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MENTAL HOSPITAL DRUGGING—ATOMISTIC AND STRUCTURAL REMEDIES

SHELDON GELMAN*

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Until 1982, when the Supreme Court remanded the case, I was the patient-plaintiff's trial and appellate counsel in a right-to-refuse-drugs case, *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), 653 F.2d 836 (3d Cir. 1981) (en banc). (The attorney of record in *Rennie*, and my employer, was the New Jersey Public Advocate.) Grants from the Cleveland-Marshall Enrichment Fund, which I gratefully acknowledge, supported my subsequent research on the problems of state psychiatry.

INTRODUCTION: THE IMPORTANCE OF A REMEDY

Thirty years have passed since the discovery of Thorazine, a neuroleptic drug,¹ and the drugging of American state mental patients has become commonplace. All our state hospitals rely heavily on neuroleptics,² and the general public has long since been educated about the decisive role of drugs in public policy toward the seriously mentally-ill. Yet it was not until 1975,³ with the advent of "right to-refuse-treatment" lawsuits, that courts seriously confronted mental hospital drug problems, and the legal issues raised then remain open. In 1982 the Supreme Court remanded two right-to-refuse-drug cases without reaching the merits of either.⁴

These lawsuits have proved unusually contentious.⁵ On the one hand, the fiscal, administrative, and human consequences of limiting drug use by court fiat would be far-reaching and, many argue, disastrous. These drugs are the mainstay of present-day public mental-health services.⁶ They are credited with preserving order in state hospitals, reducing the population of hospitals, facilitating other psychiatric treatments, and making "community care" for the mentally ill a reality.⁷ At the same

¹ "Neuroleptic" refers to a family of drugs that are also known as "major tranquilizers" or "antipsychotics." Because of the neuroleptics' unique effects and side effects, they deserve—and have received—attention apart from that paid to other drugs, such as lithium and antidepressants, that are used in mental hospitals. See *Rogers v. Okin*, 634 F.2d 650, 653 n.1 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. ___, 102 S. Ct. 2442 (1982). Thorazine was the first of these drugs to be marketed in the United States, in 1953. See generally J. SWAZEY, *CHLORPROMAZINE IN PSYCHIATRY: A STUDY OF THERAPEUTIC INNOVATION* (1974) (an enthusiastic account of Thorazine's discovery and use in the United States during the mid-1950's).

² See generally Crane, *Clinical Psychopharmacology in Its Twentieth Year*, 181 SCIENCE 124 (1973) (discussion of the role of neuroleptics in mental health care, their side effects and professional attitudes toward them).

³ That year marked the filing of—and grant of preliminary injunctive relief in—*Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, and *remanded*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. ___, 102 S. Ct. 2442 (1982).

⁴ *Mills v. Rogers*, 457 U.S. ___, 102 S. Ct. 2442 (1982); *Rennie v. Klein*, ___ U.S. ___, 102 S. Ct. 3506 (1982).

⁵ Compare Appelbaum & Gutheil, "Rotting With Their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal By Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & LAW 306 (1979) (supporting the use and effectiveness of drugs and questioning what patients really win in right-to-refuse lawsuits) with Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, in *REFUSING TREATMENT IN MENTAL INSTITUTIONS—VALUES IN CONFLICT* 56 (1982) (the *Rogers* plaintiff's lawyer addressing the patients' position in such lawsuits).

⁶ See generally J. SWAZEY, *supra* note 1; Crane, *supra* note 2; Shavill, *Patients' Rights v. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado*, 58 DEN. L.J. 567 (1981) (wide-spread use of drugs in the treatment of mental patients).

⁷ See sources cited *supra* note 6; Bassuk & Gerson, *Deinstitutionalization and Mental Health Services*, 231 SCI. AM. 46 (1978).

time, however, the drugs inflict physical and mental harms on a broad scale—a scale perhaps unprecedented in modern law. It is not uncommon for the drugs to cause anxiety,⁸ subjective torment,⁹ zombiism,¹⁰ health-threatening physical complications,¹¹ and a permanent partial loss of motor control¹² in those who receive them.

This is no simple matter of the integrity of a bureaucratic system versus the physical and mental integrity of individuals, however. For many of the mentally ill, drugs reduce the intensity of psychotic symptoms,¹³ relieve some of the distress of naturally-occurring mental illness,¹⁴ and prolong the intervals between acute psychotic relapses.¹⁵ Moreover, it is arguable that the mentally ill, as a class, benefit because drugging has rendered state hospital confinement safer and made community treatment settings possible.

For a variety of reasons, questions of legal remedy¹⁶—as opposed to the doctrinal issue of the existence vel non of a constitutional right to refuse these drugs—deserve close attention. First, given the seriousness and high incidence of drug side effects, it is almost inconceivable that the Constitution does not speak to the issue and limit drugging in some way; thus, patients' entitlement to some measure of constitutional protection seems a foregone conclusion. As questions of "right" fade in importance, issues of remedy necessarily come to the foreground. Indeed, more than one court has downplayed the question of a textual, constitutional source for the right to refuse drugs,¹⁷ in the views of these courts, the existence of

⁸ Van Putten & Matalipassi, *Fluphenazine Enanthate Induced Decompensations*, 16 PSYCHOSOMATICS 37, 38-39 (1975).

⁹ Van Putten & May, *Subjective Response As a Predictor of Outcome in Pharmacotherapy: The Consumer Has a Point*, 35 ARCH. GEN. PSYCHIATRY 477, 478-79 (1978).

¹⁰ Rifkin, Quitkin & Klein, *Akinesia: A Poorly Recognized Drug-Induced Extrapyramidal Behavioral Disorder*, 32 ARCH. GEN. PSYCHIATRY 672, 673 (1975).

¹¹ Rennie v. Klein, 462 F. Supp. 1131, 1138 (D.N.J. 1978), *class injunction issued*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, ___ U.S. ___, 102 S. Ct. 3506 (1982), *on remand*, No. 79-2576 (filed Oct. 13, 1983) (en banc).

¹² See *infra* notes 31-35 and accompanying text.

¹³ Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & LAW 179, 182-83 (1980).

¹⁴ Appelbaum & Gutheil, *supra* note 5, at 307.

¹⁵ Hogarty, Goldberg, Schooler & Ulrich, *Drugs and Sociotherapy in the Aftercare of Schizophrenic Patients*, 31 ARCH. GEN. PSYCHIATRY 603 (1974); May, Tuma, Yale, Potepan & Dixon, *Schizophrenia—A Follow-up Study of Results of Treatment*, 33 ARCH. GEN. PSYCHIATRY 481 (1976).

¹⁶ On the nature of legal remedies in what has been called "institutional" or "public law" litigation, see the authorities cited *infra* notes 27 and 30.

¹⁷ See, e.g., Rennie v. Klein, 653 F.2d 836, 844 (3d Cir. 1981) (en banc), *vacated and remanded*, ___ U.S. ___, 102 S. Ct. 3506 (1982), *on remand*, No. 79-2576 (filed Oct. 13, 1983) (en banc); Rogers v. Okin, 634 F.2d 650, 653 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. ___, 102 S. Ct. 2442 (1982).

some right is clear, and it matters little whether "privacy,"¹⁸ the first amendment,¹⁹ the liberty protected by the fourteenth amendment,²⁰ or some other constitutional provision²¹ is the source of that right.

A second reason for focusing on remedies relates to the pivotal role of the drugs in state psychiatry. Even if a right to refuse drugs exists, courts are not about to decree the state mental hospitals into a state of chaos by casually imposing too far-reaching a remedy. Nor, given the threat of individual torment and physical deformity from drugging, are courts about to announce casually an ineffective remedy. The competing interests are such that judges will not be content to declare the existence of a right and leave the rest of society to accommodate to that new right as best it can; rather, judges will want to fine-tune the remedy in light of its individual, bureaucratic, and society-wide effects.

Moreover, there are special features in the mental hospital setting that make judges unusually sensitive to issues of remedy and social impact. State mental hospitals are relatively closed, discrete systems, and, in such a social context, the results of court intervention may easily be both pronounced and—at least by comparison—readily ascertainable. One might wonder about the social effects of a constitutional ruling on the scope of the first amendment, for instance, but the effects of a judicial decision allowing mental patients to refuse drugs will be only too obvious—or so it seems. The pronounced impact of a judicial decree in this setting is the third reason why courts closely attend to the question of remedy.

Finally, the courts are unusually solicitous of the welfare of the mentally ill in state hospitals.²² Whether the mentally ill deserve to be singled out in this way and whether they in fact benefit from this special consideration are different questions; but the fact is that courts are unlikely to impose a remedy that—in the judge's eyes—worsens the overall lot of the mentally ill. To return to the example given above, courts may accord first amendment protection to forms of expression even if, in their opinion, the speaker will be made somewhat more miserable as a result.²³ However, courts will not so readily apply the Constitution to impair the quality of life of the mentally ill. Thus, assessing the social impact of a remedy in this area is a matter of the first importance.

Despite their importance, the discussion of remedies for state hospital

¹⁸ *E.g.*, *Rennie*, 462 F. Supp. at 1144.

¹⁹ *E.g.*, *id.* at 1143.

²⁰ *E.g.*, *Rennie*, 653 F.2d at 844.

²¹ *E.g.*, Symonds, *Mental Patients' Right to Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment*, 7 HASTINGS CONST. L.Q. 701 (1980); *cf.* *Rennie*, 653 F.2d at 844 (eighth amendment inappropriate as a basis for non-criminal mental patients' constitutional rights).

²² *See, e.g.*, *Rennie*, 653 F.2d at 844; Brotman, *Behind the Bench in Rennie v. Klein*, in *REFUSING TREATMENT IN MENTAL INSTITUTIONS—VALUES IN CONFLICT* 31, 40-41 (1982).

²³ *See*, R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 190-92 (1977).

drugging has been largely ad hoc and uninformed.²⁴ This study attempts to fill that gap. It explores four such remedies, attempting to identify the vision of the drug problem that underlies each one; to evaluate that vision and its plausibility; and to determine what the actual effects of imposing the remedy would be. All of the remedies examined exhibit serious flaws, I believe.

Part I distinguishes between two approaches to remedy—"structural" and "atomistic"—and, as a basis for testing the two, describes a state hospital's handling of the most serious drug side effect. This account also provides a sense of the dimensions of the drugging problems in state hospitals.

Part II explores a family of atomistic remedies. These would address drugging problems by seeking to ensure that state doctors are knowledgeable about drugs and/or reasonably careful in administering them. I reject this approach because it flies in the face of the realities of state drugging—as described in Part I—and promises no relief for state patients.

Part III explores a rather different kind of atomistic remedy, one which conditions drugging on either the patient's competent consent or, assuming the patient is incompetent, on the prosecution of full-fledged incompetency proceedings and the subsequent consent of a guardian. I argue that this remedy promises to be ineffective too, though for somewhat different reasons.

Part IV discusses a structural remedy that looks beyond the narrow confines of the state doctor-patient relationship and uses commitment hearings as a vehicle for ensuring that post-commitment drugging comports with high medical standards. Although an elegant and internally coherent scheme, I argue that it imposes an untenable choice on society in practice and will prove futile or worse in operation.

Part V analyzes another structural remedy, though one with a different vision of the problem and a different solution to it. In *Rennie v. Klein*,²⁵ the district judge developed an elaborate procedural system to address what he perceived to be the organizational root of state hospital drugging excesses.²⁶ This section attempts to show, however, that the theory under-

²⁴ See, e.g., *Rennie*, 653 F.2d at 850; but see *id.* at 865-70 (Gibbons, J., dissenting).

²⁵ *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3d Cir. 1981) (en banc), vacated and remanded, ___ U.S. ___, 102 S. Ct. 3506 (1982), on remand, No. 79-2576 (filed Oct. 13, 1983) (en banc).

²⁶ *Rennie*, 476 F. Supp. at 1311-15. Although the court of appeals overturned the procedures Judge Brotman established, other federal court consent decrees have adopted Brotman's work as a model. E.g., ORDER APPROVING PLAN FOR INDEPENDENT REVIEW OF DISPUTED PSYCHIATRIC/MEDICATION DECISIONS, *Davis v. Hubbard*, No. C73-205 (N.D. Ohio May 18, 1981) (reported at 15 CLEARINGHOUSE REV. 528 (1981)). Moreover, these procedures have received wide praise. See Brooks, *supra* note 13, at 182-83; Note, *Involuntary Commitment and the Right to Refuse Treatment with Anti-Psychotic Drugs*, 16 CREIGHTON L. REV. 719, 741 (1983); Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make It Work*, 38 ARCH. GEN. PSYCHIATRY 358 (1981). "Rennie . . . reflects the efforts of a

lying this solution to the problem is mistaken and that, as a result, the system simply did not work when put into place.

I. STRUCTURAL AND ATOMISTIC APPROACHES: THE CASE OF TARDIVE DYSKINESIA

State hospital drugging can be approached either by focusing on the state doctor-patient relationship or by looking to the forces that arguably shape that relationship. The first approach I call "atomistic" because it views the doctor-patient relationship as the irreducible unit of legal analysis, regarding it as something entirely independent of its social, political, and professional setting. The second approach, generally called "structural," presupposes that the problems in state hospital drugging are attributable to organizational, bureaucratic, or structural conditions that constrain the actions of individual state doctors.²⁷

For each of these views there is a corresponding type of remedy. Atomistic remedies are directed at the doctor-patient relationship and usually seek to ensure that the relationship is actually in place. Structural remedies address the supposed underlying constraints on doctors' drugging decisions.

Atomistic views and remedies have an intuitive appeal in the state mental hospital context. In ostensibly medical settings, it is natural to look to the competence and conscience of a physician—and no further—as such views do. Moreover, an atomistic approach better comports with the position of courts in our society. A judge who reasons from the nature of the doctor-patient relationship remains well within bounds of traditional adjudication, while a judge who speculates about the deeper causes of social phenomena may appear to be over-stepping the judicial role.²⁸ Thus, the atomistic approach deals in concepts which are amenable to constitutional analysis.

Since mental hospital controversies lend themselves so well to atomistic

thoughtful judge attempting to balance rights against needs." *Id.* at 360.

Dr. Stone's view of the decree is of particular interest. He served as President of the American Psychiatric Association (A.P.A.) when the A.P.A. filed an amicus brief urging the Third Circuit to overturn the district court's *Rennie* injunction. Brief of the American Psychiatric Association as Amicus Curiae, *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) [hereinafter cited as Amicus Brief]. Yet in the cited article, Dr. Stone—writing on his own behalf and not for the Association—observed that "if the facts were as . . . [Judge Brotman] portrayed them"—and no serious question about the fact findings was ever raised—"he was certainly correct" in requiring second opinions by qualified psychiatrists, that being at the heart of the decree. Stone, *supra* note 26, at 360.

²⁷ See Chayes, *The Supreme Court 1981 Term—Foreword: Public Law Litigation and the Burger Court*, 96 HARV. L. REV. 4 (1982) (discussion of the Court's involvement in structural reform of various institutions); Fiss, *The Supreme Court 1978 Term—Foreword: The Forms of Justice*, 93 HARV. L. REV. 1 (1979) (institutional reform and the Court).

²⁸ Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353 (1978); Mishkin *Federal Courts as State Reformers*, 35 WASH. & LEE L. REV. 949 (1978).

approaches in these ways, it is ironic that the courts' sensitivity to mental hospital remedies²⁹ dictates close judicial attention to the real causes and limits of overreaching in this area—a circumstance that may impel the court toward a structural approach. Moreover, despite the attractions of atomism, social phenomena do not necessarily arrange themselves so as to afford ease or manageability in judicial analysis, and the facts of mental hospital life may make an atomistic model or viewpoint untenable.

Indeed mental hospital drugging does not conform to atomistic strictures. The salient aspects of state drugging practices simply cannot be explained in terms of lapses from the state doctor-patient relationship; entirely different forces appear to be at work, or so I shall argue. This appears most clearly from a representative state hospital system's posture toward the most serious potential side effect of the drugs—tardive dyskinesia.

A. Tardive Dyskinesia: The Disorder

Although neuroleptics cause numerous distressing side effects,³⁰ one—called tardive dyskinesia—is generally regarded with the most concern. It is common, affecting perhaps twenty percent of drugged patients.³¹ In advanced cases its symptoms render the patient's appearance bizarre³² and—unlike other drug *sequelae*—it is often irreversible, not abating after drugs are discontinued.³³

Tardive dyskinesia's symptoms resemble those of naturally-occurring

²⁹ See *supra* text accompanying notes 17-23.

³⁰ See R. BALDESSARINI, CHEMOTHERAPY IN PSYCHIATRY (1977); American College of Neuropsychopharmacology—Food and Drug Administration Task Force, *Neurological Syndromes Associated With Antipsychotic Drug Use*, 28 ARCH. GEN. PSYCHIATRY 463, 463 (1973) [hereinafter cited as Task Force]; Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 474-79 (1978). The side effects include anxiety and inability to remain still ("akathisia"); lack of will, drive, or energy ("akinesia"); tremor, stiffness, and shuffling gait (pseudo-parkinsonism); physical complications; and the inducement of subjective states that may range from mildly unpleasant to unbearably tormented. Regarding these subjective states, see Alarcon & Carney, *Severe Depressive Mood Changes Following Slow Release Intramuscular Fluphenazine Injection*, 1969 BRIT. MED. J. 564; Opton, *Psychiatric Violence Against Prisoners: When Therapy Is Punishment*, 46 MISS. L.J. 605, 641 (1974); Van Putten & May, *supra* note 9; Van Putten & Mutalipassi, *supra* note 8; cf. Rennie, 653 F.2d at 844 n.9 and sources cited therein (possible link between psychotropic drugs and suicidal depression).

³¹ Gardos & Cole, *Overview: Public Health Issues in Tardive Dyskinesia*, 137 AM. J. PSYCHIATRY 776, 776 (1980); Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 AM. J. PSYCHIATRY 297, 300-01, 307-09 (1981) (citing published studies). See generally AMERICAN PSYCHIATRIC ASSOCIATION, TARDIVE DYSKINESIA: REPORT OF THE TASK FORCE ON LATE NEUROLOGICAL EFFECTS OF ANTIPSYCHOTIC DRUGS (1979) (a general study undertaken at about the same time that the pending right-to-refuse-drugs cases began attracting public attention).

³² Rennie, 462 F. Supp. at 1138.

³³ *Id.*; see also authorities cited *supra* note 31.

brain diseases such as Huntington's chorea or Wilson's disease.³⁴ Characteristically, there are incessant abnormal movements of the face, limbs, and occasionally the trunk. In the area of the mouth, tardive dyskinesia causes the tongue to protrude, the jaw to move from side to side, and the lips to pucker or extend themselves. Comparable movements may affect the fingers, hands, ankles or torso; indeed, it is not clear that any part of the body is immune.³⁵ Cases of tardive dyskinesia vary in severity; some are so mild as to be almost unnoticeable while others are physically disabling.

More than anything else, tardive dyskinesia's irreversibility makes it unique among the drug side effects. Drug-induced distress, pacing, tremors, stiffness, and blank expressions can also reach severe proportions, but these conditions either abate with continued drugging, respond in some measure to so-called antiparkinsonian medications, or disappear when—and if—drugging stops.³⁶ By contrast, tardive dyskinesia's permanence means that the decision to drug can touch the rest of one's life.³⁷

B. Assessing the State Hospitals' Response

The response to tardive dyskinesia affords a window into the processes of state psychiatry and illustrates fairly—albeit dramatically—the problems of drugging in state hospitals. As the most seriously-regarded side effect of the drugs, this disorder is an important test of hospital paternalism. Hospitals unwilling or unable to diagnose it are still less likely to diagnose other side effects accurately—effects arguably less worthy of attention and more easily overlooked. For these reasons, an examination of the response of state physicians to tardive dyskinesia promises to be instructive about atomistic and structural remedies and the limitations of each.

1. Sources of Information

To my knowledge there have been only two even modestly systematic attempts to look beyond research settings and to describe state physicians' actual postures in the face of the symptoms of tardive dyskinesia. One is the work of Dr. George Crane,³⁸ who surveyed a number of state

³⁴ Crane, *Tardive Dyskinesia in Patients Treated With Major Neuroleptics: A Review of the Literature*, 124 AM. J. PSYCHIATRY 40, 45 (Supp. 1968).

³⁵ See authorities cited *supra* note 31.

³⁶ Rennie, 462 F. Supp. at 1138.

³⁷ Although tardive dyskinesia is generally regarded as the drugs' most serious side effect, Rennie, 653 F.2d at 843, I believe that patients often view the subjective *sequelae* of drugging with greater horror. However that may be, tardive dyskinesia is certainly serious enough to warrant close attention and extreme caution.

³⁸ Dr. Crane was the leading force in gaining recognition for tardive dyskinesia among academic psychiatrists in the late 1960's and early 1970's. See Crane, *supra* note 2; Crane,

hospital systems in the 1970's and found that state physicians as a rule ignored both the disorder and its symptoms.³⁹ According to Crane, hospital charts neither diagnosed obvious cases nor even acknowledged the obvious symptoms which may accompany the disorder; this neglect of a serious iatrogenic disorder was "unprecedented" in modern medicine, Crane concluded.⁴⁰

The other source of information about tardive dyskinesia in the state hospital setting is the *Rennie v. Klein* trial record.⁴¹ A class action right-to-refuse-drug case involving all of New Jersey's state hospitals, *Rennie* documented this large state system's response to tardive dyskinesia through the year 1978, when the trial ended. The picture that emerges is the one painted by Crane: a virtually total refusal by state physicians, bureaucrats, and consultants to acknowledge tardive dyskinesia or its symptoms. Moreover, *Rennie* depicted the response of state hospitals when tardive dyskinesia or its symptoms were, despite everything, pointed out; the lengths to which doctors went in order to discredit those who told the truth about the disorder is remarkable and revealing.

2. Objections to Reliance on the *Rennie* Record

Before turning to the *Rennie* record, some possible objections to its use deserve attention. One might attempt to explain the record away, arguing for example that tardive dyskinesia was a little-known condition in the 1970's—one with which ordinary mental hospital doctors, acting in all good faith, might be unfamiliar. However, tardive dyskinesia has been a focal point of psychiatric concern about drugging since, at the latest,

supra note 34; Crane, *Tardive Dyskinesia in Schizophrenic Patients Treated With Psychotropic Drugs*, in 2ND INTERNATIONAL SYMPOSIUM ON ACTION, MECHANISM AND METABOLISM OF PSYCHOTROPIC DRUGS DERIVED FROM PHENOTHIAZINES AND STRUCTURALLY RELATED COMPOUNDS 209 (1967) [hereinafter cited as Crane, *Tardive Dyskinesia*]; see also United States Court of Appeals for the Third Circuit Joint Appendix at 1087a-88a, *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (testimony of Dr. Crane) [hereinafter cited as Joint Appendix].

³⁹ Joint Appendix, *supra* note 38, at 1087a.

⁴⁰ *Id.* at 1093a.

⁴¹ 462 F. Supp. 1131 (D.N.J. 1978), *class injunction issued*, 476 F. Supp. 1294 (D.N.J. 1979). Initiated in 1977 as an individual mental patient's action for injunctive relief in drugging matters, *Rennie* subsequently became a class action involving the drug refusal rights of every New Jersey mental hospital patient. See the text accompanying notes 136-63 for a discussion of the *Rennie* decisions and see the note accompanying the title of this article for an explanation of my involvement in the case. At this point in this article the case is of interest because it develops the fullest portrait available of actual state hospital drugging practices. Compare, e.g., *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979) (another federal class action right-to-refuse-drug decision). In *Rogers* proof focused on fewer 10 patient-litigants who were identified as such to state physicians and who—not surprisingly—suffered no serious drug reactions during the litigation. Neither *Rogers* nor other cases known to me other than *Rennie* purport to give an overall picture of state hospital drug use and the actual evidence of side effects. See also *infra* note 52 and accompanying text (the medical literature about actual state drug practices is almost non-existent).

1972, when drug package inserts were reformulated and major medical journals alerted the psychiatric profession to the dangers of tardive dyskinesia.⁴² Moreover, as will appear, the New Jersey hospitals claimed to know all along about tardive dyskinesia; they simply refused to acknowledge that any of their patients suffered from it.⁴³

Again, one might argue that tardive dyskinesia is *sui generis* among drug side effects and that doctors' disdain for it does not mean that they ignore other harmful *sequelae*. It is true that some other side effects have been more readily acknowledged than tardive dyskinesia. However, it would be a serious indictment of state psychiatry indeed if the most serious drug side effect, and that one alone, was ignored. Moreover, the possibility that state doctors ignored tardive dyskinesia—presumably because of its very seriousness and implications for future drug use⁴⁴—but paid close attention to other serious drug side effects is remote. At the least, one could conclude that the more serious the drug side effect the more likely it will be ignored.

Probably the most important possible objection, however, is that New Jersey hospitals themselves are *sui generis* and not representative of what occurs in other state hospital systems. Indeed, the American Psychiatric Association, which acknowledged the serious abuses in the *Rennie* record, adopted this approach.⁴⁵ This objection is misplaced for two reasons.

First, something must be done with New Jersey and other state systems—should there be any—that exhibit New Jersey's abuses. At a minimum, then, "good" state systems must be distinguished from "bad" ones and some remedy must be tailored for the latter cases. Abuses should not be ignored merely because they are less than universal.

More basically, however, there is every reason to regard New Jersey as typical of other states. Nothing in the New Jersey hospitals' history, organization, or approach suggests they are unique.⁴⁶ Indeed, physicians transfer from state hospital to state hospital—within and across state lines—and it does not appear that any physician ever regarded New Jersey's hospitals as unusual. New Jersey hospitals enjoy accreditation from the Joint Commission on Accreditation of Hospitals.⁴⁷ Moreover, the picture that the *Rennie* record paints accords precisely with Dr. Crane's

⁴² See, e.g., Task Force, *supra* note 30.

⁴³ See *infra* notes 50-67 and accompanying text.

⁴⁴ See *Rennie*, 476 F. Supp. at 1302-03.

⁴⁵ Amicus Brief, *supra* note 26, at 18-22.

⁴⁶ In *Rennie* outside experts testified that New Jersey's mental hospitals were typical of large state institutions in general appearance and operation. See, e.g., Joint Appendix, *supra* note 38, at 1593a, 1082a (testimony of Drs. Mosher and Crane).

⁴⁷ One of the state hospitals, Trenton Psychiatric, lost the accreditation of the Joint Commission on Accreditation of Hospitals in 1975 and regained it in 1981; problems with the physical plant appear to have been the primary deaccreditation consideration. See Brief on Behalf of Appellants/Cross-Appellees Douglas J. Cospito at 6-7, *Cospito v. Califano*, Nos. 83-5201, 83-5202 (3d Cir. 1983).

findings in the other state hospital systems.⁴⁸ There is no study, to my knowledge, showing that state doctors have ever forthrightly acknowledged tardive dyskinesia or allowed it to restrict their drugging of the mentally ill.⁴⁹

In sum, attitudes of state physicians toward tardive dyskinesia should be indicative of their attitudes toward all drug-caused harms, and New Jersey doctors' attitudes in this regard—as disclosed by *Rennie*—should be representative of state psychiatry's.

C. Tardive Dyskinesia in a State Hospital System

1. The Surveys: 1974 and 1978

In 1974, tardive dyskinesia attracted more attention from New Jersey residents than it ever had before—or would, in the near future at least, attract again. The attention it commanded in that year came not from state doctors, at least not in the first instance, but from newspaper readers. Two social workers had issued a widely-reported press release charging that “permanent neurological disorders [i.e. tardive dyskinesia] have become common” in the state’s mental hospitals.⁵⁰ That claim—indeed, the language of the press release—echoed an article Dr. Crane had published the year before in *Science* magazine.⁵¹ The social workers’ allegations were certainly true: New Jersey patients, like drugged patients everywhere, fell victim to tardive dyskinesia.

The state mental hospital system did not take these charges lightly, or so a counter-press release made it appear.⁵² The head of New Jersey’s mental health system, Ann Klein, quickly announced the commissioning of an “independent” study by faculty members at the New Jersey College of Medicine and Dentistry to investigate the charges.⁵³ This independent investigation was necessary, Commissioner Klein said, to address the “anxieties” that the social workers’ “serious charges [had] created in the minds of the public, the patients and their families.”⁵⁴

In short order, independent surveyors reported that they had “found no evidence of permanent neurological damage due to drug therapy”⁵⁵—the first in what was to become a series of official denials that

⁴⁸ Joint Appendix, *supra* note 38, at 1087a.

⁴⁹ Generally, the medical (and, one might add, legal) literature pays little attention to “actual prescription practices in mental hospitals.” Mason, Nerviano & DeBurger, *Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals*, 1977 *DISEASES OF THE NERVOUS SYSTEM* 541, 541.

⁵⁰ Joint Appendix, *supra* note 38, at 791b.

⁵¹ See Crane, *supra* note 2.

⁵² Joint Appendix, *supra* note 38, at 772b.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.* at 771b.

tardive dyskinesia existed within the state. The conclusion itself, which, if taken at face value, was inherently incredible—indeed, ridiculous—was no less remarkable than the surveyors' means of arriving at it. The independent doctors had been described as "surveyors,"⁵⁶ and although they did in fact visit hospitals, their investigation of tardive dyskinesia consisted entirely of sending questionnaires to hospital physicians and reviewing patient charts that the mental hospitals themselves had provided. Since, as the study itself demonstrated, the mental hospitals had never diagnosed tardive dyskinesia, the surveyors learned of no cases from their charts and questionnaires; they could then report that they had found "no evidence of it."⁵⁷

It is simply inconceivable that these academic doctors would be uninformed about tardive dyskinesia or would be unable to recognize it, if they had wished to. Although tardive dyskinesia did not dominate the medical journals in 1974, it had received wide academic recognition by then and, as noted above, drug manufacturers and psychiatric leaders had issued special warnings about it within the previous two years. The social workers themselves had obviously learned of it in Dr. Crane's *Science* magazine⁵⁸ article published the year before.

The political, legal, and moral consequences of this incident—and similar ones that would follow it—are serious. The physical damage done to thousands of patients was ignored, and the government misrepresented its actions: it claimed it was not deforming mental patients, when it was. Moreover, the government had enlisted doctors not just from its own hospitals, but the respected leaders of the state medical school in constructing its official version of the truth about drugs.

Not the least-remarkable thing about the 1974 survey was its repetition in essentially the same format and with essentially the same results four years later, in 1978.⁵⁹ Klein had commissioned a second drug survey in the wake of the *Rennie* case,⁶⁰ which was filed in December 1977 and was receiving District Judge Brotman's close attention. This second survey was performed by high-ranking officials in the state mental health bureaucracy (rather than by the state medical college) and it was to have "a specific concern as to the identification of cases of tardive dyskinesia."⁶¹

The 1978 surveyors chose the so-called "format"⁶² of the earlier investigation: that is to say, they reviewed charts without examining any patients. Once again, the surveyors reported that "[n]o case of tardive dys-

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Crane, *supra* note 2.

⁵⁹ Joint Appendix, *supra* note 38, at 264b.

⁶⁰ 462 F. Supp. 1131 (D.N.J. 1978).

⁶¹ Joint Appendix, *supra* note 38, at 289b-91b.

⁶² *Id.*

kinesia was uncovered,"⁶³ attributing these "favorable findings" to "the aggressive in-house educational program Ancora Psychiatric Hospital had had relative to the use of antipsychotic medication. . . ."⁶⁴ Ancora was the focal point of the second survey and, not coincidentally, of the *Rennie* suit. The same hospital performed a drug "audit" at about this time, reporting a by-now-familiar conclusion to the Joint Commission on Accreditation of Hospitals: not a single case of tardive dyskinesia existed.⁶⁵ The Joint Commission accredited the hospital.⁶⁶

Thus, as late as 1978, the New Jersey state hospitals had never admitted to a case of permanent drug-caused harm, although the number of such cases was almost certainly in the thousands.⁶⁷ These surveys and audits were inadequate as if by design. They presumed that state doctors recorded on charts what every informed person knew the doctors invariably ignored.

The reality behind the hospitals' surveys and reports came to light when Dr. Crane, as an expert witness for the *Rennie* plaintiffs,⁶⁸ performed his own New Jersey survey. Dr. Crane testified that his results showed that about twenty percent of the patients examined had manifested clear-cut tardive dyskinesia symptoms. Further, not a single one of the affected patients' charts contained a diagnosis of tardive dyskinesia. In nearly all instances, the hospital chart simply ignored the patient's bizarre movements. It was as if hospital physicians could not see what was not only obvious, but eye-catching and grotesque. For example, one patient, according to Crane,

of age sixty had a variety of symptoms [of tardive dyskinesia], very obvious ones, and this particular patient had, I would consider it as—each condition being moderately severe, but since he had various parts of the body involved, I would say the condition was at least severe. He was receiving currently Thorazine, one hundred milligrams three to four times a day. The physical on admission, April 16, 1979 reported no neurologic findings, and I can assure you that the symptoms could not have developed in

⁶³ *Id.* at 266b.

⁶⁴ *Id.*

⁶⁵ Trial Record exhibit D-63, *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979) [hereinafter cited as Trial Record].

⁶⁶ *Rennie*, 462 F. Supp. at 1136.

⁶⁷ See *supra* note 31 and accompanying text. The assumption is that 20% of the patients at New Jersey's four state hospitals were afflicted. See *Rennie*, 476 F. Supp. at 1299. The state system's population being about 4,000 at any one time, it is obvious that many more thousands of patients are admitted to a hospital and spend some time there during a year. For Dr. Crane's testimony describing his findings, see Joint Appendix, *supra* note 38, 1065a-69a, 1081a-83a.

⁶⁸ See Joint Appendix, *supra* note 38, at 1065a-95a. As to Dr. Crane's findings on the incidence of tardive dyskinesia, see *id.* at 1070a, 1074a, 1082a-83a.

one month [i.e., between the physical and Dr. Crane's examination of the patient]

There were no findings pertaining to the neurological question on admission and there was an AIMS [an examination designed solely to detect and rate the severity of tardive dyskinesia], which was found negative.⁶⁹

Another example was a patient with

dyskinesia, tremor, and a large number of symptoms, not only in the mouth but in the whole body so that the patient had a very bizarre . . . [gait] and very conspicuous motor abnormality. On admission, the patient had been put on Halodal [sic]. . . . This was discontinued and . . . he is receiving now Lithium, which I think is justified. . . . The only thing that was noted was in one note that the patient had tremor, but nothing about tardive dyskinesia and his very diffused symptom[s]⁷⁰

In a very few cases, the patients received examinations by hospital neurologists. However, the neurologists generally only described some symptoms; they did not diagnose tardive dyskinesia.

Mental hospitals are left with three remaining options upon their refusal to acknowledge tardive dyskinesia. They can ignore the symptoms, as Dr. Crane discovered. Hospitals also can attribute the movements to faking. Finally, they can decide that mental illness itself, rather than the drugs used to treat that illness, causes the problem. Although cases of hospitals' recognizing the symptoms and using the "faking" or "mental illness" excuses appear to be exceptional—Crane's survey found none—such cases do exist; the appendices to this article describe three. All reflect a firm unwillingness to admit to non-trivial, drug-caused harms.

II. THE DOCTOR-PATIENT RELATIONSHIP: ATOMISTIC REMEDIES

When doctors' decision-making and judgment fall below acceptable standards, or threaten to do so, it is natural to attempt medical remedies: the doctors should be made more careful; their education should be improved; and there should be medical checks on the work of individual physicians. In any event, these are the considerations that have motivated some courts in mental hospital drugging cases.

An examination of each of these approaches follows, with an emphasis on the underlying judicial vision of the problem and the likely effectiveness of the corresponding remedy.

⁶⁹ *Id.* at 1077a-78a.

⁷⁰ *Id.* at 1086a.

A. Careful Medical Decision-Making

Two federal appellate courts have reached the merits of a state mental hospital drugging dispute,⁷¹ and each has viewed the problem as one of physician care and deliberateness in decision-making. That is, both courts chose a remedy which, if fully implemented, would ensure that state physicians consciously and carefully deliberate about their individual drug prescriptions.⁷²

Undoubtedly, some drugging decisions in state hospitals are made carelessly, with doctors paying too little attention to the problem or the patient. Courts can discourage this kind of carelessness by requiring doctors to listen to patients and actually deliberate over the decision to drug. However, as the accounts of tardive dyskinesia in the appendices demonstrate,⁷³ the principal problems of state drugging do not result from this cause, and so they will not respond to this remedy.

Carelessness does not explain why state hospital physicians overlooked the drug-induced physical movements that were consistently ignored in charts. For example, in one case documented in *Rennie*, a man with severe dyskinetic movements throughout his body and limbs was reported by his doctors as having "normal" motor status.⁷⁴ Profound mouth and tongue movements in other patients were overlooked for years on end.⁷⁵ In the case of John Rennie himself, symptoms that were visible to judges, outside experts, other patients, hospital nurses, and even small children could not be detected by state doctors despite repeated examinations.⁷⁶

If the hospitals had merely been slow to detect tardive dyskinesia, first noticing it months after onset, perhaps one might attribute the problem to casual or careless observation. Even then, the staff's day-to-day exposure to patients—feeding them, getting them out of bed, escorting them from place to place—would make this explanation implausible. If doctors were merely careless, rather than biased against reporting tardive dyskinesia, that disorder would be over- as well as under-diagnosed. However, state hospitals *never* acknowledge tardive dyskinesia, and random, individual acts of carelessness simply cannot account for that oversight.

Even when carelessness has played a role in the non-acknowledgement of tardive dyskinesia, other factors are also at work. In one patient's

⁷¹ *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (en banc) *vacated and remanded*, ____ U.S. ____, 102 S. Ct. 3506 (1982); *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. ____, 102 S. Ct. 2442.

⁷² See, e.g., *Rennie*, 653 F.2d at 847; *Rogers*, 634 F.2d at 657. See also Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 446 (1981) (legal procedures should ensure compliance with medical norms).

⁷³ See *infra* apps. A-C.

⁷⁴ See *infra* app. B.

⁷⁵ See *infra* app. A.

⁷⁶ See *infra* app. C.

case⁷⁷—remarkable because the hospital neurologist had used the words “tardive dyskinesia” (without actually making a definitive diagnosis)—the report of the neurologist was lost in the chart. Perhaps there was haphazard hospital record keeping. However, the fate of that one report is part of a larger pattern: any inference, fact, or record tending to support the diagnosis of tardive dyskinesia was rejected, overlooked, or rationalized away. Thus, doctors “blatantly ignored”⁷⁸ this patient’s manifest symptoms for years. Indeed, losing the suggestive report was not very different from the daily failure to record this woman’s symptoms in the chart; every day that doctors, nurses, and other employees failed to acknowledge her abnormal movements represents another comparable episode. Although doctors managed not to lose a later, similar neurology report, that made no difference; they still diagnosed the patient as a “faker.”⁷⁹ No neurology referral was required to support the “faking” diagnosis, just as no number of referrals could successfully establish a diagnosis of tardive dyskinesia.

Unfortunately, the patient’s fate was typical. Far from being the result of carelessness, the doctors’ approach here was a predictable part of systematic hospital routine. Indeed, as to the principal plaintiff in *Rennie*, John Rennie, hospital doctors were as careful as possible. Judge Brotman had admonished them to take extra pains, and the medical director of the hospital examined Mr. Rennie every week.⁸⁰ However, the hospital took care only to see that no report of drug side effects appeared in Mr. Rennie’s chart. A nurse who recorded his drug-related movements was reprimanded for doing so,⁸¹ and every artifice was used to avoid reporting Mr. Rennie’s tardive dyskinesia.⁸²

Of course, the doctors’ actions appear foolish, perhaps unsustainably foolish, in retrospect. The physicians underestimated the fact-finding processes of the courts and overestimated the weight that their own written chart entries would carry. (After all, the failure to record tardive dyskinesia had led the New Jersey College of Medicine and Dentistry⁸³ and, apparently, the Joint Commission on Accreditation of Hospitals⁸⁴ to suppose that there was no tardive dyskinesia in New Jersey; why should Judge Brotman be any different?) The doctors’ litigation posture was untenable and probably would not be repeated. But the diagnostic approach toward Mr. Rennie was not an artifact of the litigation; it was the invariable rule, and it cannot be explained in terms of physician carelessness.

⁷⁷ See *infra* app. A.

⁷⁸ *Rennie*, 476 F. Supp. at 1302.

⁷⁹ See *infra* app. A.

⁸⁰ See *infra* app. C.

⁸¹ *Rennie*, 476 F. Supp. at 1302.

⁸² See *infra* app. C.

⁸³ See *supra* notes 53-57 and accompanying text.

⁸⁴ See *supra* notes 65-66 and accompanying text.

Since carelessness is not behind the posture of state hospitals toward tardive dyskinesia, the remedy of making doctors more careful will not address the problem.

B. Continuing Medical Education

If state doctors are not careless about drugs, then perhaps the physicians are badly trained and cannot recognize drug-caused harms. Were that so, the obvious remedy would be better-educated doctors. Such approaches, entailing mandatory continuing medical education about drugs, have proved popular with hospitals⁸⁵ and have appealed to courts.⁸⁶

However, medical ignorance is no better than carelessness as an explanation for the drug excesses of state psychiatry. It is true that many mental hospital doctors may not know as much about drug side effects as they should. Some gaps in their knowledge may even be remarkable. But it cannot be said that every state physician is ignorant of, for example, tardive dyskinesia, the most notorious side effect. Yet the pattern of non-recognition—or, more precisely, non-acknowledgement—is nearly universal. Nor can lack of education explain why medical reviewing organizations,⁸⁷ special medical-school review boards,⁸⁸ and supervising physicians⁸⁹ accepted reports of tardive dyskinesia's nonexistence and were apparently pleased to receive them.

Many of the considerations that discredit the "carelessness" theory of psychiatric excess⁹⁰ also refute "lack of knowledge" theories. Like carelessness, medical ignorance would produce only random mistakes, unless the ignorance were studied. Lack of medical training in state hospitals does not explain why every other interpretation—faking, mental illness, mistaken observation—has been preferred over the diagnosis of tardive dyskinesia. Nor does it explain why doctors do not merely misdiagnose tardive dyskinesia movements, but ignore them entirely.

Indeed, clinical ignorance of tardive dyskinesia does have a studied quality. Doctors know precisely which movements to ignore. Moreover, the alternative theories for grotesque movements—faking and mental illness—are highly implausible on their face, at least in many circumstances. The "faking" hypothesis requires that patients be fully informed about tardive dyskinesia and be willing to perform difficult, and perhaps impossible, voluntary tongue, muscle, and limb gyrations repeatedly during every minute of their waking lives, reducing themselves to human curiosities in the process: all to simulate a side effect that has never (so far

⁸⁵ See, e.g., *supra* note 64 and accompanying text.

⁸⁶ See, e.g., *Rone v. Fireman*, 473 F. Supp. 95, 109 (N.D. Ohio 1979).

⁸⁷ See *supra* notes 65-66 and accompanying text.

⁸⁸ See *supra* notes 53-57 and accompanying text.

⁸⁹ See *supra* notes 59-63 and accompanying text.

⁹⁰ See *supra* notes 71-84 and accompanying text.

as the record indicates) caused any New Jersey state doctor to discontinue drugging. Moreover, tardive dyskinesia movements themselves belie the theories of the hospitals. One *Rennie* plaintiff's movements, for example, were far too severe to be feigned, yet physicians and staff chose to regard them as faking.⁹¹ Nor is tardive dyskinesia difficult to distinguish from naturally occurring mental illness.⁹² It is not credible, for example, that one patient's doctors really believed in schizophrenic "mannerisms" of the diaphragm;⁹³ the movements, along with distress in much of the rest of the patient's body, had actually been induced by tardive dyskinesia. None of this is explicable in terms of lack of education on the doctors' part or their ignorance of drug side effects.

While all state doctors may not be well versed about tardive dyskinesia, the fact remains that if they do not know more, it is because they do not want to know. Medical articles describing the entire array of drug side effects—not just tardive dyskinesia—can be read by any lay person in an hour or less. Since drugs constitute the preeminent psychiatric response to mental illness and since tardive dyskinesia is their most notorious side effect, the fact that doctors ostensibly require more education to notice the disorder requires explanation.

The futility of requiring further medical education appears from John Rennie's own treatment. The hospital medical director reviewed Mr. Rennie's condition every week but did not recognize the classical signs of tardive dyskinesia, even though each week the director indicated on a pre-printed form that those very same symptoms were not present.⁹⁴ Not even a description of the symptoms present in front of his eyes led the medical director to acknowledge tardive dyskinesia. While it is remarkable that the medical director did not know the basic tardive dyskinesia symptoms, it would be even more remarkable if further training would have made a difference. When reading a list of symptoms contemporaneous with an examination is not enough, it is fair to conclude that further education is futile. (Of course, the entire hospital medical staff went along with the medical director's judgment.) Indeed, there are reports that medical education regarding tardive dyskinesia has no effect whatever on state doctors⁹⁵—as it should not, since ignorance is not the problem to begin with.

⁹¹ *Rennie*, 476 F. Supp. at 1301; see *infra* app. A.

⁹² Crane, *Tardive Dyskinesia*, *supra* note 38, at 218.

⁹³ See *infra* app. B.

⁹⁴ See *infra* app. C.

⁹⁵ See, e.g., Crane, *The Prevention of Tardive Dyskinesia*, 134 AM. J. PSYCHIATRY, 756-58 (1877) ("It is quite obvious that the publication of articles on tardive dyskinesia and the pleas of a few concerned investigators to use neuroleptic drugs with greater discretion have had little impact on the prescribing practices of physicians."); see also Joint Appendix, *supra* note 38, at 1411a-13a, 1614a (testimony of Drs. Crane and Mosher).

C. Peer Review and Chart Audits

Intra-hospital peer review is a remedy related to careful medical consideration and improved physician education. Presumably, a peer review mechanism would make doctors cautious about mistakes and would bring a broader body of knowledge to bear on drugging decisions.

It is clear, however, that the problems described in the previous part will not be alleviated by this remedy either. New Jersey doctors did collaborate on cases, even if they did not formally review each other's work, but a second opinion never made any difference.⁹⁶ The doctors failed to account for tardive dyskinesia individually and, when they joined together, they still took no account of it.

A variation on simple peer-review—one that uses chart audits to determine whether drug prescriptions conform to pre-determined, written standards—appears more promising, and at least one court has endorsed it.⁹⁷ The formality and the use of written standards that mark these systems is appealing. However, chart audits in their current form actually promise little, as an examination of the model audit standards⁹⁸ of the American Psychiatric Association (A.P.A.) will demonstrate.

The purpose of the A.P.A.'s standards is "to permit a knowledgeable nonphysician to select from a large number of cases a relatively small number for which physician review is appropriate. . . . Charts are selected for medical review."⁹⁹ For example, one written standard stipulates the diagnoses that should appear on the charts of patients who receive neuroleptics and, if no such diagnosis appears, the chart is "selected for medical review." But the standards do not purport to mean that charts singled out for review reflect unacceptable practice. The medical reviewer—whether the prescribing physician or, more likely, another member of the medical staff—could well conclude that, in the particular case at hand, the drug prescription was acceptable. Lest there be any doubt on this point, the A.P.A. has stated that it "strongly agrees with the AMA and other specialty societies that only physician reviewers can make an ultimate determination of the medical appropriateness or necessity of patient care in a particular case."¹⁰⁰ Thus, the system is simply one of peer review, with the failings noted above.

The limitations of peer review notwithstanding, perhaps it would be beneficial if doctors spoke to each other about their charts under the guidance of written—if still advisory—standards. While that may be true,

⁹⁶ For example, more than one doctor was almost always involved in Mr. Rennie's care. See *Rennie*, 462 F. Supp. at 1138-40.

⁹⁷ *Rone v. Fireman*, 473 F. Supp. 95, 109-10 (N.D. Ohio 1979).

⁹⁸ Dorsey, Ayd, Cole, Klein, Simpson, Tupin & DiMascio, *Psychopharmacological Screening Criteria Development Project*, 241 J.A.M.A. 1021, 1021 (1979).

⁹⁹ *Id.*

¹⁰⁰ *Id.*

the design of the A.P.A. audit protocol and the problems noted in the previous part bear little relationship to one another.

Some illustrations may prove helpful. In theory, a protocol might single out for review a physician's charts if *none of them* contained the tardive dyskinesia diagnosis; that would be a strong indication of the physician ignoring that disease. But the A.P.A.'s chart protocol singles out charts which *contain* a diagnosis of tardive dyskinesia.¹⁰¹ Although no one could quarrel with the need to think carefully about drugging someone who has already developed a permanent, drug-induced disease, the A.P.A.'s standard is meaningless in state systems that do not acknowledge tardive dyskinesia in the first place. Indeed, the audit system would discourage that diagnosis—if further discouragement were needed—because physicians would want to avoid the added paperwork and scrutiny it entails. Similarly, the criteria include acceptable drug dosage ranges,¹⁰² but the standard psychiatric dosage range has caused the high incidence of tardive dyskinesia that we now have. The protocol, as noted above, also limits drugging to patients with certain diagnoses, but it is easy enough for doctors to make the required diagnosis—indeed it is hard to believe that a doctor about to drug someone would do otherwise.¹⁰³

The problem with chart audits is that they presuppose the truthfulness and completeness of hospital chart entries—a mistaken assumption, at least if the issue is tardive dyskinesia. Moreover, the audits suppose that the physicians are indifferent as to whether drugs are used or not (so that a diagnosis will be made without any thought given to the effect of that diagnosis on the acceptability of drugging) and that they will not take pains to avoid having their charts singled out. Given the practices described above, both of these assumptions are also dubious.

Indeed, chart audits of the kind envisioned by the A.P.A. were carried out repeatedly in the New Jersey hospitals involved in *Rennie*. These reviews sought to determine whether tardive dyskinesia existed in the state; as noted above, the reviewers invariably concluded from the absence of any such diagnosis in patient charts that there was no tardive dyskinesia.¹⁰⁴ A system of chart audits of the kind envisioned by the A.P.A. would only routinize such findings.

III. LEGAL GUARDIANSHIP

A completely different approach to drugging problems would strictly apply the model of ordinary medical treatment and ordinary patient consent. According to this view, a mental patient's refusal to accept treat-

¹⁰¹ *Id.* at 1026.

¹⁰² *Id.*

¹⁰³ See, e.g., Rosenhan, *On Being Sane in Insane Places*, 13 SANTA CLARA LAW. 379, 395-96 (1973).

¹⁰⁴ See *supra* notes 57 and 63 and accompanying text.

ment, like any other patient's refusal, may be overridden only if the patient is incompetent. To determine whether that is the case, general incompetency proceedings are instituted. If the patient has been declared incompetent, he or she can be drugged with the guardian's consent; should the guardian refuse, drugging is forbidden.

Like the remedies considered in Part II, this one is atomistic. It looks to the doctor-patient relationship, narrowly conceived, for the source of drugging problems and for the appropriate remedy. However, the guardianship model has a different vision of that relationship: it regards "competent consent" as an essential feature, where medical approaches, at least in this area, generally do not.¹⁰⁶

This difference has produced some of the criticism by psychiatrists of the guardianship remedy, which does not ensure that the treatments deemed best by doctors will be administered. Indeed, some authors point out that the family may be appointed guardian and then oppose medication¹⁰⁶—"a disturbing ethical as well as legal dilemma,"¹⁰⁷ to these critics. Psychiatrists also point out that guardianship proceedings often entail long delays due to cumbersome legal procedures with patients remaining undrugged in the meantime; that the procedures are expensive; that guardians weaken the patient-doctor alliance by acting as middlemen; that informed, competent guardians may well be unavailable; and that the interference with the drug regime entailed by this remedy can cause chaos on mental hospital wards.

These considerations are important ones, but it is difficult to assess them in the abstract. There may or may not be readily available means for expediting the proceedings or obtaining interlocutory relief; the expense may or may not exceed that of other measures, including systems of medical peer review; the addition of middlemen may, in fact, help to balance doctor-patient relationships in which the doctors hold all the power and control every option; provision for competent guardians might be made at reasonable cost; and chaos on the wards may or may not be inevitable,¹⁰⁸ as charged.

¹⁰⁶ See generally Gutheil, Shapiro & St. Clair, *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137, AM. J. PSYCHIATRY 347 (1980) (discussing the ways in which the guardianship remedy in practice falls short of the medical ideal); Stone, *supra* note 26 (arguing that physicians, not guardians, are best suited to make decisions as to treatment, provided that the patient is initially adjudged incompetent).

¹⁰⁶ Gutheil, Shapiro & St. Clair, *supra* note 105, at 350.

¹⁰⁷ *Id.* (the other psychiatric criticisms noted in this paragraph also appear in the Gutheil, Shapiro & St. Clair article).

¹⁰⁸ Compare Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 AM. J. PSYCHIATRY 273, 278 (1977) (in Rogers, this type of right-to-refuse-drug decree resulted in "serious harm to both patients and staff") with Joseph, *The Civil Rights of Mental Patients: A Case Study of the Legalities and Realities* 61 (1976) (unpublished Masters thesis) (reprinted in Trial Record, *supra* note 65, exhibit D-16 (the long-term impact of the court decree in Rogers was modest)); see *infra* note 140 and accompanying text.

The problems with guardianship remedies lie elsewhere. Drugging decisions may be so personal, and their stakes so high, that even a duly-appointed guardian's inclination should not be binding. Indeed, for those reasons the Massachusetts Supreme Judicial Court has held that an adjudicated incompetent's refusal of drugs cannot be overridden by his guardian;¹⁰⁹ rather, a judge must decide whether the incompetent would have—but for his incapacity—consented to drugging (the “substituted judgment test”).¹¹⁰ To the extent that guardians cannot consent, appointing them is futile; one must still decide whether to drug forcibly.

Another problem, aside from doctrinal nuances, is that guardians may well be too quick to give consent.¹¹¹ According to one report, many relatives of patients oppose discontinuation of drugs even if physicians suggest that course.¹¹² Accordingly, when physicians urge drugging—as they almost always do—the likelihood of guardian consent is high, no matter what the consequences to the patient, and this is particularly true when hospitals blame drug-caused harms on the patients' illnesses. Moreover, state hospital staffs can unduly influence relative-guardians: they can, for example, threaten to discharge the patient—who may well have no other place to go—unless drugging is permitted; or relatives may be led to believe that staff will not care for undrugged patients.

There are additional problems. However the guardian may feel about drugging, the process of his appointment and the mechanics of his decision-making are not designed to air drugging issues openly: guardianship mechanisms operate too informally for that. It is arguable that state-caused physical damage, inflicted via drugging, requires formal, open processes of decision. If a patient's guardian consented to drugs, for example, after the guardian had been informed that the patient needed drugs and was feigning side effects or that he needed drugs and the benefits outweighed any possibility of harm, it would be far from obvious that the patient had received his due measure of consideration.

However, objections to the guardianship system's mechanics are probably less important than objections to its scope. Only patients acknowledged in the first instance to be drug refusers are affected by such measures. Incompetent patients who consent to drugging will continue to be drugged, as will patients (whether competent or not) whose drug objections the hospitals choose to ignore—and *Rennie* demonstrated that un-

¹⁰⁹ *Guardianship of Roe*, 421 N.E.2d 40, 55-56 (Sup. Jud. Ct. Mass. 1981).

¹¹⁰ See, e.g., *id.* at 56. See the Epilogue to this article for a discussion of the result in *Mills v. Rogers*, No. S-2995 (filed Dec. 15, 1983), on its remand to the Supreme Judicial Court of Massachusetts.

¹¹¹ Compare *supra* note 106 and accompanying text.

¹¹² Kurucz & Fallon, *Dose Reduction and Discontinuation of Anti-Psychotic Medication*, 31 HOSP. & COMM. PSYCHIATRY 117, 117 (1980). In my practice, I noticed that relatives who had once taken a neuroleptic were often sympathetic to a patient's drug refusal, while other relatives generally were not.

acknowledged drug refusers far outnumber the patients whose drug refusals hospitals acknowledged.¹¹³

To avoid these problems, one might canvass all patients for competence and bring guardianship actions in all cases of putative incompetence whether the person had consented to or refused drugs. But the number of such cases would be phenomenally high, as there are many unadjudicated incompetents in mental hospitals,¹¹⁴ and the administrative and financial costs of the guardianship system would be multiplied many times over in the process. Moreover, if the concern is with drugging as such, it would seem wiser to tailor a remedy for that problem than to adopt the guardianship mechanism—at greater cost in money, time, and energy—to the peculiar context of mental hospitals and their drugs.

The actual impact of the guardianship remedy may be gauged from *Rogers v. Okin*.¹¹⁵ In *Rogers*, a federal court order imposed the guardianship rule on two wards of Boston State Hospital. The hospital could force drugs only in emergencies or by obtaining a guardian's consent; the order remained in effect five years before being overturned on appeal.¹¹⁶

At the outset there was disruption, increased patient violence and disorder on the ward, and staff became demoralized.¹¹⁷ However, ward routines soon returned to near normal, with the help of the "emergency" exception. An investigator¹¹⁸ interviewed ward staff within a year and reported:

By the time of the interviews, the Austin Unit seemed to have quieted down somewhat. One month after the suit was brought, the unit chief had felt that, "The building was in bedlam." At the time of our interviews, he commented that, "The last month or two, things have been settling down." A number of subjects [i.e., members of the staff] shared this feeling, thinking that things had cooled off lately, that the building was starting to return to normal. . . .

Several of the subjects commented on the direction they saw the issue of the right to refuse treatment taking. One psychiatrist resignedly stated that the suit "was a sobering, saddening experience leaving me wiser and less naive. Little was actually accomplished in terms of providing better patient care; the only thing will be more red tape." Referring to the effect of the injunction,

¹¹³ *Rennie*, 476 F. Supp. at 1303-05.

¹¹⁴ See, e.g., *id.* at 1305; Appelbaum, Mirkin & Bateman, *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170 (1981).

¹¹⁵ *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part, and remanded*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. ___, 102 S. Ct. 2442 (1982).

¹¹⁶ 634 F.2d 650 (1st Cir. 1980).

¹¹⁷ Joseph, *supra* note 108, at 61.

¹¹⁸ Joseph, *supra* note 108.

he noted that all instances of involuntary seclusion and medication must be accompanied by extensive documentation. Another subject stated that, "The main difference between now and before the suit is that the actions we take now require clear documentation." An attendant agreed, saying, "Staff is more accountable now, which is good. People are putting more things in writing, and documenting more. This leads to better charts, and makes things legally sound."¹¹⁹

This attendant perfectly expressed New Jersey physicians' attitudes toward charts in *Rennie*. No heightened staff consciousness of drug side effects seems to have come out of this experience. Furthermore, it appears that patients will have little relief under such a system, since, to achieve it, patients will have to convince their doctors (or their guardians) to respect their refusal of treatment when the state mental health care system is committed to denying the harmful effects of drugs.

IV. DETERMINING INCOMPETENCE AT COMMITMENT HEARINGS

Doctor Alan Stone's proposal to confront treatment-refusal issues at commitment hearings¹²⁰ represents an entirely different approach. Although Stone's orientation is medical, his approach is also the first structural remedy to be explored.

Dr. Stone argues that inappropriate drug use is common in mental hospitals both because untreatable patients may be admitted and because treatment facilities may be ineffective.¹²¹ These hospitals use drugs to control patients.¹²² It follows that drug audits, careful physician attention, peer review, medical education, and similar measures cannot prevent abuse of drugs; underlying circumstances compel drug abuse and compelling necessity will corrupt reform measures.

Dr. Stone's views mark his proposal as "structural." He does not suppose that the doctor-patient relationship can thrive in all circumstances or operate free of institutional constraints. However, Stone's solution does not address the attendant circumstances and constraints directly. Rather he would prevent troubled doctor-patient relationships from ever being formed in state hospitals via civil commitment.

Dr. Stone would have the underlying issues considered at commitment hearings. Competent treatment (i.e. drug) refusers could not be committed; nor could patients be committed to facilities incapable of delivering

¹¹⁹ *Id.* at 84-85.

¹²⁰ A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 66-70, 97-106 (1975); see also Roth, *A Commitment Law For Doctors, Patients and Lawyers*, 136 AM. J. PSYCHIATRY 1121 (1979) (a similar proposal).

¹²¹ A. STONE, *supra* note 120, at 19, 66-70.

¹²² See, e.g., Panel Discussion, Second Circuit Judicial Conference, Sept. 8-9, 1978, 82 F.R.D. 221, 271 (address by Dr. Stone).

treatment. The result is that all properly committed persons could be forcibly drugged.

This elegant scheme has two components, which will be considered separately. (Stone's recent modifications¹²³ to his proposal will be explored last.) First, the quality of the institution is supposed to provide assurances of reasonable treatment; second, the commitment process is supposed to afford patients an opportunity to be heard on competency questions, and by implication, drug questions as well. In the context of mental hospital drugging, both components of Dr. Stone's proposal raise serious practical issues. Despite its intentions, the proposal, as it is likely to be implemented, would not ease and might even exacerbate drug problems in state mental hospitals.

A. Upgrading Hospitals

First, it has not been established that "upgraded" hospitals heed their patients' complaints about drug side effects or weigh drug harms seriously. Substituting "better hospitals" for legal procedures may work to some extent, but that is not self-evident, as the intervention of medical school professors in the New Jersey tardive dyskinesia debate perhaps demonstrated.¹²⁴ Some excellent doctors may value freedom from psychotic relapse more than freedom from tardive dyskinesia. Furthermore, the costs of the required hospital upgrading might be phenomenally high. These costs would be incurred at a time when there are serious doubts concerning the power of the federal courts to order state expenditures for such purposes.¹²⁵

Such questions aside, it is doubtful whether courts or legislatures would really bar patients from substandard mental hospitals either en masse or on a case-by-case basis, as Stone suggests. Doing so would place dangerous and helpless persons "on the street" or in jail. If commitment was otherwise in order, neither outcome would be acceptable. The public would be jeopardized and patients would suffer. For similar reasons, right-to-treatment courts have not ordered patients released from sub-

¹²³ Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 330-35, 348-57; but see Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make It Work*, 38 ARCH. GEN. PSYCHIATRY 358, 361-62 (1981).

¹²⁴ See *supra* notes 50-57 and accompanying text.

¹²⁵ See, e.g., *New York State Assoc. for Retarded Children v. Carey*, 631 F.2d 162 (2d Cir. 1980) (federal courts cannot hold governor in contempt for failure to expend funds); see also *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1 (1981) (White, J., dissenting in part) (where receipt of federal funds is conditioned on compliance with federal standards, the state retains the right to withdraw); *New York State Assoc. for Retarded Children v. Carey*, 706 F.2d 956 (2d Cir. 1983) (substantial consideration must be given to public interest and effect on state budget); cf. *Rennie*, 653 F.2d at 851 (district court order would impose "substantial additional financial burdens" on the state).

standard hospitals.¹²⁶

Further, it is doubtful that legislatures would enact such a commitment law and then vote the necessary funds for upgrading hospitals. By enacting the commitment law, legislatures put themselves in a bind: either vote more funds for hospitals or face the politically unthinkable prospect of causing state commitment mechanisms to self-destruct. If a legislature desired either better hospitals or an end to patient commitments it could act more directly, and with less political cost, to achieve the chosen goal.

Moreover, even if a commitment law were enacted in the proposed form, the standards of care—and of adjudication, as well—inevitably would be compromised in practice. Judges would face the unpleasant prospect, already mentioned, of remitting dangerous or helpless persons to the street. In practice, judges are likely to find any “treatment” satisfactory under those circumstances. It is still less likely that judges will decree a hospital generally substandard and foreclose all commitment. Further, it is not clear what agency would have the resources, the independence, or the interest to litigate such hospital-wide issues; I know of none.

As a result of the pressures noted above, judicial decisions would stretch the legal standards to suit the realities, ultimately upholding substandard treatment. Little benefit would come from this exercise, and in some respects it would even make things worse. The public might believe hospitals had been reformed because of court decisions, when reformation had not happened. In the unlikely event a hospital was deemed unsuited for commitments, various devices—such as the threat of prison terms—would inevitably be brought to bear in order to convince patients to enter the hospital “voluntarily.”¹²⁷ It would be preferable to keep things as they are; at least, compulsion should be openly and honestly applied.

Further, even if patients were turned away from substandard hospitals, the problem of what to do with them would remain. If these patients really would benefit from drugs, it would seem irrational not to administer medication simply because the hospital was substandard. Many of these people could conceivably be held in a jail, shelter, or other state facility where, arguably, drugs should be used. However, the issues one avoided

¹²⁶ The court in the landmark right-to-treatment decision, *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), observed that “[u]nconditional or conditional release may be in order if it appears that the opportunity for treatment has been exhausted or treatment is otherwise inappropriate.” *Id.* at 458. However, I know of no case—including *Rouse* itself—that resulted in an otherwise committable person’s being released because of lack of treatment. See also *O’Connor v. Donaldson*, 422 U.S. 563 (1975) (declining to address the right-to-treatment issues).

¹²⁷ See, e.g., *Gilboy & Schmidt, Voluntary Hospitalization of the Mentally Ill*, 66 Nw. U.L. Rev. 429 (1971) (individuals may be induced into voluntary commitment under threat of involuntary commitment proceedings).

by denying commitment would simply reappear—and be no less pressing—in these other contexts.

B. Evaluating Competence to Refuse

Even if the hospital is presumed adequate for treating the patient, serious practical problems remain.

Under Dr. Stone's original proposal, an incompetent person could not be committed when a reasonable person might refuse the hospital's proposed treatment.¹²⁸ Since competent drug-refusing patients would not be committed even if the hospital's proposed treatment were reasonable, the result, as already noted, is that everyone committed to a mental hospital would be subject to forced drugging.

This proposal can have the effect of punishing both patients and society at large for the mistakes or intransigence of the hospital. The problem is that patients are excluded from mental hospitals based solely on their disagreement with proposed treatment plans. An example will show the possible consequences.

Suppose a former patient with a case of tardive dyskinesia and a history of tormented drug response becomes psychotic and dangerous outside the hospital. Suppose also that, at the commitment hearing, the hospital insists on drugging. The possibility is not far-fetched at all; New Jersey hospitals, for example, insisted on administering drugs to Mr. Rennie despite a similar psychotic and medical history.¹²⁹ Suppose finally that the hypothetical patient refuses drugs. Although psychotic and dangerous, this patient may well be competent¹³⁰ and his decision to refuse drugs well-founded. Indeed, any other decision might be *prima facie* incompetent, all other things being equal; and even if the patient is incompetent, a reasonable person with his history might not accept drugs. Under either assumption, according to Stone's proposal, commitment should be denied. The problem with this outcome is that it burdens the patient and the community because of hospital mistakes; both suffer (the patient by being denied hospital care and the community by being exposed to someone dangerous and mentally ill) so that the hospital can be free of undruggable patients. That result serves no purpose except to augment the authority of the hospitals.

However, another consideration bears on the reasonableness of drug refusal. A reasonable person may refuse a drug because it causes distress, but refusal of the same drug may be unreasonable if it means that admission to the hospital will be denied. The patient may be dangerous and face imprisonment. The patient may simply be helpless. In either case, a well-founded drug refusal may be undercut by the drastic consequences

¹²⁸ A. STONE, *supra* note 120, at 67.

¹²⁹ *Rennie*, 476 F. Supp. at 1302-03; *Rennie*, 462 F. Supp. at 1140-41.

¹³⁰ See A. STONE, *supra* note 120, at 69; Stone, *supra* note 123, at 359-60.

of not being committed; what is "reasonable" depends as much on the consequences of drug refusal as stipulated by Dr. Stone's proposal as on the properties of the drugs themselves. At a minimum this situation will result in strong pressures to accept the hospital's proposed treatment. The patient may feel compelled to submit to drugs. His attorneys may advise him to do so, considering the alternatives. If the patient persists in refusing, the judge may be moved to find his refusal incompetent and unreasonable. As noted, Dr. Stone's proposal may make an otherwise reasonable refusal unreasonable.

The only party escaping these pressures is the hospital. It can be as arbitrary as it likes. Indeed, mental hospitals may take advantage of their position to propose draconian treatment programs for patients they are reluctant to admit. This reluctance might be due to the difficulty of managing the patient, the fact that the patient complains about hospital conditions, or the fact that past drugging has brought the patient an early case of tardive dyskinesia and the hospital does not wish to risk further liability.

As a result of Dr. Stone's proposal, the authority of hospitals over patients would be augmented, their accountability to outsiders would be lessened, and those who least deserve it would bear the burdens of hospital mistakes. The proposal flounders, I believe, for these reasons.

C. Competence Without Reasonableness

Doctor Stone's original proposal, as already noted, would allow incompetent patients to refuse treatments that a "reasonable man might reject."¹³¹ In later articles,¹³² however, Stone abandons this position. Stone would now permit all involuntary patients to be drugged forcibly so long as they had been found incompetent at their commitment hearings.¹³³ "Reasonableness" of refusal is no longer a factor. His new analysis includes a proviso that drugging be "consistent with good medical practice,"¹³⁴ but there appears to be no regular forum where patients could challenge drugging for that reason—it would not happen at commitment hearings¹³⁵—and so hospital compliance with this standard is a moot point.

One can only speculate about the reason for Stone's change of mind, but it is not inconceivable that the acknowledged harshness of drug side effects lies behind it. If Stone has come to believe that a reasonable man "might" refuse drugs because of the danger of tardive dyskinesia, for example, then forced drugging would be ruled out by the first proposal. To

¹³¹ A. STONE, *supra* note 120, at 67.

¹³² *E.g.*, Stromberg & Stone, *supra* note 123.

¹³³ *Id.* at 330, 348.

¹³⁴ *Id.* at 348.

¹³⁵ *Id.* at 330.

accommodate drugging, then, the "reasonable man" proviso must be dropped.

However that may be, making patient incompetence a blanket license for forcible drugging invites all the abuses described in Part II. Indeed, the proposal does not even purport to restrict forced drugging in any way previously-committed patients can enforce. The objections noted in connection with the earlier proposal (except those directed at the "reasonableness" provision) apply here as well; but in this version nothing at all protects incompetents—who may need protection most—from the drugging regimes of state psychiatry.

V. "INDEPENDENT" PSYCHIATRISTS: THE RENNIE DISTRICT COURT DECREE

A different version of state drugging lay behind the district court's *Rennie* injunction.¹³⁶ There, institutional bias and loyalty were cast as the villains.

District Judge Brotman deemed review of physicians' forced drug decisions a constitutional necessity,¹³⁷ but he disqualified the hospital medical director¹³⁸ and, by implication, other members of the hospital staff from the reviewer's role. Judge Brotman found that staff physicians' demonstrated loyalty to each other and to the hospital itself would prevent unbiased judgments.¹³⁹ As a solution, he decreed a system of "independent psychiatrists"¹⁴⁰ comprised of non-state doctors hired by the state department of mental health on a case-by-case basis to review forced drugging episodes. In theory these doctors could render unbiased decisions, free of the institutional taint that, in Judge Brotman's opinion, distorted state doctors' drug judgments.¹⁴¹

The outside physicians, who were "independent" only in the sense that the state mental health department, rather than individual hospitals, employed them, would informally review¹⁴² each patient's case and then render a binding decision. But the independents were not the only feature of the decree: it also provided for written consent forms,¹⁴³ emergency drugging,¹⁴⁴ and drugging (without the necessity of independent review) of patients whom state doctors deemed "functionally incompetent."¹⁴⁵ Further, Judge Brotman also mandated a system of "patient advo-

¹³⁶ 476 F. Supp. 1294 (D.N.J. 1978) (class injunction issued).

¹³⁷ *Id.* at 1307; *Rennie*, 462 F. Supp. at 1145-47.

¹³⁸ *Rennie*, 476 F. Supp. at 1310.

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 1312, 1313-14.

¹⁴¹ *Id.* at 1310.

¹⁴² *Id.* at 1314.

¹⁴³ *Id.* at 1313.

¹⁴⁴ *Id.* at 1313-14.

¹⁴⁵ *Id.* at 1314.

cates"¹⁴⁶—nurses, social workers, or lawyers hired by the state mental health department—who would assist patients in presenting their side of drugging questions and who would also review cases of “functional incompetence.”¹⁴⁷ The “patient advocate,” but not the patient himself, could obtain independent physician review of functional incompetents’ drug regimes.¹⁴⁸ The heart of the decree, however, was the independent physician.

Unlike the approaches already considered, the “institutional bias” theory includes an important non-medical component. Although improved medical decision-making remains the goal, this approach regards medical improvements as impossible without organizational changes. Thus, it is a structural¹⁴⁹ approach. It also represents a fresh view. For the first time, doctors’ hearts rather than their minds—or the quality of the institution—become the focus of legal concern. Further, the theory can plausibly account for such phenomena as the failure of state doctors to notice their patients’ drug-caused disorders—a failure all but inexplicable as the product of inadequate medical education or physician carelessness.¹⁵⁰

Nonetheless, as a explanation of what goes wrong in state drugging and of what went wrong in *Rennie*, this institutional bias theory is flawed; its account of the problem is incomplete and it mislocates the focal point of state physicians’ blind allegiance.

Perhaps state hospital medical directors hesitate to second-guess their own staff physicians because of the superior’s loyalty to his subordinates. Still, that does not explain why the treating doctors themselves ignored tardive dyskinesia in the first place. All the New Jersey doctors—whether they were treating patients or reviewing other physicians’ decisions—proved unwilling to admit inconvenient facts that would threaten future drugging. This conduct represents a kind of allegiance to drugging per se, not loyalty to a hospital. However, if hospital loyalty is not the source of the drug problems, bypassing the network of intra-hospital friendship and professional association will not contribute to the solution.

More plausibly, perhaps, one might argue that state hospitals, as institutions, tend to administer drugs excessively, and the solution lies therefore in a drug decision-maker who is not associated with the hospitals. In the *Rennie* injunction, that decision-maker is the “independent psychiatrist.” This argument, however, fails to explain why state hospitals drug to excess in the first place. Without knowing that, one cannot predict whether the “independent” psychiatrists will act “independently” of the factors that cause drugging problems.

¹⁴⁶ *Id.* at 1313, 1314.

¹⁴⁷ *Id.* at 1314.

¹⁴⁸ *Id.*

¹⁴⁹ See *supra* notes 27-29 and accompanying text.

¹⁵⁰ See *supra* notes 71-84 and accompanying text.

There is reason to doubt the performance of "independents." Whatever has perverted the doctor-patient relationship and intra-hospital peer review would seem likely to make similar inroads into this system of "outside" medical consultants. Moreover, the state department of mental health—which manages all the state hospitals—chooses the "independent psychiatrists" (as well as the patient advocates).¹⁵¹ It seems improbable that the head of the state hospital system could be immune to something that influences every hospital that she supervises and all the hospital employees that she hires. Nor is this only speculation. The 1974 and 1978 surveys¹⁵² reporting no tardive dyskinesia in state hospitals were performed by independent psychiatrists accountable to the department of mental health.

The mechanics of independent psychiatrist review lead to similar pessimistic conclusions. Although the district court decree styled the review as a "hearing"¹⁵³ and the Third Circuit called it an "adversary proceeding,"¹⁵⁴ nothing more than a traditional medical consultation is involved. The "independent" must have access to medical records and see the patients. He will rely on charts prepared by the hospital and since the charts are often voluminous, it will generally be necessary to accept the treating physician's version of what the chart indicates.¹⁵⁵ Although the "patient advocate" assists patients, there is no set hearing; the patient advocates themselves may be nurses and social workers. This remedy requires nothing more than that a psychiatrist with an unusual designation perform an examination and speak with a non-physician hospital employee (the "advocate") about the case.

Moreover, independents will likely regard themselves as consultants with functions subordinate to those of the treating physician. There is no other role model for them. Given the powerful tradition of doctors' deferring to other doctors and the complete absence of any sign—other than legal jargon about "hearings"—that the independent ought to adopt a different posture, it would be remarkable if the independent psychiatrist were not extremely deferential. The "patient advocates" are subject to parallel constraints, and as non-physicians in an institution where power flows from credentials, they are doubly handicapped. Combine these considerations with the prerogative of the state hospital system to hire and fire "independents" or "advocates" and the likelihood of a realistic check on state hospital drug decisions appears slight indeed.

These pessimistic conclusions are borne out by the experience of hospitals and patients under Judge Brotman's decree (before the Third Circuit

¹⁵¹ *Rennie*, 476 F. Supp. at 1298, 1310.

¹⁵² See *supra* notes 50-64 and accompanying text.

¹⁵³ *Rennie*, 476 F. Supp. at 1314.

¹⁵⁴ *Rennie*, 653 F.2d at 851.

¹⁵⁵ See *Rennie*, 462 F. Supp. at 1148.

overturned it¹⁵⁶ in July, 1981). The independent psychiatrists' "opinions," which Judge Brotman envisioned as reflective, revealing documents that would address patients' medical and constitutional interests, were in fact checkmarks on a hospital-supplied pre-printed form with, in most cases, a few scribbled sentences added.¹⁵⁷ The independents saw themselves as consultants reporting to treating physicians; it was customary, therefore, for their remarks to be styled as "recommendations." Beyond considerations of form, the sample of "opinions" I was able to examine¹⁵⁸ reflected the usual bias in favor of drugging. For example one of the very few independents to write an "opinion" as long as three-quarters of a page began his remarks as follows: "Patient is an eighteen year old white female who is contradicting her need for medication." Not infrequently, the independent recommended higher dosages than the hospital thought advisable. There was also a tendency for the independents to suggest adding more drugs—the independent's own preference plus the treating doctor's choice, even though polypharmacy is generally frowned upon. In one instance the patient was taking the neuroleptic Haldol and the independent "recommended" the addition of two drugs of a different class one of which, Lithium, is reported to be possibly toxic in combination with Haldol.¹⁵⁹ This course was recommended because "pt. [patient] may be salvagable [sic]."

Judging from their reports, the independents were hardly concerned with side effects—these generally were not remarked upon—but in a few cases, where independents took the trouble to provide some background information, patient reactions were in some fashion mentioned. These cases give a sense of how little patient distress ever weighed with the best and most careful of the independents.

Judge Brotman had observed that drug refusers are often threatened with Prolixin,¹⁶⁰ which is notorious because it causes the most pronounced side effects. Not surprisingly, many patients the independents saw were receiving Prolixin; but no independent recommended a change to a less obnoxious drug. As for individual side effects, one retarded, lobotomized patient was rigid and drooling; the independent "recommended" a drug that often alleviates those symptoms, but did not insist on it and did not explore the hospital's failure to take that simple step. Thus, doctors could continue drugging as before if they so chose. Signs of tardive dyskinesia were tentatively noted in a few cases, but that issue was not explored and consistent with past hospital practice there was no firm diagnosis or mandatory follow-up. The independent simply recom-

¹⁵⁶ *Rennie*, 653 F.2d 836.

¹⁵⁷ Sample of Independent Psychiatrists' Reports, *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979).

¹⁵⁸ *Id.*

¹⁵⁹ 1983 PHYSICIANS' DESK REFERENCE 1756.

¹⁶⁰ *Rennie*, 476 F. Supp. at 1304.

mended evaluation by the hospital doctors.¹⁶¹ In another instance the independent himself casually evaluated a possible tardive dyskinesia case without bothering to use standard instruments or to take the elemental step of mandating a brief drug-free period. (True tardive dyskinesia symptoms are briefly exacerbated by drug withdrawal, and this is a means of testing for the disorder.)

These desultory exercises did not succeed in airing drug issues, assuring patient dignity, or even adding to hospital deliberateness. They were hardly what Judge Brotman envisioned and seem to have contributed little besides weak, sometimes harmful recommendations which the hospitals in all likelihood ignored.

The independents' performance was paralleled by that of the patient advocates, whose role under the *Rennie* decree was to see that doctors acknowledged patient refusals and set the review machinery in motion. As noted previously, hospitals had bypassed the pre-*Rennie*, self-imposed review system by the simple expedient of not admitting that drugs were being forced.¹⁶² It appears that the same practices continued. Indeed, by the time the Third Circuit vacated Judge Brotman's injunction, this system of over 4,000 patients was holding four "independent" drug reviews per month—and it appears that many hospitals and wards reported no refusals at all.¹⁶³

In sum, the *Rennie* decree was unlikely to succeed because of its limited vision of the drug problem. More information would be desirable, but the decree's implementation was never studied. Thus, from all that is known, the *Rennie* decree accomplished little.¹⁶⁴

¹⁶¹ In these three cases I have seen the independent's "opinion" but do not have those documents in my possession. Nor, to my knowledge, are they part of the public record.

¹⁶² See *supra* note 113 and accompanying text.

¹⁶³ Motion for Leave to File and Brief For the New Jersey Department of the Public Advocate, Division of Mental Health Advocacy as Amicus Curiae In Support of Respondents at 3C, *Mills v. Rogers*, 457 U.S. —, 102 S. Ct. 2442 (1982).

¹⁶⁴ Professor Brooks has maintained that Judge Brotman's decree "significantly improved" the "administration of medication" in that "[t]here is much less medication being used . . . [and] fewer side effects" in New Jersey state hospitals. Brooks, *supra* note 13, at 213. "Nor have these improvements been accomplished at any significant cost to treatment values," Brooks argued, since "treatment itself has improved" and no "substantial additional burdens [have] been placed on treatment personnel." *Id.*

I draw quite different conclusions because of the independents' and advocates' documented performance; indeed, Professor Brooks expressed doubts on those same points. *Id.* at 199-201, 213. However, if the advocates and independents fail, the decree as a whole fails with them. For information, Brooks seems to have relied on informants in the Department of Mental Health, an organization whose knowledge—and/or candor—about drugging has been consistently minimal. See, e.g., *id.* at 214. Thus hospital informants, based on their previous performance, can hardly be relied upon. Like all students of the subject, Professor Brooks is handicapped because no serious study of the *Rennie* decree—via litigation discovery or otherwise—was ever undertaken. For what it is worth, informants known to me suggest that the decree was unsuccessful in practice.

CONCLUSION

Each of the four remedies studied is flawed by an overly-limited vision of drugging problems. Medical deliberateness, hospital peer review, and continuing medical education do not respond to what is actually wrong in the hospitals, since carelessness, lack of medical consultation, and physician ignorance cannot account for the drugging practices noted in Part II.

Guardianship remedies on the *Rogers* district court model are not promising because they fail to air drug issues, they are cumbersome, and—like medical remedies—they ignore the actual methods of physician overreaching. The least of what state physicians do wrong is override drug refusals by competent patients.

Proposals to restrict commitment to incompetent, druggable patients at viable treatment institutions 1) shift drugging problems to other social contexts without resolving them; 2) mistakenly regard physician competence as a guarantee of just drugging; and 3) create powerful incentives for judges, lawyers, and the public to overlook or disregard or make light of drug-caused harms.

Judge Brotman's *Rennie* decree—though in my opinion a most thoughtful attempt to resolve these issues—is flawed because state physicians' obeisance to the principle of drugging the mentally ill regardless of side effects is responsible for drugging abuses, rather than the hospital allegiances that Judge Brotman cited.

If there is to be a right against state hospital overreaching via drugs, other remedies—which reach more deeply into the structure of state psychiatry—will be required to enforce it.

APPENDICES

As demonstrated by Dr. Crane's investigations and hospital surveys,¹⁶⁵ New Jersey doctors rarely took official notice of the symptoms of tardive dyskinesia. However, the *Rennie* record includes a number of cases where, due to unusual circumstances, doctors did briefly take notice, but then attributed the patient's movements to "faking" or "mental illness." Three such patient episodes are summarized below.

A. *Elsie Sinke*¹⁶⁶

Mrs. Sinke was a sixty-six-year-old, long-time mental patient whose mouth and tongue were constantly writhing¹⁶⁷ from an obvious case of tardive dyskinesia. Her abnormal movements "jumped right out at

¹⁶⁵ See *supra* notes 68-70 and accompanying text.

¹⁶⁶ Although she is not identified by name, see *Rennie*, 476 F. Supp. at 1031, for Judge Brotman's findings as to Mrs. Sinke.

¹⁶⁷ Joint Appendix, *supra* note 38, at 2141a, 2144a, 2166a.

you,"¹⁶⁸ in the words of one *Rennie* expert witness.

Mrs. Sinke saw a hospital neurologist in 1975 because of her own complaints about "difficulty in swallowing and talking."¹⁶⁹ The referring doctors had noted that she exhibited "central facial weakness,"¹⁷⁰ a cryptic observation that was as far as doctors would go in acknowledging her drug-caused symptoms.

The neurologist reported that Mrs. Sinke's movements were in the "classical tardive dyskinesia pattern."¹⁷¹ Thus he did not commit himself to any diagnosis, but simply reported what he saw. This report, which was truly remarkable because it mentioned the words "tardive dyskinesia" (no patient record called to the court's attention by either side in *Rennie*, other than Mrs. Sinke's, contained the words), was then lost or ignored. Drugging continued.

Thirteen months later, Mrs. Sinke was referred again to the neurologist, probably because of her own continued complaints.¹⁷² Her documented, severe symptoms had been ignored for this entire period. The neurologist responded to the referral by sending ward physicians another copy of his original report which they duly filed without referring to its findings.¹⁷³

Fourteen more months passed and still another ward physician, new to her case, referred Mrs. Sinke to the hospital neurologist; the previous findings had been forgotten.¹⁷⁴ Perhaps in frustration, the neurologist replied that the patient had tardive dyskinesia.¹⁷⁵ Since Mrs. Sinke's case was the only one in which the diagnosis was made, it provides a unique insight into the hospital's response to documented tardive dyskinesia.

Less than a year later, doctors set about forcing neuroleptics on the unwilling Mrs. Sinke.¹⁷⁶ Without any further neurological referral, they diagnosed her tardive dyskinesia as "faking"¹⁷⁷ and proceeded to drug her. The hospital did not hesitate to acknowledge the fact of her movements, however, in explaining why she was dentureless: "The patient, according to her, has been unable to control her mouth movements and a denture fitting has been impossible."¹⁷⁸

¹⁶⁸ *Id.* at 2160a.

¹⁶⁹ *Id.* at 2144a-45a.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 2147a.

¹⁷² *Id.* at 2145a.

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 2146a.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 2148a.

¹⁷⁷ *Id.* According to plaintiffs' expert witness, Mrs. Sinke's movements were too "gross" to be feigned. *Id.* at 2149a.

¹⁷⁸ *Id.*

B. Annibale Ricuitti

Mr. Ricuitti was a fifty-three-year-old man who came to the hospital in 1977 depressed over separating from his wife.¹⁷⁹ Less than two years later, Dr. Crane, the plaintiffs' expert, found him there, severely afflicted with tardive dyskinesia. His jaw, tongue, arms, legs, torso, and diaphragm all exhibited pronounced dyskinetic movements.¹⁸⁰

His doctors did not notice these movements as they developed, or so it appeared from the hospital chart. After approximately a year—it must have required some explanation why a man as harmless as Mr. Ricuitti had remained hospitalized that long—the following note was entered in his chart:

Mr. Ricuitti was seen during a team evaluation today. His bodily movements seem to be an embarrassment [sic] for him and appear to be chorealike movements. A neurological evaluation was suggested. He had quit the workshop due, he said, to his bodily movements interfering. I questioned him about being in the hospital, he said he preferred to stay here, that he didn't feel that he could handle the outside, especially with the bodily movements. He has been on shopping trips with the Social Skills Program but needs to have confidence built. . . .¹⁸¹

A physician's note for July 27, 1978 reports that the Ancora neurologist saw Mr. Ricuitti and that "it is to be recognized" that Mr. Ricuitti's problems could be "drug-induced."¹⁸² The neurologist refrained from making any diagnosis, as Mrs. Sinke's neurologist had refrained. Doctors chose to regard Mr. Ricuitti's movements as "functional"¹⁸³ in nature—that being another possibility mentioned by the neurologist—meaning that the movements were a manifestation of Mr. Ricuitti's mental illness. Accordingly, the physicians continued neuroleptic drugs.¹⁸⁴ Four months later, the Ancora hospital records no longer even acknowledged Mr. Ricuitti's dyskinetic movements; a doctor's summary of his case in November 1978 indicated that Mr. Ricuitti's "motor activity" was "normal."¹⁸⁵

Mr. Ricuitti believes that his dyskinetic movements are the result of nervousness; he does not know that neuroleptics caused them.¹⁸⁶ This is understandable when the hospital either refuses to acknowledge his movements or attributes them to mental illness. Quite understandably,

¹⁷⁹ *Id.* at 1080a (Mr. Ricuitti is referred to as patient No. 102).

¹⁸⁰ *Id.* at 1080a-81a.

¹⁸¹ *Id.* at 568b.

¹⁸² Trial Record, *supra* note 65, exhibit p-77.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ Joint Appendix, *supra* note 38, at 566b.

¹⁸⁶ Trial Record, *supra* note 65, exhibit p-77.

then, a hospital orderly wrote the following note in Mr. Ricuitti's chart one night:

Res. [resident] usually sleeps all night. He doesn't shower in A.M. He is very quiet usually only speaks when spoken to. Res. has a moving motion at times which he says is from nerves. N/C [no complaints] offered to this shift. . . .¹⁸⁷

C. John Rennie

Mr. Rennie's tardive dyskinesia was milder than Mrs. Sinke's or Mr. Ricuitti's, but Judge Brotman had urged the hospital to monitor him closely for the disorder.¹⁸⁸ Nonetheless, the hospital declined to make the diagnosis or—it appeared—to notice the movements of his tongue and jaw.

Random movements of the fingers are often precursors of more obvious tardive dyskinesia symptoms,¹⁸⁹ and Mr. Rennie had manifested these in December, 1977.¹⁹⁰ However, his doctor labelled the movements "faking"¹⁹¹—a poor attempt, she testified, at imitating a different side effect.

In subsequent months, as court hearings in the case continued, Mr. Rennie's experts¹⁹² and hospital employees who lacked authority to make chart entries noticed lip, tongue, and jaw movements. As revealed by her later testimony, one hospital employee had observed that Mr. Rennie's mouth would move in different directions and "his speech would be slurred;" there was also a "quivering, wavy-like motion of his tongue," which "sometimes" protruded from his mouth.¹⁹³ This employee had "to holler at the other patients and tell them to stop making fun of John. They would always ask what he was eating or why he was making those funny faces."¹⁹⁴ Mr. Rennie was aware of this condition too, of course. He testified in July, 1979 that:

A. I seem to a lot of times almost bite my tongue in half for no conscious reason. I just do it all of a sudden. I just seem to just—my tongue gets bit and my tongue is all chewed up at times.

Q. What about your jaw? Does that move?

A. I don't know if it moves much but the fact that I have to

¹⁸⁷ *Id.*

¹⁸⁸ *Rennie*, 462 F. Supp. at 1141, 1153.

¹⁸⁹ AMERICAN PSYCHIATRIC ASSOCIATION, TARDIVE DYSKINESIA—REPORT OF THE APA TASK FORCE ON LATE NEUROLOGICAL EFFECTS OF ANTI-PSYCHOTIC DRUGS, 23 (1979).

¹⁹⁰ Trial Record, *supra* note 65, Transcript of Testimony Volume III at 148 (testimony of Dr. Bugaoan).

¹⁹¹ *Id.*

¹⁹² Joint Appendix, *supra* note 38, at 1080a, 1318a (testimony of Dr. Crane and Dr. Dyson).

¹⁹³ *Id.* at 131b (testimony of Mrs. Suelto).

¹⁹⁴ *Id.* at 137a.

grind my teeth, I bit my tongue a lot. That there frightens me.

Q. Now, going back in time, was there a time when your jaw moved more than it does now?

A. Yes. I mean a time when people were constantly asking me for chewing gum or something like that because they thought I was chewing, you know, and it was just the unconscious movement of my jaws. . . . In fact, sometimes, especially small children, two and three and four-year olds, would ask me for gum, so I knew they were seeing something that was [obvious to] . . . a small kid.¹⁹⁵

The attitude of Ancora physicians was described by a hospital nurse who herself had observed "obvious" movements.¹⁹⁶ After Mr. Rennie's attorneys had discussed the problem with her, she spoke with the treating physician, Dr. Balita. But Dr. Balita would not acknowledge anything:

He [Dr. Balita] listen. . . [ed] to me and it was after a team meeting. He had been there. I think in my mind I felt he saw [Mr. Rennie's movements]. If he didn't see it, he didn't say he didn't see it. He didn't say he did see it. We just—I just said it to him and we left the room.¹⁹⁷

Dr. Balita never admitted the existence of Mr. Rennie's symptoms.

Nonetheless, Mr. Rennie had received especially close scrutiny from the hospital because of his position in the litigation and Judge Brotman's admonitions. Each week throughout 1979, the medical director examined him. However, the medical director consistently reported that Mr. Rennie showed no abnormal movements.¹⁹⁸

There was a second school of thought among hospital doctors, however. This view held that Mr. Rennie did display tardive dyskinesia-like movements, but that he was faking.¹⁹⁹ No acknowledgement of movements was recorded in the chart, however; Ancora physicians only discussed this possibility among themselves.²⁰⁰

The mental hospital had a third alternate position: Mr. Rennie displayed movements, and he was not faking. His movements, according to this view, resulted from mental illness or psychological difficulties.²⁰¹

In his testimony, the hospital medical director spoke of these inconsistent positions as viable alternatives: "If there were abnormal movements, they . . . could have been a number of other things. . . ." ²⁰² "I felt that if

¹⁹⁵ *Id.* at 1211a-12a.

¹⁹⁶ *Id.* at 124b.

¹⁹⁷ *Id.* at 1363a-64a.

¹⁹⁸ *Rennie*, 476 F. Supp. at 1302.

¹⁹⁹ Joint Appendix, *supra* note 38, at 1343a.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.* at 1342a.

he were doing these movements or whatever it was part of his psychological difficulties."²⁰³

Upon cross-examination, it developed that the medical director had seen strange movements all along, despite his chart entries to the contrary.²⁰⁴ When the medical director wrote, week after week, that there were "no abnormal movements," he meant that there *were* bizarre movements, but neuroleptic medication did not cause them.²⁰⁵ What the director actually saw was "the equivalent of a grimacing movement" by Mr. Rennie.²⁰⁶ "[A] movement that would be as if he had silent speech; movements similar . . . [to] the way some persons when they read they almost mouth the words that they are reading."²⁰⁷ He then testified that these movements were not symptoms of tardive dyskinesia.²⁰⁸

The medical director was wrong. Grimacing and mouth opening are classical symptoms of tardive dyskinesia.²⁰⁹ Furthermore, the director claimed to have performed the so-called "AIMS" examination of Mr. Rennie.²¹⁰ This involves looking at the examinee and rating him for the presence and severity of movements that are listed on a form. This AIMS form includes mouth opening and grimacing among the symptoms of tardive dyskinesia.²¹¹ However, Dr. Pepernik (the medical director) found Mr. Rennie negative on all aspects of the AIMS examination.

Mr. Rennie received a second AIMS examination on June 6, 1979—one week before Dr. Crane found a mild-to-moderate dyskinesia.²¹² This AIMS examination was negative; it disclosed no grimacing, no mouth opening, and none of the movements that Dr. Crane found and that the medical director in fact saw. No one signed that AIMS examination. On a form specifically prepared for the litigation, an Ancora doctor later explained that he disagreed with Dr. Crane's observations about Mr. Rennie because the patient "was seen on 3 occasions in June, 1979 by Dr. Pepernik and no evidence of abnormal involuntary movements noted by Dr. Pepernik."²¹³

EPILOGUE

I had completed work on this article when the Supreme Judicial Court

²⁰³ *Id.* at 1343a (emphasis added).

²⁰⁴ See *supra* note 198.

²⁰⁵ Joint Appendix, *supra* note 38, at 2307a-08a.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.* at 2308a.

²⁰⁹ Joint Appendix, *supra* note 38, at 746b-47b (A.I.M.S. form).

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² Trial Record, *supra* note 65, exhibit J-1 (Mr. Rennie's hospital chart).

²¹³ *Id.* exhibit D-70 (hospital reports).

of Massachusetts decided *Rogers* in December, 1983.²¹⁴ This latest *Rogers* opinion deserves notice because it appears to be the most far-reaching of the "right-to-refuse-drugs" decisions.

Starting from the premise that competent state mental patients can refuse neuroleptic drug treatment,²¹⁵ Justice Abrams went on to decide that: 1) a judge—not an affiliated or even an "independent" physician—must ordinarily adjudicate hospital challenges to patient competence; 2) as a general rule, a patient adjudicated incompetent must be allowed to refuse drugs, and indeed is barred from accepting drug treatment,²¹⁶ unless the judge also determines that the patient, if competent, would have consented to drugs (the "substituted judgment" test); 3) notwithstanding (1) and (2) above, for a brief period drugs may be forced upon a patient "whom doctors, in the exercise of their professional judgment believe to be incompetent"²¹⁷ if drugging promises to "avoid the immediate, substantial and irreversible deterioration of a serious mental illness,"²¹⁸ provided that "if the patient objects" to continued drugging doctors must then obtain an adjudication of incompetence and a judge's "substituted judgment" decision; 4) in addition, drugs may be forced on patients to prevent violence or maintain hospital order, but in such cases "drug treatment is being administered for the benefit of others,"²¹⁹ constitutes chemical "restraint," and can be imposed only if: a) "a patient poses an imminent threat of harm to himself or others,"²²⁰ b) no "less intrusive alternative"²²¹ exists; and c) the statutory requirements of careful documentation and medical monitoring are satisfied.

This approach resembles the "guardianship" remedies described in Part III.²²² The main practical differences are 1) a judge, rather than a guardian, makes the drugging decision on behalf of the incompetent patient; and 2) the judge must employ the "substituted judgment" test. Of course, those who find simple guardianship remedies too cumbersome will object even more strongly to the Supreme Judicial Court's decision, with its "two-stage" legal procedure and its frank acknowledgement of values higher than medical cure. At the same time, critics of the informality of

²¹⁴ See *supra* note 1. *Rogers* was determined in the Massachusetts Supreme Judicial Court pursuant to the certification of nine questions by the United States Court of Appeals for the First Circuit. The certified questions dealt with the standards and procedures under Massachusetts law for medicating involuntarily committed patients with antipsychotic drugs.

²¹⁵ *Mills v. Rogers*, No. S-2995, slip. op. at 12 n.15 (Mass. Sup. Jud. Ct. Dec. 15, 1983).

²¹⁶ *Id.* at 12 n.14.

²¹⁷ *Id.* at 29.

²¹⁸ *Id.* quoting *Guardianship of Roe*, Mass. Adv. Sh. 981, 1008 (Sup. Jud. Ct. 1981).

²¹⁹ *Id.* at 25.

²²⁰ *Id.* at 27.

²²¹ *Id.*

²²² See *supra* notes 105-19 and accompanying text.

guardians' decisions,²²³ or the vulnerability of guardians to hospital suasion and threats,²²⁴ will find "substituted judgment" determinations a distinct improvement. In terms of this article's classification of remedies, this one, like simple guardianship proposals, is atomistic. Here however, the social atom belongs to the world of citizens' relations to other citizens, not doctors' relations to patients. The court here is plumbing civic obligations, not medical ethics.

The test of the Massachusetts remedy will come in its actual application. The day-in-day-out ability of judges to resist deferring to mental hospital decision-making will be crucial. However, it is not premature to point out that this remedy has some of the potentially crippling flaws of a simple guardianship system. Only patients that the hospital acknowledges as drug refusers receive any protection, and as pointed out above, hospitals generally ignore patient reluctance about, or outright resistance to, drugging.²²⁵

Moreover, a "patient's acceptance of antipsychotic drugs ordinarily does not require judicial proceedings."²²⁶ After a patient has been adjudicated incompetent—that is, after an actual period of drug refusal that the hospital is willing to acknowledge—"a substituted judgment by a judge should be undertaken for the incompetent patient even if the patient accepts medical treatment."²²⁷ But incompetent drug acceptances go entirely unchecked unless a patient has first incompetently refused and the hospital has pursued incompetency proceedings. This distinction between equally incompetent drug refusers is difficult to justify on its merits and will have the added effect of further discouraging hospitals from acknowledging patient drug refusers. Moreover, not all acknowledged acts of drug refusal lead to court proceedings. Under the *Rogers* decision, as noted above, doctors can forcibly drug patients to prevent "immediate, substantial and irreversible deterioration of a serious mental illness." In that event, court proceedings are required *only* if "the patient objects" *after* the initial course of drugs. This represents a large loophole, however. The length of that initial course of drugging is open to question. Many doctors believe that a single moment of drug-free life invariably threatens the requisite degree of deterioration in health. Patients would be warranted in doubting their rights to refuse drugs after such an initial show of force by the hospital.

A vociferous patient blessed with competent counsel may overcome these obstacles and enjoy the benefits of *Rogers*, such as they are. However, few patients harmed by drugs will be so fortunate.

²²³ See *supra* note 242.

²²⁴ *Id.*

²²⁵ See *supra* notes 242-43.

²²⁶ *Rogers*, slip. op. at 12 n.14.

²²⁷ *Id.*

