rogers and Rennie seem to render the cases’ legal standards incomprehensible or futile.

B. TWO INTERPRETATIONS

The Rennie and Rogers opinions are susceptible to two interpretations. The crucial consideration is the courts’ attitude toward damage actions to redress, on a case-by-case basis, the deprivation of an individual mental patient’s substantive constitutional rights in matters of drugging. Under one interpretation, Rogers and Rennie adopt legalistic substantive standards to make those standards available in individual damage actions. Under the other interpretation, the legalistic tests are only judicial exhortations to state psychiatrists, which will never be applied or enforced as written. Both of these possibilities require some explanation.

1. The Legalistic Standards Apply to Individual Damage Actions

Although individual damage cases nominally raise many of the same substantive issues as class-action lawsuits, their potential impact—in the context of state drugging, at least—is very different. Individual substantive claims do not directly involve the court in hospital-wide operations, as class actions threaten to do. Likewise, the damage remedy, unlike the injunction, does not entail judicial oversight of mental hospitals. Moreover, substantive legal claims do not have the same potential for across-the-board impact as do procedural claims. A procedural due process ruling, even in a nonclass-action suit, promises change in the hospital’s approach to every patient’s case. Assuming that the defendants regard the court’s legal conclusions as binding, the procedures mandated for one must be applied to all. By contrast, a court’s decision that a particular forced drugging episode violated a substantive, legal standard—the least restrictive alternative doctrine, for example—may have precedential value, but it does not necessarily dictate changes in the hospital’s approach toward every patient. One can quibble about the decision’s meaning since the dispositive elements in the case will often be unclear, and very little, in fact, may have been decided.259

259. Of course, a legal test might be definite and precise enough to provoke change across the board. For example, if courts ruled that any permanent drug side effect constituted an actionable constitutional wrong under the least restrictive alternative doctrine, the effect on state psychiatry would be drastic, immediate, and widespread. It is doubtful, however, that courts soon will devise such a definitive, far-reaching interpretation of the “least restrictive alternative” test.
Divorced from issues of procedure in cases involving a single patient asking for compensation rather than an injunction, and thereby subjecting himself to trial by jury, these individual damage lawsuits arguably tilt the scales toward a political characterization of state drugging. The arguments against political characterization—that it would cast courts in the role of medical usurpers, dissipate the courts’ social capital, and lead to intrusive or futile remedies—apply with much greater force to class-action lawsuits and, because of their inherent, across-the-board quality, to procedural claims. Thus, a judge might decide on a professional characterization for class-action forced drugging cases and, without any moral or logical inconsistency, on a political characterization for individual, substantive damages actions. If legalistic standards are to govern individual damage actions, however, they must be constitutionally based and must at least be acknowledged in every litigation context, including class-action suits. Based on this view, the medical procedures of Rennie and Rogers never were designed to advance the legal substantive standards. Rather, these courts decided against enforcing patients’ substantive rights via a class action and instead created legal rights to be asserted in individual suits for damages.

Although such a judicial stance is not self-defeating or incoherent, it does raise its own problems. Legalistic substantive standards can have a dramatic, sudden impact on state drugging even if individual damage actions are their only means of enforcement. The legal standard’s potential reach is uncertain: a great deal of the state’s professional enterprise could fall before it, perhaps in unanticipated ways. The “least restrictive alternative” doctrine, to the extent it has any definite content, may turn out to proscribe most state hospital drugging practices, for instance. Should that happen, either state psychiatric institutions will undergo sudden, radical change because of legal rules—a circumstance this view is supposed to avoid—or the law will have to beat an unseemly retreat and reformulate itself to accommodate existing psychiatric practices. Failing either of those alternatives, the Constitution will be markedly out of harmony with state psychiatric institutions since much of what the relevant state officials do would be unconstitutional according to the prevailing legal interpretation. This discrepancy between law and practice exacts a high price—if not in monetary damages assessed, then in lost judicial credibility. Furthermore, doctors might regard the announced “least restrictive alternative” doctrine (or other legalistic standards) as sharply discordant with their drugging practices, and react accordingly, even if judges in fact take a more modest view. The result of that misunderstanding would be minimum constitutional protection and maximum disruption of state psychiatry.

The ultimate impact of this judicial stance is hard to gauge. It depends on the vagaries of litigation. A series of successful, individual lawsuits could provoke a strong reaction among state psychiatrists and dramatic changes—particularly if damages were assessed because of some common occurrence, such as doctors causing tardive dyskinesia without acknowledging or attempting to ameliorate it. On the other hand, if few mental patients litigate individual damage actions (because jurors prove unsympathetic, unbelieving, or ungener-

260. See supra notes 200 to 216 and accompanying text (discussing traditional allocation of authority in drugging matters).
ous) and if state doctors do not react strongly to the mere promulgation of a legal standard, then the impact will be slight or nil. As already noted, the first possibility leads to the kind of upheaval this view is presumably designed to avoid. The second possibility transforms the denial of class-action relief into a death blow for patients’ drugging rights, since no effective avenue of judicial relief would remain.

2. The Legalistic Standards Are Only Judicial Exhortations to State Psychiatry

Whatever difficulties attend the first interpretation of Rennie and Rogers, the courts’ opinions themselves suggest that the interpretation itself can be wrong and that the judges had something else in mind. Both decisions imply that their legal standard is only hortatory—nothing more than a judicial admonition to state psychiatrists—and that the patients’ substantive constitutional entitlement is medical, not legal, in nature after all.

Thus, the Rennie court described the initial decision to forcibly administer drugs as “medical” and stated that “promulgation of the [least restrictive alternative] standard merely serves to advise the psychiatric community that a conscious weighing of the constitutional liberty interest in any determination of proper treatment alternatives is necessary.” Rogers is similar. The array of factors bearing on a decision for forced drugging, according to the First Circuit, “almost defies . . . reviewability.” Such an observation is surely inapposite to the application of stringent legal standards in individual damage actions. Moreover, Rogers instructed the district court to “leave [the] difficult, necessarily ad hoc balancing [of interests] to state physicians [whose conclusions ‘defy reviewability’] and limit its own role to designing procedures for ensuring that the [dangerous] patients’ interests in refusing antipsychotics are taken into consideration [by doctors] and that antipsychotics are not forcibly administered absent a finding by a qualified physician that those interests are outweighed in a particular situation and less restrictive alternatives are unavailable.” Procedures should be designed only to see that “treating physicians are in fact attempting to make treatment decisions as the patients themselves would were they competent.”

261. Indeed, this approach may produce more disharmony between judges and state psychiatry than would coupling legal procedures with legal standards. Arguably, legal-type procedures stand a better chance of producing decisions that are not actionable when judged by legal criteria. By contrast, medical procedures—not designed with legal criteria in mind—will produce decisions comportable to those criteria only by happenstance. Thus, the likelihood of actionable outcomes may be increased by day-to-day medical procedures.

262. 653 F.2d at 848.

263. Id. at 847 (emphasis added). Rennie is not consistent on this point, however. The majority opinion had stated earlier that the least restrictive alternative standard “directs attention to and requires avoidance of . . . [intrusions] which are unnecessary or whose cost benefit ratios, weighed from the patients’ standpoint, are unacceptable.” Id (emphasis added). The court also stated, “What is reviewable is whether the choice of a course of treatment strikes a proper balance between efficiency and intrusiveness.” Id. Judge Weis, who had authored the court of appeals’ first Rennie opinion, stated in his later Rennie concurrence, “[T]he least intrusive means standard . . . simply requires a carefully considered choice.” 720 F.2d at 277.

264. Rogers, 634 F.2d at 656.

265. Id. at 657 (emphasis added).

266. 634 F.2d at 661 (emphasis added).
With language such as that, Rogers and Rennie turn the “least restrictive alternative” and “substituted judgment” doctrines into legal chimeras. State doctors are only being admonished to apply the doctrines in day-to-day decision-making. The physicians’ consideration, rather than whether their decisions comport with the legal standards, is decisive. Procedures should ensure only that doctors are “taking the relevant interests into consideration” or “attempting to make” the proper decision; they should not ensure that the doctors’ decisions comport with independently ascertainable legal standards. Whatever any doctor says is the least restrictive alternative, for example, is the least restrictive alternative. Indeed, it is difficult to imagine drug decisions being impeached merely because the physician had never heard of that doctrine or had refused to give it lip service. In fact, under Rogers and Rennie, patients seem to enjoy the right—not to the “least restrictive alternative” or “substituted judgment”—but to a doctor’s deliberate medical consideration.

C. AN ACT OF JUDICIAL FAITH AND ITS EXPLANATION

1. Faith in the Harmony between Law and Psychiatry

To the extent that Rogers and Rennie transform legal rights into medical ones, an act of misplaced judicial faith about the relationship between legal and psychiatric reasoning is responsible. According to Rennie, medical procedures promise to “adequately focus . . . the administrative proceedings [the doctors’ attention] on the facts that shape the constitutional standard [the least restrictive alternative] and thereby protect the patients’ interests at stake.” Rogers adopts a similar perspective; as already noted, the First Circuit sought procedural assurances that “patients’ [constitutional] interests in refusing antipsychotics are taken into consideration [by state doctors].” In both cases, the idea is that judges’ and state psychiatrists’ reflections about the same problem will necessarily arrive at compatible conclusions. Based on this view, the judges’ conclusions come in the form of general constitutional principles, like

267. This is an application of the model that philosophers call “pure procedural justice.” J. RAWLS, supra note 23, at 85-86.

268. This approach translates without difficulty into appropriate jury instructions for individual damage actions—that is, instructions that would acknowledge the least restrictive alternative doctrine, for example, while in fact measuring state drugging by medical standards.

One possibility is to charge the jury in Rennie’s and Rogers’ language. The instructions would cite the least restrictive alternative doctrine and go on to advise jurors that the defendants were liable only if they failed to “consciously weigh” less restrictive alternatives. Since a court is unlikely to impose liability merely because a doctor failed to use the words “least restrictive alternative,” jurors also would be instructed that defendants’ use of the words was unnecessary. The result is that “conscious weighing,” and nothing more, would be required. Compare Romeo, 644 F.2d at 172-73 (if defendants considered other alternatives and ascertained that program adopted was least intrusive available, jury must find defendants not liable).

Another possibility is to follow the Supreme Court’s example in Romeo of announcing a legal standard and then hedging it with a “presumption” in favor of the doctors. The Romeo Court recognized a mental patient’s right to “reasonable” conditions of institutional safety—“reasonableness” being a legal test. It then proceeded to vitiate the “reasonableness” standard by ruling that “decisions made by the appropriate professional are entitled to a presumption of correctness . . . [which] is necessary to enable institutions of this type—often, unfortunately, over-crowded and understaffed—to continue to function.” Romeo, 457 U.S. at 324. This transforms the reasonableness test into, in effect, a medical standard.

269. Rennie, 653 F.2d at 851.

270. Rogers, 634 F.2d at 657.
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the least restrictive alternative doctrine, while the doctors’ conclusions will be drug prescriptions. The courts’ conclusions are those that doctors would have formulated as guides to medical decision-making, if doctors thought in legal terms, and the drug prescriptions will be those judges would have arrived at, if they possessed the necessary psychiatric expertise.

This places an inherent and inevitable harmony between constitutional doctrine and state-psychiatric decision-making. There is no support for such a view, however. In fact, it runs counter to the basic premises of state-professional analysis and leads to self-contradictions.

Even after carefully deliberating, state psychiatrists often reach drug decisions no court could or would endorse on the merits. Moreover, to assume the existence of this harmony is to deny that politics and professionalism constitute distinctive social realms subject to different charters: there is no occasion to worry about the distinctive logic of professionalism if the Constitution and its judges invariably follow that logic too. If the Constitution and psychiatry are really pre-ordained to follow the same track, far-reaching judicial decisions will be in perfect harmony with state psychiatric practice. That is, courts could substantively review drug decisions under the least restrictive alternative standard and enforce broad class-action injunctions in drugging matters without disrupting the hospitals. In reality, as these courts are well aware, that is not the case. Thus, when Rogers and Rennie posit a sublime consistency between psychiatry and legal constructs, they contradict their own rationales and views of limited intervention.

2. An Explanation

An interesting question is why these courts bothered to create the chimera of a legalistic standard (and legal-medical concordance) when they could have announced, simply and forthrightly, the “deliberate medical consideration” test. The explanation may lie in constitutional symbolism and the great difficulty and delicacy of state drugging cases.

An overtly professional characterization of state drugging is unattractive to judges, who cannot bring themselves to ignore serious drug-caused harms or state psychiatry’s predrug-era excesses. Yet a political characterization’s consequences may appear too far-reaching. The solution, it seems, is the attempt to have it both ways. Rogers and Rennie announce a legalistic standard in

271. See, e.g., Rennie. The Third Circuit’s apparent conviction that medical procedures inevitably produce acceptable substantive drug decisions led that court to ignore inconvenient facts in the trial record. The Third Circuit majority was “satisfied that the state’s procedures, if carefully followed, pose only a minor risk of erroneous deprivation.” 653 F.2d at 830. Yet the trial record was a litany of cases in which patients were examined by their treating doctors, treatment teams, and medical directors—all during the pendency of litigation—and the result was inadequate medical fact-finding, lying by doctors, punishment of the patients who complained about drugs, and the rigid insistence on drugging most patients that is now characteristic of state psychiatry. See Rennie, 476 F. Supp. at 1300-03. Of course, one might argue that “careful” adherence to medical procedures, as the Third Circuit envisioned it, would avoid such results. However, the New Jersey doctors in fact were not careless in adhering to the rules in these situations, although it is true that the rules were ignored in many other instances. See supra note 213 (discussing resistance to nonjudicial effort to regulate drugs). The court’s belief in the as-yet unproven wonders to be worked by careful adherence to medical procedure is another example of the misplaced judicial faith that underlies the rhetoric of Rogers and Rennie.
deference to drugging's seriousness and enforce a medical test in deference to the practical obstacles confronting any such legal test.

The cases' symbolism, however, is not without significance. Although the Rogers-Rennie legalistic standards are only exhortations to psychiatrists, the exhortations might conceivably do some good. It is one thing when doctors know, because of their training and obvious moral considerations, that deliberate medical consideration is in order. It is another thing when courts remind doctors of it.272

Moreover, Rogers and Rennie refuse to acknowledge state psychiatry as an enclave where government can cause serious biological harms unhampered by traditional constitutional standards. Those standards, under the decisions of the First and Third Circuits, remain nominally in force, however, and express the idea that courts will not go beyond some as yet undefined point in tolerating drugging harms. The cases leave a door to the future open.273

Nonetheless, given the importance placed upon drugging in state psychiatry and the courts' actual decisions, significant changes do not seem likely.274 In addition, the courts' stance adds another problem—a lack of constitutional candor—to the drugging cases. Courts appear to be enforcing basic political rights (though the state hospitals probably know better) when, in fact, they are ignoring them.

D. FROM EXHORTATION TO RITUAL: THE DISTRICT COURT RENNIE DECREE

The district court's Rennie decree,275 although overturned on appeal,276 was

272. "Any reluctance that some hospital staff members might have in meeting the standards [of the state's Division of Mental Health and Hospitals] is unlikely to continue when it becomes apparent that the court is prepared to enforce them." Rennie, 653 F.2d at 851. As a practical matter, however, staff are likely to have learned the opposite lesson from the litigation: taking the courts lightly had no disadvantages for the hospitals and doctors in Rennie.

273. Both Rogers and Rennie hold out the prospect of a more political characterization of drugging in the event that medical procedures do not work. Thus:

Accepting the premise that application of the Constitution to the setting of a state mental health institution requires the most sensitive combination of deference to professional judgment and respect for competent individual judgment as to personal autonomy, we have demonstrated our conviction that such a balance is most likely to be achieved through a variety of procedural devices designed for their suitability to this kind of institutional life rather than for their similarity to judicial models. The record of exploration and evaluation of such safeguards has yet to be made.

Rogers, 634 F.2d at 664.

The Third Circuit in Rennie went still further, cautioning that "if, after a reasonable time, it develops that the state procedures are not working, then the [district] court may explore other methods to guarantee the patient's constitutional rights." 653 F.2d at 851.

Both courts refused to accept their own analyses as conclusive, leaving open the possibility that continued abuses would lead to a political characterization of state drugging. One might even speculate that the courts are unwilling to take the drastic step of declaring a political characterization unless the events that justify it take place, as it were, before their very eyes. At least in Rennie (as of the end of 1983) there had been no discovery or other formal proceeding directed at assessing the impact of the state's procedures; indeed, the Rennie plaintiffs had not even asked the district court to reinstate the court's requirement of written consent as a prerequisite to any drugging of state mental patients, even though the Third Circuit once had invited such a request. 653 F.2d at 852 n.17. It seems even more unlikely that the plaintiffs would retry the entire case—as the Third Circuit, in effect, had required to obtain any additional relief beyond the written consent forms.


an original approach to the drugging dilemma—an approach in many ways more interesting than that of the court of appeals. Because of its inherent interest, and because it has become a model for federal court consent decrees, the solution of District Judge Brotman deserves notice here. It, too, reflects a judicial conscience torn between the professional and political characterizations of state drugging.

The political element appears, on first impression, to be dominant. Substantively, Judge Brotman held that the constitutionality of forcible drugging depended on “four factors”: the patient’s dangerousness, the patient’s competence, the risk of permanent side effects, and the existence of less restrictive alternatives. “Dangerousness,” “competence,” and “less restrictive alternative” are obviously legal constructs, even though considerations of mental illness play an important part in their application. The fourth factor, “the risk of permanent side effects,” entails a discreet inquiry into physiological matters of a kind quite familiar to courts. In these respects, the “four-factor” test seems to bespeak a political characterization.

Nonetheless, the test has nonlegal overtones. “Dangerousness,” “competence,” and the “least restrictive alternative” are usually ultimate legal concepts since certain consequences follow if a person is “dangerous” or “competent” or if a measure is not the “least restrictive alternative.” Here, however, none of the factors is meant to be decisive. The least dangerous (or most competent) patient might be drugged when other factors point to that conclusion, just as the most dangerous (or least competent) patient could escape drugging, depending on the other factors. Similarly, the risk of permanent side effects and the availability of less restrictive alternatives are questions of degree. Although couched in legal terms, Judge Brotman’s test can accommodate in this way a discretion broad enough to comport with medical decision-making, indeed with almost any decision. It recalls the First and Third Circuits’ visions of doctors “weighing” the facts about drugging and reaching constitutional conclusions automatically. On the other hand, these factors are starting points of analysis and, in the course of a succession of cases, could crystallize into clear rules. The possibility of refining drugging tests does exist in Judge Brotman’s scheme, but it did not exist when courts attributed conclusive force to the deliberate decisions of doctors.

Given such open-ended standards, the crucial question is the forum: who will apply the four factors? Judge Brotman’s first opinion in the Rennie case envisioned an administrative forum with the patient represented by counsel, evidence taken via witnesses, and so on. This process reflected a political characterization of the problem, and it would have legalized drug decision-making. After further consideration and testimony, however, Judge Brotman recanted this procedural system and replaced it with a hybrid of medical and

276. 653 F.2d 836 (3d Cir. 1981), on remand, 720 F.2d 266 (3d Cir. 1983).
legal elements.\textsuperscript{280}

Every aspect of the resulting \textit{Rennie} decree constituted a blending of the medical and the legal into an apparently new judicial creation. The decree's principal features were the "independent physicians"\textsuperscript{281}—independent in the sense that the state department of mental health, rather than individual state hospitals, hired them.\textsuperscript{282} These "independents" evaluated drug refusers and made the final decision about forced drugging.\textsuperscript{283} Judge Brotman's insistence on their "independence"—even independence in name only—suggests a legal, not a medical, structure, as does the added requirement that they write "opinions" addressing the legal standards (including the first and eighth amendments) for forced drugging.\textsuperscript{284}

The decree's other important principals—"patient advocates"\textsuperscript{285}—represented an even more obvious cross of medical and legal components. The "advocates" could be nurses, social workers, or attorneys.\textsuperscript{286} Their role was to assist patients in presenting drug objections to doctors.\textsuperscript{287} Like the "independent" reviewing physicians, "advocates" would be attached to the central, state-wide mental health office and not to the individual treating institution.\textsuperscript{288}

Thus, the "advocates" would speak to doctors on behalf of patients and were independent—like lawyers. Since they would report to the hospital system, however, and could possess nursing or social service backgrounds, they were like medical personnel. True to their hybrid, legal-medical nature, the advocates were to be supervised by both a lawyer and a doctor in the central office of the mental health department, which itself is a blend of a political institution and a hospital.\textsuperscript{289} Moreover, the "advocates" had another power. Judge Brotman allowed hospital doctors to declare a patient "functionally incompetent" and, based on that declaration, to force drugs unless the patient advocate, in his or her own right, requested review by the "independent" physician.\textsuperscript{290} In this context, an "advocate" is a combination of lawyer confessing judgment against a client, medical reviewer, and lay juror passing on a question of civil incompetency.

Although it was in force for almost two years, Judge Brotman's decree was never subjected to close scrutiny in the litigation and its implementation deserves more attention than can be given it here. Some things, however, seem obvious. The attempt to avoid a frank choice between a political and professional charter is clear. Here, the "political" or legal component is not a one-time exhortation, as it was in the courts of appeals' subsequent decisions. The presence and work of the patient advocates and independent psychiatrists, and the day-to-day paperwork routines entailed by the decree, constitute daily ritu-

\begin{thebibliography}{99}
\bibitem{280} 476 F. Supp. 1294.
\bibitem{281} Id. at 1306, 1313.
\bibitem{282} Id. at 1310, 1313.
\bibitem{283} Id.
\bibitem{284} Id. at 1314-15.
\bibitem{285} Id. at 1313.
\bibitem{286} Id.
\bibitem{287} Id. at 1314.
\bibitem{288} Id. at 1313.
\bibitem{289} Id.
\bibitem{290} Id. at 1314.
\end{thebibliography}
als that remind hospitals of the court’s presence and interest in mental patients’ fates. Repeated rituals are a more powerful token of the court’s interest than a one-time judicial exhortation.

There is little more than this ritual to the district court decree, which adopts, in the end, a medical characterization of the problem. Stripped of its legal-sounding terms, the district court injunction required only: that mental hospitals, in special cases, use physicians hired by the state department of mental health, which is the ultimate employer of all persons working at the state hospitals; that, if a hospital wishes to avoid using those physicians, it must deem the patient incompetent and obtain the concurrence of a mental health department nurse or social worker; and finally, that this nurse or social worker should also assist patients in speaking about drugs with their doctors.

Perhaps the admonitory force of all this is more powerful than any one-time exhortation, but both are paltry measures when compared to the drugging regime and the thrall in which it holds state psychiatry. A few more doctors hired by the state and some additional nurses with the title “advocate” simply are not going to change the imperatives of drug regime in state psychiatry or to accomplish much more than the hospitals’ own internal procedures, which also failed. Although the decree’s supposed effects have been praised, and despite its obvious elegance, it seems unlikely that a state mental hospital system subject to the decree will behave very differently from one that is free from it. Indeed, in the last months of the decree’s validity, few patients were acknowledged to be drug refusers entitled to see the independent physician. It appears that drugging went on much as before. The drug regime will not yield to mere judicial admonitions or ritual reminders of patients’ human and legal dignity.

IV. JUDICIAL CANDOR AND BROADENING THE BASE OF DECISION-MAKING

While approaching other problems of state-professionalism, the Supreme Court has often paid close attention to the existence of social and political processes behind the extraordinary means at issue, such as sterilization, corporal punishment, and involuntary psychiatric hospitalization of children. The Court has looked for assurances of a decision-making process that was genuinely democratic, political, social, and moral.

An informed, truly democratic decision erases the taint of state overreaching, since the decision can be said to be that of the people themselves, and not just that of the state. Moreover, given the clash of social principle in these cases, the broadest possible base of social decision-making is desirable. If forced administration of drugs to mental patients is to receive cultural sanction as a state device, for example, courts should require more of a warrant than the

291. See supra note 213 (discussing state hospital and physician resistance to nonjudicial efforts to regulate drugs).
292. Motion for Leave to File Amicus Curiae Brief, supra note 217.
293. Id.
edict of a state bureaucrat, the consensus of an American Psychiatric Association Convention, or the first impression of an as-yet-uninformed body politic.

The clearest example of the court’s approach is *Ingraham v. Wright*, which challenged corporal punishment in public schools. In declining to require a pre-punishment due process hearing, the Supreme Court observed that the corporal punishment issue had been debated exhaustively in educational and political circles. It noted that many legislatures had spoken directly to the issue, usually authorizing corporal punishment. It portrayed schools as open institutions, traditionally subject to close community control via the local school board and direct parental scrutiny. *Ingraham* would have been written very differently—and the decision itself may well have been different—if corporal punishment had constituted a little-noticed social practice, accepted without debate by an uninformed, disinterested, and largely unaffected citizenry and administered by bureaucrats without explicit legislative authorization.

Other state-professionalism opinions sound similar themes. *Jacobson v. Massachusetts*, upholding compulsory vaccination, found that the legislature had spoken about vaccination with the voice of the people on a matter of pressing individual concern. Moreover—although the *Jacobson* court did not say so—everyone’s susceptibility to smallpox constituted a guarantee of genuine popular interest, comparable to the *Ingraham* parents’ profound interest in their children’s schools.

In these respects, sterilization of habitual criminal offenders obviously is a different matter, and in *Skinner v. Oklahoma*, the Supreme Court struck down a sterilization statute on equal protection grounds. *Skinner* introduced the concept of strict scrutiny of legislative enactments touching fundamental rights, such as the right to procreate. It is worth noting, however, that compulsory sterilization of repeat criminal offenders does not potentially affect the entire population, as did the disease in *Jacobson* or the measures regarding schoolchildren in *Ingraham*. For this reason, the issue held no personal immediacy for most people, and there was no guarantee of strong public interest and real democratic deliberation. Furthermore, the statute brought into doubt fair decision-making when it exempted white collar-type crimes—presumably the crimes some legislators themselves are more prone to commit—from the sterilization edict.

State psychiatry will never be fully subject to these strong social and democratic influences, and as a result, the predicament of courts in state-psychiatric controversies—and particularly in state drugging cases—is heightened. Unlike smallpox, mental illness is not a democratic disease: people do not expect to contract it, its victims are regarded as a distinct subclass of the population, and there is generally little interest in the fate of the mentally ill. The judiciary

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298. 197 U.S. 11 (1905).
299. *Id.* at 34-35.
300. 316 U.S. 535 (1942).
301. *Id.* at 537. The statute exempted “offenses arising out of the violation of the prohibiting laws, revenue acts, embezzlement, or political offenses.” *Id.*
302. See Note, Mental Illness: A Suspect Classification, 83 YALE L.J. 1237, 1258-68 (1974) (laws based on mental health classifications should be strictly scrutinized due to minority status of classified
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cannot spark the conscience of the nation on these topics, because the mentally ill do not sufficiently engage our attention or affect our interests. Our collective conscience is either silent, unthoughtful, or preoccupied. For the same reason, courts cannot look askance at state psychiatric measures that lack broad social endorsement, and we have no right to expect that endorsement in the first place. Moreover, state drugging cases, where technical issues further cloud the picture, are the most difficult of all state-psychiatric problems from this point of view. Well-established social conventions about physical custody can guide courts even in a mental hospital context, but drugs are new and unfamiliar, with few cultural conventions about them worthy of judicial consideration.

Notwithstanding the above, the judiciary could broaden the base of social decision-making about drugs as much as possible by involving the legislature and by engendering meaningful public debate. This approach would accomplish some diffusion of responsibility, and the more nonjudicial, nonpsychiatric deliberation there is, the better.

With regard to legislatures, courts might demand explicit statutory authorization for forcible drugging, and, in its absence, construe state statutes to bar the practice. Of course, legislatures could enact perfunctory authorizations without thoroughly examining the issue, and, where statutes expressly authorize forced drugging already, no court-ordered reconsideration would result. Somewhat more ambitiously, courts might demand that statutes speak specifically to questions such as the amount and kind of harm which precludes further drugging, the procedures open to complaining patients, the available alternatives other than drugs, and so on. Demand for such detail in a statute would be an unusual judicial step, but no more extraordinary than the exhortations to psychiatrists that now appear in right-to-refuse drug opinions. It could also provoke a broad public exploration of the issue.

Moreover, courts themselves, through their decisions and their factual findings, can call attention to state drugging and spur public debate. Already, litigation records are the most reliable and comprehensive sources of information about actual drug practices at state hospitals. If class-action remedies were reserved for demonstrated cases of hospital-wide abuse—the courts refusing to characterize drugging politically except upon a full factual showing of abusive local conditions—plaintiffs would have to focus their litigation on actual drugging as opposed to theoretical drug harms and benefits, and the truth would be known. Furthermore, conditioning political characterizations on local facts mitigates the taint of judicial usurpation. Certain named institutions, not psychiatry as a whole, would be the perceived targets of judicial action, and debate about the propriety of the court's action would focus upon facts, not upon stereotypes.

Airing the facts about state drugging serves a more basic judicial obliga-

group); cf. Schweiker v. Wilson, 450 U.S. 221, 230-31 (1981) (Court leaves open question whether classifications based on mental illness are suspect due to group's political powerlessness); Doe v. Colautti, 592 F.2d 704, 710-12 (3d Cir. 1979) (court notes that argument that mental illness is suspect classification requiring strict scrutiny not likely to succeed).

303. See Rennie, 653 F.2d at 865 (Gibbons, J., dissenting) (noting trial court record of ongoing substantive violation by state officials of patients' liberty interests).
tion—in Judge David Bazelon's words, the duty not to "play handmaiden" to "social hypocrisy" by glossing over wrongs when the court is powerless to right them. 304 "Courts cannot force legislatures to provide adequate resources for treatment," 305 Bazelon said appropos of the newly recognized right to treatment, and when legislatures do not do so, the claim that "treatment" justifies civil commitment is "chicanery" and "intolerable." 306 If courts can do nothing else and are not about to order an end to civil commitment altogether, they still should avoid this "hypocrisy," Bazelon argued. 307

Whether courts defer to the drug regime or try to right it, judicial candor about state drugging is even more of an imperative. With respect to the "right to treatment," few people ever really believed that state hospitals were tolerably good treatment institutions. By speaking of "hypocrisy," Judge Bazelon acknowledged this fact. In contrast, the history of drug treatment is a litany of truths not told, decisions not taken, and judgments never candidly made. What is involved is the judicial role as educator of the current generation, witness to wrongs that will not be corrected and, if one is optimistic, prophet of future right.

V. CONCLUSION

Opinions in the style of the Rennie and Rogers courts obscure the real nature of the drug issue, yield too much to professionalism, and add to the burden—at least the moral burden—of the mentally ill. They depict drugs as a self-evident medical concern, when in fact profound political issues are raised. They portray drug excesses as aberrations when excess is in fact widespread, systematic, and inevitable. In addition, they propound an unfounded faith that deliberate medical consideration will necessarily produce drug decisions consonant with general constitutional values.

Mental patients who must endure drug harms deserve not the symbolism of a spurious harmony between psychiatry and the Constitution but, at a minimum, acknowledgement of their suffering. Almost surely, these victims observe more, though it is doubtful that courts will—or can—give it to them.

305. Id.
306. Id.
307. Id.