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"Just Say No!": The Right to Refuse Psychotropic Medication in Long-Term Care Facilities

*George P. Smith, II**

I. INTRODUCTION AND OVERVIEW

In early October 2002, the State of New York sought to end a six-year-old practice that had been in place and was designed to lower its large economic investment in psychiatric hospital care: namely, discharging patients to secure or locked units in private nursing homes.¹ With its annual cost of maintaining a patient in a psychiatric hospital having risen to approximately \$120,000, New York decided that it would be more cost-effective to move the mentally disabled to special units within nursing homes where its share of support would be \$20,000.² Federal funds would absorb the remainder through the Medicaid program.³

The economic success of this plan is indisputable. The number of occupied beds in state psychiatric hospitals dropped from 9000 in 1995 to its present level of 4300,⁴ which resulted in saving of tens of millions of dollars.⁵ Critics of this policy have raised civil rights concerns, citing the virtual imprisonment of the patients and their restricted ability to contest confinement.⁶ Prompted by this criticism, the United States Department of Justice is evaluating whether such levels of confinement violate the Civil Rights of Institutional Persons Act.⁷ The situation in New York dramati-

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1. Clifford J. Levy, *Hospitals Will Stop Sending Mentally Ill to Nursing Homes*, N.Y. TIMES, Oct. 19, 2002, at A1. See generally George P. Smith, II, *Patient Dumping: Implications for the Elderly*, 6 ELDER L.J. 165 (1998).

2. Levy, *supra* note 1.

3. *New York's Mentally Ill Deserve Better*, N.Y. TIMES, Oct. 9, 2002, at A26.

4. *Id.*

5. Levy, *supra* note 1.

6. *Id.*

7. Associated Press, *Housing of Mentally Ill in Nursing Homes Questioned*, HOOSIER TIMES, Oct. 13, 2002, at A5, available at <http://www.heraldtimesonline.com>.

cally illustrates the scope of the major issues confronting nursing homes. Specifically, it illustrates the following issues: whether the deliverance of psychiatric care to nursing homes safeguards the best interests of the residents; whether it protects their civil rights to decline various levels of treatment administered; and, whether this goal is achieved within a cost effective administrative framework.

Each year more than 1.5 million individuals are admitted to nursing homes in the United States.⁸ In 1997 there were more than 17,000 nursing homes with over 1.7 million beds.⁹ In 1998, the Health Care Financing Administration reported to Congress that residents of nursing homes in America were continuing to suffer from inadequate care and neglect.¹⁰

With the precipitous increase in the elder population nationwide, problems peculiar to the elderly have demanded increased attention and resources from policy-makers and their constituents.¹¹ In response to this situation, Congress has recognized the importance of devising strategies to implement a policy of protecting the rights of residents of long-term care facilities. One congressional solution, developed and subsequently incorporated by amendment into the Older Americans Act of 1965, provides for the establishment of a long-term care ombudsman¹² program by any state re-

8. Angela S. Quin, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Deterring Inadequate Health Care and Improving the Quality of Care Delivered?*, 43 ST. LOUIS U. L.J. 653, 654 (1999). See also ADMIN. ON AGING, U.S. DEPT. OF HEALTH & HUMAN SERVS. (DHHS), A PROFILE OF OLDER AMERICANS: 2001 (2001) (noting that the percentage of Americans over sixty-five years of age or older has more than tripled since 1900 and is expected to more than double by 2030), available at http://www.research.aarp.org/general/profile_2001.pdf. See also Heidi Boerstler & Scott W. Nolte, *Colorado Nursing Homes: Litigation and Public Policy Issues Concerning Abuse and Neglect*, 29 COLO. LAW 93, 93 (2000) (noting that an estimated forty-four percent of all Americans will be forced to spend some amount of time in a long-term care facility during their lifetime).

9. Quin, *supra* note 8, at 654.

10. DHHS, HEALTH CARE ADMINISTRATION FACT SHEET: ASSURING THE QUALITY OF NURSING HOME CARE (June 21, 1998), at <http://www.hhs.gov>. See also Boerstler & Nolte, *supra* note 8, at 93 (noting that it has been projected that the number of nursing homes is likely to grow by 400% in the next thirty years).

11. Audrey S. Garfield, *Elder Abuse and the States' Adult Protective Services Response: Time for a Change in California*, 42 HASTINGS L.J. 859, 861 (1991).

12. See BLACK'S LAW DICTIONARY 1115 (7th ed. 1999) (defining ombudsman as an "official appointed to receive, investigate, and report on private citizens' complaints about the government"). See also P.S. Atiyah, *Tort Law and the Alternatives: Some Anglo-American Comparisons*, 1987 DUKE L.J. 1002, 1033-35, 1042 (1987). This article discusses how other countries have made greater use of this type of office as a means of resolving claims outside the court system. For example, in Britain an ombudsman functions as a grievance commissioner with investigatory powers. *Id.* at 1033. This office made its first appearance in Britain in the field of public administration as a result of a perceived need to protect private citizens against government mal-administration. *Id.* In Britain, an ombudsman now assists in the resolution of private disputes in the areas of banking, insurance, and nuisance law. *Id.* at

ceiving federal funds under Title III of the Act.¹³ Thus, Congress made the receipt of significant amounts of federal funds conditional on a state's development and adherence to a comprehensive plan in compliance with the Act.¹⁴ Congress incorporated another proposed solution in The Omnibus Budget Reconciliation Act of 1987 (OBRA '87).¹⁵ OBRA '87 included extensive revisions to the statutory Medicare and Medicaid requirements for long-term care facilities.¹⁶

This article will examine the provisions of OBRA '87, surveying the case law that deals with the rights of patients in mental institutions to refuse psychotropic medication. It will first focus on the different substantive and procedural rights afforded to patients under state common law, state constitutions, and the Federal Constitution. Then, it will proceed to evaluate the long-term impact of OBRA '87 on the rights of long-term care patients, who refuse medication, to minimal administrative hearings instead of to full judicial proceedings. Finally, this article will evaluate the Long-Term Care Ombudsman Amendments to the Older Americans Act of 1965 concluding that, unlike OBRA '87, the amendments articulate no right or cause of action. Thus, their effect is only discernable with respect to state decisions that have implemented provisions as a condition for the receipt of federal funding.

The conclusion to be drawn is that more legislative fine-tuning must be undertaken if the elderly in America are to be guaranteed protection of their dwindling bundle of rights. At best, federal and state reforms here are seen

1042.

13. See 42 U.S.C. § 3021(c) (1990), *amended by* Pub. L. 102-375 (1992) (substituting "in accordance with section 3058g of this title, and to individuals within such programs designated under section 3058g of this title" for "and to individuals designated under such section"), Pub. L. 103-171 (1993) (substituting "Assistant Secretary" for "Commissioner" wherever appearing), Pub. L. 106-501, § 801(c)(1) (2000) (substituting "3027(a)(9)" for "3027(a)(12)"); 42 U.S.C. § 3027(a)(12)(A) (1990), *amended by* Pub. L. 102-375 (1992) (restructuring paragraph (12)), Pub. L. 103-171 (1993) (substituting "Assistant Secretary" for "Commissioner" wherever appearing), Pub. L. 106-501, § 306(5), (6) (2000) (redesignating paragraph (16) as (12) and striking out former paragraph (12), and substituting new paragraphs for paragraph (8) and (9)). See also 42 U.S.C.A. § 3021(c) (West 2003); 42 U.S.C.A. § 3027(a) (West 2003). See generally Lisa T. Evren, *Longterm-Care Ombudsmen: A National Survey of Their Views*, GENERATIONS, Summer 1987, at 43.

14. See § 3021(c); § 3027(a)(12)(A). Congress employs this method in many other areas, essentially conditioning a grant of federal funds upon the recipient state or entity's agreement to comply with a regulatory framework. See, e.g., 42 U.S.C. § 1396 (2000) (providing for the reimbursement of patient's expenses at a nursing home through Title XIX of the Social Security Act, commonly known as Medicaid).

15. See The Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, 101 Stat. 1330-275.

16. See generally Medicare and Medicaid; Requirements for Long Term Care Facilities, 54 Fed. Reg. 5316 (1989) (codified at 42 C.F.R. §§ 405, 442, 447, 483, 488-89, 498).

as imbalanced and, in part, erratic. Even with civil monetary penalties, violations by nursing homes continue. Current OBRA '87 regulations are deficient in that they do not provide any civil remedies to residents for non-compliance.¹⁷

Due to the psychosociogenic and pathophysiologic changes occurring with age, prescribing drugs for the elderly is far different from prescribing for other members of society.¹⁸ In addition to other mental problems, depression is often associated with, and attributable to, elderly patients taking multiple drugs ("polymedication"), which complicate and worsen their conditions.¹⁹ A lack of knowledge of pharmacogeriatrics by physicians also increases the risk of side effects for elderly patients.²⁰

Antipsychotic drugs, commonly referred to as psychotropic or neuroleptic, are often used for the treatment of severe mental disorders.²¹ Their effects are both positive and negative, for they not only reduce the symptoms of the various disorders for which they are administered (e.g., schizophrenia) but also undercut individual willpower and therefore often subject patients to levels of custodial control.²² For this reason, the common law right of informed consent (or here, the right to refuse unwanted medical treatment) is crucial to safeguarding a patient's civil rights. The right to refuse this modality of treatment varies from jurisdiction to jurisdiction.²³ In California, for example, the right is grounded in statutory law, which guarantees

17. See Ellen J. Scott, *Punitive Damages in Lawsuits Against Nursing Homes*, 23 J. LEGAL MED. 115, 116 (2002). See also Jennifer N. Phan, Comment & Note, *The Graying of America: Protecting Nursing Home Residents by Allowing Regulatory and Criminal Statutes to Establish Standards of Care in Private Negligence Actions*, 2 HOUS. J. HEALTH & POL'Y 297 (2002). See generally GEORGE P. SMITH, II, LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY (Joyce Duncan & Holly Seltzer eds., 1996).

18. James A. Jernigan, *Update on Drugs and the Elderly*, 29 AM. FAM. PHYSICIAN 238, 238 (1984).

19. Tina M. Champion, *The Elderly Suing Doctors: Reasons and Recovery*, 12 ALB. L.J. SCI. & TECH. 895, 900 (2002). See also Ann Kahl et al., *Geriatric Education Centers Address Medication Issues Affecting Older Adults*, 107 PUB. HEALTH REP. 37, 38 (1992). See generally Michael D. Greenberg, *Treatment Implications of Psychiatric Comorbidity*, in FROM PLACEBO TO PANACEA: PUTTING PSYCHIATRIC DRUGS TO THE TEST 57 (Seymour Fisher & Roger P. Greenberg eds., 1997).

20. Jernigan, *supra* note 18, at 241; Champion, *supra* note 19, at 900.

21. David E. Gross, *Presumed Dangerous: California's Selective Policy of Forcibly Medicating State Prisoners with Antipsychotic Drugs*, 35 U.C. DAVIS L. REV. 483, 484 & n.1 (2002) (citing *Riese v. St. Mary's Hosp. & Med. Ctr.*, 209 Cal. App. 3d 1303, 1310 (1987) (defining antipsychotic drugs)).

22. *Id.* at 484. See also ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 109 (2002) (noting that psychotropic drugs are commonly seen as "mind-altering" and "thought-suppressing," making them highly suspect, while contrary opinion holds that the drugs achieve psychological normalization).

23. Gross, *supra* note 21, at 486. See generally Marshall B. Kapp, *Nursing Home Restraints and Legal Liability*, 13 J. LEGAL MED. 1 (1992).

to patients a judicial hearing in order to determine their competency to refuse medication administered by the state.²⁴ Until 2000, there had been no question that this right also extended to state prisoners challenging orders to administer antipsychotic medication.²⁵

However, in a challenge to the constitutionality of a prisoner's right of refusal, the California Court of Appeal determined in April 2000 that prisoners who are found not guilty by reason of insanity, and subsequently committed, no longer have a right to such a competency hearing.²⁶ The court held that the initial verdict constitutes a determination of dangerousness, which thereby precludes a right to a judicial hearing.²⁷

In seeking to protect the safety of its citizens, the State is often allowed to compromise the interests of the individual in order to protect the public good.²⁸ It is for this very reason—a need for protection—that justification for forcible medication is found on either an emergency or dangerousness standard.²⁹

The Court of Appeals for the District of Columbia was recently confronted with a unique issue: could the government forcibly medicate a mentally ill criminal defendant in order to render him competent to stand trial for murder without violating the Fifth Amendment's Due Process clause?³⁰ The court held in the affirmative, declaring that the government may medicate such an unwilling defendant if, and only if, the defendant has been charged with a serious (e.g., dangerous) crime and the medication is necessary to render him competent to stand trial.³¹

24. CAL. PENAL CODE § 2600 (West 2000); CAL. WELF. & INST. CODE § 5332(b) (West 1998 & Supp. 2003).

25. CAL. PENAL CODE § 2600.

26. *In re Locks*, 79 Cal. App. 4th 890, 892, 897 (2000).

27. *Id.* at 896-97.

28. See *Goldblatt v. Town of Hempstead*, 369 U.S. 590, 593 (1962) (discussing state protection of public interests in the context of eminent domain proceedings). See generally Penney Lewis, *Procedures That Are Against the Medical Interests of Incompetent Adults*, 22 OXFORD J. LEGAL STUD. 575, 609-10 (2002) (discussing state action in determining levels of burdens that can be imposed on incompetent subjects of therapeutic versus non-therapeutic research).

29. See *Cochran v. Dysart*, 965 F.2d 649, 650 (8th Cir. 1992). See also SAKS, *supra* note 22, at 3 (noting that the key to finding a humane policy is to strike a balance between paternalism and autonomy in a rational way that does not have the effect of discriminating against the mentally ill).

30. See *United States v. Weston*, 255 F.3d 873, 874 (D.C. Cir. 2001).

31. *Id.* at 880-83. In June 2003, the Supreme Court decided the case of *Sell v. United States*, 123 S. Ct. 1274 (2003), and sought to resolve the issue of forcibly medicating a defendant too mentally ill to stand trial. See 123 S. Ct. at 2178. Writing for the majority, Justice Stephen G. Breyer found involuntary medication, by use of antipsychotic drugs, to be valid constitutionally if it furthered significantly an "important" government objective. *Id.* at 2185. Specifically, the drugs must be "substantially likely" to render the defendant compe-

The final rules for the application of OBRA '87, promulgated by the Department of Health and Human Services in 1991, raised expectations of sweeping reform in the nursing home industry.³² The final rules ranged from the implementation of Congressional intent to protect the rights of nursing home residents to freedom from "any physical or chemical restraints imposed for purposes of discipline or convenience."³³ The regulations clarify that freedom from restraint also encompasses the resident's right to refuse treatment.³⁴ This seemingly broad mandate defers to state law in one important respect: in the case of a resident determined to be incompetent under state law, an individual is appointed by the State to exercise the rights of the resident and to act on his behalf.³⁵ Moreover, in response to public comments, the agency further clarified that it defers entirely to state law regarding the degree of process necessary to deprive a patient of these rights, "tak[ing] into account the fact that gradations of incapability exist to which the States have adopted . . . graduated remedies."³⁶

Although OBRA '87 enumerates specific rights for nursing home residents, it leaves to the states the task of selecting the residents to whom they are due. Therefore, the applicability of OBRA '87 to a specific resident refusing treatment is contingent on whether the individual has been deemed competent to do so as a matter of state law.³⁷

tent and "substantially unlikely" to produce effects that interfere with a defendant's ability to receive a fair trial. *Id.* at 2184-85. These rules would apply to trial-competency determinations "whether the offense is a serious crime against the person or a serious crime against property." *Id.* Procedures for balancing the new criteria are notably absent in the Court's decision. See generally Stephan Beyer, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs* ch. 7, in 2 ETHICAL, LEGAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD (George P. Smith, II ed., 1982).

32. Cf. Don Colburn, *Untying the Elderly; New Rules Seek to Limit Overuse of Restraints in Nursing Homes*, WASH. POST, Feb. 12, 1991, at Z7 ("The issue of physical and chemical restraints . . . is 'a key to unlock the bad box we've been in' with nursing homes 'and to open up the door to a whole new approach, where a person is viewed as someone with life to live.'"), available at 1991 WL 2156413.

33. 42 U.S.C. § 1395i-3(c)(1)(A)(ii) (2000). See also 42 U.S.C.A. § 1395i-3(c)(1)(A)(ii) (West 2003). A "Bill of Rights" for nursing home patients was also enacted under OBRA '87, mandating care facilities to refrain from using "verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion." See 42 C.F.R. § 483.13(b) (2003). Another section sets out minimum "quality of life" standards, requiring that each facility "must provide a safe, clean, comfortable, and homelike environment." See 42 C.F.R. § 483.15(h)(1) (2003).

34. 42 C.F.R. § 483.10(b)(4) (2003).

35. 42 U.S.C. § 1395i-3(c)(1)(C); 42 C.F.R. § 483.10(a)(3). See also 42 U.S.C.A. § 1395i-3(c)(1)(C).

36. Medicare and Medicaid; Requirements for Long Term Care Facilities, 54 Fed. Reg. 5316, 5320 (codified at 42 C.F.R. §§ 405, 442, 447, 483, 488-89, 498), available at 1989 WL 280638.

37. See Scott, *supra* note 17, at 116.

II. THE SOURCE OF THE RIGHT TO REFUSE: THE COMMON LAW AND THE CONSTITUTION

A. Substantive Rights

In *Davis v. Hubbard*,³⁸ the United States District Court for the Northern District of Ohio outlined the issues and arguments that subsequent courts would examine in grappling with the issue of whether patients in a state mental hospital have a right to consent to the administration of medication.³⁹ The court concluded that the State did not have the unlimited power to administer psychotropic medication "to all persons confined in institutions for the mentally ill without limitation."⁴⁰

In an action challenging conditions at the Lima State Mental Hospital, plaintiffs asserted that the State must obtain a patient's informed consent before subjecting him to psychotropic drugs.⁴¹ In support of this argument, plaintiffs claimed that the compulsory treatment implicated three legal rights: (1) the patient's interest in bodily integrity and personal dignity; (2) the patient's interest in independent decision-making; and, (3) the patient's interest in maintaining his ability to think and communicate freely.⁴²

38. 506 F. Supp. 915 (N.D. Ohio 1980).

39. *Id.* at 925. See James A. King, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 OHIO ST. L.J. 1135, 1150 (1987) (arguing that a qualified right to refuse treatment is more consistent with the mental health system as a whole). See also SAKS, *supra* note 22, at 95-109 (analyzing the typical motives for refusal, presented in Table 1 on page 97; also pointing out that health care providers often surmise that disturbed patients' reasons for refusing psychiatric are tainted by mental illness and thus invalid, even though these reasons are essentially the same as those that patients with physical illnesses provide).

40. *Davis*, 506 F. Supp. at 937.

41. *Id.* at 925. Originally, the issue before the court was whether the state must obtain the patient's informed consent prior to administration of psychotropic drugs, convulsive therapy, or behavior modification programs. The latter two, however, were mooted by the enactment of Ohio Revised Code § 5122.271 (2000), which required "fully informed, intelligent, and knowing consent . . . and the right to refuse for . . . (1) Surgery; (2) Convulsive therapy; (3) Major aversive interventions; (4) Sterilization; (5) Any unusually hazardous treatment procedures; [and] (6) Psycho-surgery." *Id.* at n.3.

42. *Id.* at 930. Moreover, as a practical matter, a patient's interest in avoiding forced administration of psychotropic drugs is substantial. See *Washington v. Harper*, 494 U.S. 210 (1990) (dealing with the rights of prison inmates to refuse forced administration of psychotropic drugs). Although the drugs' purpose is to alter the chemical balance in a patient's brain and thereby lead to beneficial changes, these drugs can have serious, even fatal, side effects. *Id.* at 229. One such side effect is acute dystonia, a "severe involuntary spasm of the upper body, tongue, throat, or eyes." *Id.* at 229-30. Other side effects include akathisia (motor restlessness); neuroleptic malignant syndrome (a potentially deadly cardiac dysfunction); and tardive dyskinesia (a sometimes irreversible neurological disorder that is characterized by involuntary uncontrollable muscle movements, especially of the face). *Id.* at 230.

In its analysis of the first interest, the court examined the history of the common law, observing that "there is . . . no right which is older than a person's right to be free from unwarranted personal contact."⁴³ The court further noted that this "'violation of the person or . . . breaking of the close'" is "the wrong upon which the modern tort of battery is premised."⁴⁴ Thus, liability based on battery is not denied even though the touching was for the benefit of the patient or was otherwise harmless.⁴⁵ The court also cited constitutional authority, noting many references to the "inviolability of the person,"⁴⁶ emanating from the guarantees of the Fourth Amendment,⁴⁷ the Eighth Amendment,⁴⁸ and the Due Process Clauses of the Fifth and Fourteenth Amendments.⁴⁹

The corollary and second interest cited by plaintiffs was a person's interest in making decisions about his body.⁵⁰ The court saw this interest reflected in the common law tort concept of consent, a necessary prerequisite for nonemergency treatment by a physician.⁵¹ The principle underlying this doctrine is that only the patient has the right to weigh the risks associated with a particular course of treatment.⁵² The court then extended this rationale to decisions that a person is constitutionally entitled to make.⁵³ Analogizing the patient's right in the case at bar to a criminal defendant's right to

43. *Davis*, 506 F. Supp. at 930. Indeed, the court notes that as early as the middle of the thirteenth century, English law allowed monetary recovery for unpermitted contact with a person through the writ of trespass vi et armis. *Id.* (citing F.W. MAITLAND, *THE FORMS OF ACTION AT COMMON LAW* 40, 43, 53 (1971 ed.)).

44. *Id.* at 931 (quoting F. HARPER, *A TREATISE ON THE LAW OF TORTS* § 14, at 36 (1933 ed.); citing RESTATEMENT OF TORTS §§ 13, 18 (1934); citing RESTATEMENT (SECOND) OF TORTS §§ 13, 18, 19 (1965)).

45. *Id.* (citing *Lacey v. Laird*, 139 N.E.2d 25 (1956)).

46. *Id.* (citing *Union Pac. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

47. *Id.* (citing, e.g., *Sibron v. New York*, 392 U.S. 40, 66 (1968); *Schmerber v. California*, 384 U.S. 757, 772 (1966)).

48. *Id.* (citing, e.g., *Estelle v. Gamble*, 429 U.S. 97 (1976)).

49. *Davis*, 506 F. Supp. at 931 (citing *Ingraham v. Wright*, 430 U.S. 651, 672-74 (1977); *Rochin v. California*, 342 U.S. 165, 172, 174 (1952)). See also *Griswold v. Connecticut*, 381 U.S. 479 (1965). Justice Douglas applied similar reasoning in *Griswold*, recognizing emanations from various constitutional rights. *Id.* at 485. These fundamental guarantees, when taken together, created a penumbral zone of privacy, within which the Supreme Court located the right of married couples to use contraception. *Id.*

50. *Davis*, 506 F. Supp. at 931.

51. *Id.* (noting that treatment rendered without the patient's informed consent is actionable as battery). See also *Pratt v. Davis*, 79 N.E. 562, 564 (1906) (forbidding violation of a patient's bodily integrity by surgeon operating without consent); *Mohr v. Williams*, 104 N.W. 12, 13, 16 (1905) (imposing liability for the nonconsensual performance of an otherwise beneficial surgical procedure).

52. *Davis*, 506 F. Supp. at 932. However, this rationale assumes that the patient is competent to make the decision. See *id.* at n.20.

53. *Id.*

representation by counsel, the court observed that the patient, much like a defendant, must bear the personal consequences of his decision.⁵⁴ Therefore, the patient must be as free to accept or refuse treatment as a defendant is free to retain or refuse counsel.⁵⁵ The court reasoned further that, although the Supreme Court does not recognize a specific right to refuse psychotropic drugs, it does recognize the individual's right to make intimate decisions which fundamentally affect him.⁵⁶

The third right relied upon by plaintiffs implicates the First Amendment guarantee of freedom of speech, a provision that protects not only a person's interest in communicating but also a person's interest in thinking without regard to the subject matter of his thoughts.⁵⁷ According to this theory, government action that directly affects mental processes would be unconstitutional under the First Amendment.⁵⁸ The court, however, relegated this theory to dicta by noting that a person's freedom to use his mind as he wishes need not rely on the First Amendment.⁵⁹ Indeed, "the power to control men's minds' is 'wholly inconsistent' not only with the philosophy of the first amendment but with virtually any concept of liberty."⁶⁰

54. *Id.*

55. *Id.*

56. *Id.* at 932-33 (citing *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)). According to Davis:

It indeed "would be a very curious and unsatisfactory result, if . . . a provision of constitutional law, always understood to have been adopted for protection and security of the right of the individual as against the government" (citation omitted), neither recognized the individual's interest in security nor, more importantly, his interest in being an individual. Perhaps no action directly affects this latter interest more than the State's attempt to decide for the patient whether he must take psychotropic drugs. If a patient has no protected interest in his body, in how his body will be used, and how his mind will work, in almost every sense of the word the patient ceases to be an individual and instead becomes a creature of the State. Only when a person is granted a certain sphere of autonomy does that person become an individual.

Id. at n.21.

57. *Id.* at 933. See also *Wooley v. Maynard*, 430 U.S. 705 (1977). In *Wooley*, Justice Burger, writing for the majority, questioned whether the states may constitutionally require an individual to participate in the dissemination of an ideological message by displaying it on his private property for the express purpose that it be observed and read by the public. *Id.* at 713. In its analysis, the court began with the broad proposition that the First Amendment guarantees the right of freedom of thought. *Id.* at 714 (citing *Bd. of Educ. v. Barnette*, 319 U.S. 624, 633-34 (1943)). The Court then identified the right to speak and the concomitant right to refrain from speaking as components of this concept of "individual freedom of mind." *Id.* See generally Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1 (1989).

58. *Davis*, 506 F. Supp. at 933.

59. *Id.*

60. *Id.* (quoting *Stanley v. Georgia*, 394 U.S. 557, 565-66 (1964)).

Thus, this interest flows from a much broader source than any specific constitutional provision.

The State presented two arguments in support of its contention that it had the power to medicate all persons who are mentally ill and confined to an institution. The first was based on the state police power to prevent a patient from harming himself or others within the hospital.⁶¹ The second sought to justify compulsory treatment under the State's *parens patriae* powers.⁶²

The court dismissed the first argument, observing that the challenge did not attack forced treatment where necessary to protect the safety of others.⁶³ Rather, according to the court the question at hand concerned when the danger of injury to the patient or other patients is sufficient to justify forced administration of a mind-altering drug to a competent patient who refuses to give consent.⁶⁴ In light of the significant invasion of fundamental rights represented by the forced administration of psychotropic drugs, the court reasoned that the risk of danger which the State has a legitimate interest in protecting against must be sufficiently grave and immediate, not merely a remote possibility.⁶⁵ Thus, the court concluded that, as a constitutional minimum, the State must have probable cause to believe that the patient is presently violent and constitutes a danger to himself or others before it may administer drugs over the patient's objections.⁶⁶

In response to the State's second argument the court rejected, as a preliminary matter, the State's assumption that its *parens patriae* power enabled it to drug *all* mentally ill persons confined to an institution.⁶⁷ Reasoning that a relationship between mental illness and incompetency is not

61. *Id.* at 934 (citing *Addington v. Texas*, 441 U.S. 418, 426 (1979); *Runnels v. Rosendale*, 499 F.2d 733, 735 (9th Cir. 1974); *Goodman v. Parwatikar*, 570 F.2d 801, 804 (8th Cir. 1978) (noting that the State has a constitutional obligation to protect prisoners in its custody against assault by other prisoners)).

62. *Id.* at 935.

63. *Id.* at 934.

64. *Davis*, 506 F. Supp. at 934.

65. *Id.* at 934. *Accord* *Texas v. Johnson*, 491 U.S. 397 (1989). In *Johnson*, the Supreme Court struck down a Texas statute prohibiting flag burning despite the insistence of the State that the statute promoted the valid state interest of preventing breaches of the peace. *See id.* at 407-08. As in *Davis*, the Court held that the likelihood of such breaches were remote, and that the implicated right (here free expression rather than bodily integrity) was fundamental. *Id.* at 406.

66. *Davis*, 506 F. Supp. at 935. *See also* Marvin S. Swartz, *What Constitutes a Psychiatric Emergency: Clinical and Legal Dimensions*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 57 (1987) (discussing the instances in which drugs may be administered over patients' objections).

67. *Davis*, 506 F. Supp. at 935.

necessary,⁶⁸ the court found that mental illness is no basis for compelled treatment.⁶⁹ Accordingly, mere residence in a mental hospital cannot justify forced administration of psychotropic drugs absent a determination that the patient is not capable of rationally deciding what is good for him.⁷⁰ The court held that no legitimate state interest justifies the State's administration of psychotropic drugs absent the informed consent of the competent patient, unless the patient presents a danger to himself or others in the institution.⁷¹

B. The Process Accorded

Davis presents a broad view of issues and arguments arising in drug refusal cases with respect to the existence of a patient interest under the common law and the Constitution. However, with respect to the criteria for determining when forced medication is appropriate and how much consideration is necessary in this finding, *Davis* raises more questions than it answers. *Rennie v. Klein*,⁷² though less exhaustive in its treatment of the sources of a patient's interest in refusing medication, fills in many gaps left by *Davis* with respect to the specific rights of patients with varying degrees of competency and the due process that must be afforded them.

1. *Rennie v. Klein*: The District Court Decision

In *Rennie* a class of patients in five New Jersey state-owned mental hospitals filed a motion for a preliminary injunction.⁷³ The patients sought to enjoin the hospitals and their staff from forcibly administering drugs to them without a hearing.⁷⁴ As a preliminary matter, the court accorded the

68. *Id.* (noting that the premise of this position is that incompetency, not mental illness, renders a patient unable to provide informed consent to medication); Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461, 490, 496 (1977)).

69. *Davis*, 506 F. Supp. at 935-36 (citing *Addington*, 441 U.S. at 427).

70. *Id.* at 936.

71. *Id.* at 938. At this point in the opinion the court proceeded with a due process analysis, noting that the right to refuse treatment is not absolute. *Id.* Therefore, the procedures by which a state determines forced treatment must comply with the procedural protections of the Fourteenth Amendment. *Id.* The court offered general observations in the form of dicta as to the rights of the refusing patient:

[T]his Court believes the State should provide the patient some kind of hearing before compelling the patient to take psychotropic drugs Due process, of course, requires an impartial decision-maker, but the Court does not believe that this means the decision-maker must be a judge or even a lawyer.

Id. at 938-39.

72. 476 F. Supp. 1294 (D. N.J. 1979), *modified and remanded*, 653 F.2d 836 (3rd Cir. 1981) (en banc), *vacated by* 458 U.S. 1119 (1982).

73. *Id.* at 1296.

74. *Id.* In fact, prior to the district court decision, the State of New Jersey enacted legis-

patients a qualified right to refuse treatment, thus requiring some level of procedural due process before the forcible administration of drugs.⁷⁵ The question, therefore, concerned what procedures were required, at a minimum, to protect the constitutional rights of the plaintiffs in such situations.⁷⁶

The court deemed several requirements essential as a matter of law. First, the hospital must obtain specific, written consent from patients before they are medicated with a psychotropic drug.⁷⁷ In the case of voluntary patients, the refusal is final and the hospital cannot proceed further.⁷⁸ However, the informed refusal of an involuntarily committed patient may be overridden, as this type of patient's right to refuse is not absolute.⁷⁹ Second, a neutral, independent decision-maker must be provided in the treatment context.⁸⁰ Third, because of the possibility of excessive costs to the State without a significant decrease in the risk of erroneous determinations, the court refused to require a formal hearing or even the presence of an attorney for forcible drug administrations.⁸¹

The court proceeded to recognize violations in several areas, most notably the hospital's policy of limiting the review of a physician's decision to forcibly medicate to informal hearings held before the treatment team and hospital medical director.⁸² The court reasoned that this policy was inappropriate because institutional pressures would make it impossible for the medical director to have the sufficient independence required by due process.⁸³ The court issued a preliminary injunction mandating that the hospital

lation regulating treatment of the mentally ill. See *Rennie v. Klein*, 653 F.2d 836, 848 (3rd Cir. 1981) (en banc). The legislation provided for the right to participate in planning of treatment by the patient as permitted by the patient's condition. *Id.* (citing N.J. STAT. ANN. § 30:4-24.1 (West 2001)). New Jersey also promulgated rules that guaranteed patients the right to be "free from unnecessary or excessive medication" in addition to the right to not have medication "used as a punishment, for the convenience of staff, [or] as a substitute for a treatment program." *Id.* (quoting N.J. STAT. ANN. § 30:4-24.2(d)(1) (West 2001)).

75. *Rennie*, 476 F. Supp. at 1307. The court, however, noted an unqualified right of refusal for patients who have been voluntarily committed to the mental hospital. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 1308.

79. *Id.*

80. *Id.*

81. *Rennie*, 476 F. Supp. at 1308.

82. *Id.* at 1310 (finding that the hospital had prescribed an unduly narrow review process of physicians' decisions to forcibly medicate, one that involved only informal hearings before the treatment team and hospital medical director). In addition, the court found that the hospital failed to inform patients adequately of their rights and the side effects of many drugs, and that the hospitals had not sought the required written consent to specific drug therapy. *Id.* at 1309-10.

83. *Id.* at 1310.

develop consent forms for patients to sign before they are prescribed psychotropic drugs.⁸⁴ The court further ordered the appointment of a patient advocate to assist patients who wish to refuse medication and prescribed the appointment of an independent psychiatrist to review the decisions to forcibly medicate involuntary patients.⁸⁵

Henceforth, under this judicial determination, and depending upon patient status, several levels of procedure are to be followed. The patient adjudged legally incompetent could be medicated without written consent, provided that the patient advocate was notified and the medication was otherwise allowable under state law.⁸⁶ This order also prescribed the same procedure for patients certified functionally incompetent by the treating physician and would, by necessity, involve a determination by the physician that the patient, although not declared incompetent under state law, was unable to provide knowledgeable consent to treatment.⁸⁷ Voluntary patients had an absolute right to refuse medication in nonemergent situations and any review of a patient refusal brought before the independent psychiatrist required at least five days notice between the patient's first refusal and the hearing.⁸⁸ The patient was permitted to have an attorney and independent psychiatrist at the hearing.⁸⁹ In addition, all hospital records were to be made available to the independent psychiatrist at the hearing, who was also permitted to examine the patient.⁹⁰ While no cross-examination was required, the independent psychiatrist could request the appearance of hospital employees.⁹¹ Finally, the order required the independent psychiatrist to issue a written opinion explaining the basis of his determination.⁹²

84. *Id.* at 1313.

85. *Id.* As of January 7, 1980, no patient over age eighteen could be medicated without signing a consent form, regardless of whether he or she was voluntarily or involuntarily committed. *Id.* However, when a treating psychiatrist certified that an immediate emergency situation existed, medication could be forcibly administered for seventy-two hours. *Id.*

86. *Id.* at 1314. The patient advocate could, in his discretion, initiate a review of the decision to medicate with the independent psychiatrist.

87. *Rennie*, 476 F. Supp. at 1314.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.* at 1314-15.

2. The Third Circuit: Residual Liberty Interests and the Least Intrusive Means Standard

On appeal, the United States Court of Appeals for the Third Circuit agreed that plaintiffs had a liberty interest that was infringed by compulsory medication.⁹³ First, the court found that, in determining that a state statute does not create a liberty interest, a liberty interest found directly in the United States Constitution may nonetheless exist.⁹⁴ Responding to the defendants' argument that because there was no due process under New Jersey law none was due, the court concluded that liberty interests may spring from the Constitution itself and can be recognized without regard to state law.⁹⁵

Second, the court revisited the issue of whether an individual's freedom to refuse medication is extinguished by involuntary civil commitment.⁹⁶ Rejecting the State's argument that involuntary commitment takes away all aspects of a person's liberty interest, the court found that "the patient 'retain[s] a residuum of liberty that would be infringed' by compulsory medication 'without complying with minimum requirements of due process.'"⁹⁷ In its decision, the court reasoned that "even when pursuing a legitimate

93. *Rennie*, 653 F.2d at 838.

94. *Id.* at 842.

95. *Id.* (citing *Meachum v. Fano*, 427 U.S. 215, 228-29 (1976); *Montanye v. Haymes*, 427 U.S. 236, 242-43 (1976)). Defendants analogized the interests of the patients with those of inmates seeking to be incarcerated in a particular prison. *Id.* Similarly, the court rejected plaintiff's reliance on the Eighth Amendment as a bar to forced medication as cruel and unusual punishment. *Id.* at 844. Clearly, this court sees much to distinguish the interests of patients who have been deprived of certain liberty interests for treatment purposes from the interests of inmates who have been deprived of liberty for punishment purposes.

96. *Id.* at 843. Much as one with a terminal illness may refuse treatment or ask that it be withdrawn, in psychiatry what is known as the Ulysses contract allows one to refuse medication if she reaches a state of incompetence and is unable to refuse. The central issue then becomes how to medically determine when such a person is incompetent to choose. In the context of a civil commitment, the patient declares that she "does not want to be committed even if she becomes incompetent to decide on hospitalization." Drawing its context from the sage of Ulysses who instructed his crew of sailors to bind him to the ship's mast and not release him when the sirens sang, within psychiatry the Ulysses contract is but a form of paternalism that allows one's prior self to choose for the current self. In a very real way, it validates the principle of autonomy and allows for a "more mastery over one's fate." See SAKS, *supra* note 22, at 73, 202-204, 209, n.37. See generally John A. Robertson, *Paying the Alligator: Precommitment Theory in Bioethics and Constitutional Law*, 81 TEX. L. REV. 1729 (2003); Paul F. Stavits, *The Nexum: A Modest Proposal for Self-Guardianship by Contract: A System of Advance Directives and Surrogate Committees-at-Large for the Intermittently Mentally Ill*, 16 J. CONTEMP. HEALTH L. & POL'Y 1 (1999).

97. *Rennie*, 653 F.2d at 843 (quoting *Vitek v. Jones* 445 U.S. 480, 491 (1980)).

interest, a State may not choose means that unnecessarily restrict constitutionally protected liberty” interests,⁹⁸ and concluded that this “least intrusive means” standard, although not prohibiting all intrusions, “requires avoidance of those which are unnecessary or whose cost benefit ratios, weighed from the patient’s standpoint, are unacceptable.”⁹⁹

After delving into the scope of the constitutional right to refuse treatment, the appeals court addressed the issue of whether the due process safeguards imposed by the district court injunction were proper.¹⁰⁰ In doing so, the court observed that “[d]espite detailed mechanisms established by [New Jersey Administrative] Bulletin 78-3, the district court held that the procedures failed to meet due process standards.”¹⁰¹ As the appeals court noted, the district court expanded on the State’s requirements, outlining the necessary procedures in the injunction.¹⁰² Therefore, in deciding whether the district court acted properly, the Third Circuit framed the scope of its inquiry in much narrower terms, asking whether the procedures established by the State of New Jersey satisfied due process.¹⁰³ The court determined that a federal court should not substitute its judgment for that of state legislatures and executive authorities absent a state’s failure to meet constitutional standards.¹⁰⁴

In light of its narrow construction of a federal court’s scope of review, it should come as no surprise that after the application of *Matthews v. Eldridge*,¹⁰⁵ the Third Circuit found that the district court had overstepped its authority.¹⁰⁶ The Third Circuit concluded that the district court “erred in engrafting its own procedures onto the requirements set out in [New Jersey] Administrative Bulletin 78-3,” reasoning that deficiencies in due process provided to patients should be remedied by enforcing the pre-existing state regulations, not by providing additional requirements.¹⁰⁷

3. *Rennie v. Klein* on Remand: The Professional Judgment Standard

More than a year later, *Rennie v. Klein* returned to the United States Court of Appeals for the Third Circuit, on remand from the Supreme

98. *Id.* at 846 (quoting *Kusper v. Pontikes*, 414 U.S. 51, 58-59 (1973)).

99. *Id.* at 847.

100. *Id.* at 848.

101. *Id.* at 849.

102. *Id.*

103. *Rennie*, 653 F.2d at 849-50.

104. *Id.* at 850.

105. 424 U.S. 319 (1976).

106. *Rennie*, 653 F.2d at 851.

107. *Id.* at 851.

Court.¹⁰⁸ At this point, the issues were refined to present one question: what standard should be applied to determine whether a decision to override a patient's refusal was constitutional?¹⁰⁹ In the first *Rennie* appellate decision, the court of appeals applied a least intrusive means standard, holding that "[t]he means chosen to promote the state's substantial concerns must be carefully tailored to effectuate those objectives with minimal infringement [on the patient's] protected interests."¹¹⁰

In *Rennie* the Third Circuit applied the same standard it set forth in *Romeo v. Youngberg*, a case involving the physical restraint of a mentally retarded patient in a state institution.¹¹¹ However, while *Rennie* was still pending, the Supreme Court vacated the *Romeo* decision and held that the appropriate standard only required courts to make certain that the staff of an institution exercised professional judgment.¹¹² Since the Supreme Court eliminated the least intrusive means standard, *Rennie* was remanded to the Third Circuit specifically for reconsideration in light of *Youngberg's* less stringent "professional judgment" standard.¹¹³

Nonetheless, on remand the Third Circuit reached the same result using the new standard imposed by the Supreme Court.¹¹⁴ The court held that "antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others."¹¹⁵ However, in its decision the court stated that "[t]he elimination of the concept of 'least intrusive means' from this analysis does not . . . require that any change be made in the decree portion of [its] en banc opinion, which held that New Jersey procedures were adequate in implementing the rights of the mentally ill."¹¹⁶

Rennie was not the only refusal case that came before the United States Supreme Court in 1982. *Rogers v. Okin*¹¹⁷ was proceeding through the First

108. 720 F.2d 266 (3rd Cir. 1983).

109. See *id.* at 268.

110. *Rennie*, 653 F.2d at 846 (citing *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965)).

111. 644 F.2d 147, 154 (3rd Cir. 1980), *vacated by* 457 U.S. 307 (1982).

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

113. *Rennie*, 720 F.2d at 268. See *Youngberg*, 457 U.S. at 321-22 (adopting the "professional judgment" standard).

114. *Rennie*, 720 F.2d at 269.

115. *Id.*

116. *Id.* at 270. In fact, the new reasoning makes even more persuasive the Third Circuit's position that the New Jersey state regulations were adequate because the new standard mandated by the Supreme Court is less stringent.

117. 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.* *Mills v. Rogers*, 457 U.S. 291 (1982).

Circuit at the same time. In fact, the Supreme Court issued the *Youngberg* and *Rogers* opinions on the same day.¹¹⁸

III. *ROGERS V. OKIN* AND ITS PROGENY: STATE CREATED INTERESTS PROTECTED BY THE FOURTEENTH AMENDMENT

A. *State Law Explicitly Provides a Judicial Determination of Competency*

In *Rogers*, the United States Court of Appeals for the First Circuit was asked to determine under what circumstances a state official may administer psychotropic drugs to mental patients without violating the Fourteenth Amendment.¹¹⁹ The First Circuit agreed with the district court, holding that mental patients enjoy constitutionally protected liberty and privacy interests in deciding whether to submit to drug therapy.¹²⁰ The reviewing court also affirmed the trial court determination that an involuntary commitment under state law provides no basis for an inference of legal incompetency.¹²¹ However, the reviewing court reversed the lower court's decision on the circumstances under which the State's interests might override the patient's liberty interests.¹²²

The United States Supreme Court, in a brief opinion, never reached the merits of the issue on appeal because of the intervening decision of a Massachusetts state court on the same issue: whether an involuntarily committed mental patient has a constitutional right to refuse treatment with anti-psychotic drugs.¹²³ Because the Supreme Judicial Court of Massachusetts delineated a broader liberty interest than those protected by the Federal Constitution, the Supreme Court declined to decide the federal constitutional issue.¹²⁴ The Court observed that where a state confers greater procedural protection of liberty interests than the Constitution of the United States, the Constitution does not control and need not be looked to as a source of the legal rights and duties of persons within the state.¹²⁵ Therefore, the Supreme Court vacated the First Circuit decision and remanded for

118. Both decisions were issued on June 18, 1982.

119. *Rogers*, 634 F.2d at 653. Clearly the court here has already established that the patient has a protected interest and the constitutional source of that interest. The First Circuit is trying to delineate the situations that might override those of the patient.

120. *Id.*

121. *Id.* at 658.

122. *Id.* at 659-60. See generally SAKS, *supra* note 22, at ch. 5.

123. See *In re Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981).

124. *Mills*, 457 U.S. at 305.

125. *Id.* at 300.

reconsideration in light of the holding of the Supreme Judicial Court of Massachusetts.¹²⁶

On remand, the First Circuit observed that the Federal Due Process Clause “provides procedural protections for state-created substantive liberty interests.”¹²⁷ According to the First Circuit, the enumerated provisions of Massachusetts law, as outlined in *Rogers v. Commissioner*, required a judicial determination of incompetence prior to forced medication.¹²⁸ In addition, the First Circuit held that the rights outlined therein created a legitimate, objective expectation and were thus entitled to the procedural protection of the Due Process Clause of the Fourteenth Amendment.¹²⁹ Furthermore, the court held that because the procedures listed by the Supreme Judicial Court of Massachusetts were articulated in “explicitly mandatory language” and were coupled with specific substantive predicates, it could only conclude that the State had created a protected liberty interest in the procedures as well as in the substantive rights.¹³⁰

126. *Id.* at 306. Indeed, the Massachusetts holdings go well beyond the federal constitutional minimum as outlined in *Rennie v. Klein*. After the issuance of *In re Guardianship of Roe*, The United States Court of Appeals for the Third Circuit requested clarification of the issues of state law by certifying several issues to the Supreme Court of Massachusetts. See *Rogers v. Commissioner*, 458 N.E.2d 308, 310 (1983). The decision, summarized here, outlines the extent of patient substantive and procedural rights under Massachusetts statutory, regulatory and common law: (1) civil involuntary commitment of a person to a state mental institution does not constitute a determination of incompetency to make treatment decisions, *id.* at 312-14; (2) a patient declared mentally incompetent is entitled to a substituted judgment treatment decision, involving consideration of (a) the patient’s expressed treatment preference, (b) his religious beliefs, (c) the impact of the decision on the patient’s family, (d) the probability of adverse side effects, (e) the prognosis without treatment, and (f) the prognosis with treatment, *id.* at 318-19; (3) the State may invoke its police powers without prior judicial approval only if the patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs, *id.* at 321-22 & n.26; (4) under its *parens patriae* power, the State may treat a patient against his will to prevent immediate, substantial, and irreversible deterioration of a serious mental illness in cases where even the smallest avoidable delays would be intolerable, *id.* at 322; (5) to continue treatment in such a therapeutic emergency, the treating doctors must seek an adjudication of incompetency and, if the patient is adjudicated incompetent, a substituted judgment treatment plan, *id.*; (6) the determination of incompetency must be made by a judge, not a doctor or other state official, *id.* at 313-18; (7) the judge must make the substituted judgment decision, providing adequate notice and opportunity to be heard to the parties, *id.* at 318; and, (8) following the determination of the appropriate treatment plan, a guardian or the judge must monitor the treatment to assure adherence with the substituted judgment treatment plan, *id.* at 318 & n.20.

127. *Rogers v. Okin*, 738 F.2d 1, 5 (1st Cir. 1984).

128. *Id.* at 8.

129. *Id.* at 6.

130. *Id.* at 7.

B. State Law Is Silent

In stark contrast to the holding of *Rogers v. Okin*, the United States District Court for the District of Columbia held in *United States v. Leatherman* that due process did not require a judicial determination of incompetency prior to forcible medication.¹³¹ The different holding in *Leatherman* can be explained by the absence of any state law providing substantive rights and procedures beyond those available in *Rennie v. Klein*. In light of this fact, the only role of the court would be to balance the State's versus the patient's interests, as prescribed in *Matthews v. Eldridge*.¹³² The *Leatherman* court considered the interests of the government, the risks of erroneous decisions, and the patient's liberty interest.¹³³ It further reasoned that requiring the courts to address such issues would involve them in a "never-ending controversy concerning medical judgments for which courts have neither the institutional resources nor the necessary expertise."¹³⁴ The court, therefore, concluded that the interests of the government strongly militated in favor of leaving a determination of competence to refuse treatment to the hospital rather than to the courts.¹³⁵

C. State Law Explicitly Provides Administrative Determination of Competency

Project Release v. Prevost,¹³⁶ a decision from the United State Court of Appeals for the Second Circuit, dealt with a similar issue. However, in *Prevost*, the procedures for refusal and later appeal were codified in the New York Mental Hygiene Law and the New York Code of Rules and Regulations.¹³⁷ Thus, the question in this case was the constitutionality of a

131. *United States v. Leatherman*, 580 F. Supp. 977, 980 (D.C. Cir. 1983).

132. *See Matthews v. Eldridge*, 424 U.S. 319, 334-35 (1976).

133. *Leatherman*, 580 F. Supp. at 979.

134. *Id.*

135. *Id.* *Leatherman* is also clearly distinguishable from *Rogers* in that the facts in *Leatherman* indicate that the patient in question had been adjudicated not guilty by reason of insanity prior to his commitment by the court to St. Elizabeth's Hospital. *See id.* in 978. The court, however, does not raise the issue of a possible difference in the measure of residual liberty interest attributed to a patient committed in civil or criminal proceedings. Indeed, *Leatherman* is equally distinguishable from *Rennie v. Klein* on this basis as well.

136. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

137. *Id.* at 967. The New York Code Rules and Regulations provides for a right to object to treatment and subsequent review. Forcible treatment may not be administered to voluntary patients unless "the treatment appears necessary to avoid serious harm to life or limb of the patients themselves." *Id.* (citing N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8(b)(1)-(b)(2) (2003)). An involuntary patient may object to non-emergency treatment and has a right to appeal. *Id.* at 967-68. However, before treatment may be administered over patient objection, the objection must be reviewed by the head of the service. *Id.* at 968 (citing § 27.8(c)). His decision may be appealed to the facility director, *id.* (citing § 27.8(c), (e)(1)-

statute rather than the conduct of the hospital staff.¹³⁸ Appellants argued that in nonemergent situations, the hospital may not administer psychotropic medication to legally competent but involuntarily committed individuals without a prior judicial commitment hearing.¹³⁹ The court responded to this argument by examining first the substantive, then the procedural issue.¹⁴⁰ For a delineation of the scope of the patient's substantive rights, the court looked to the Supreme Court's reasoning in *Mills v. Rogers*, concluding that involuntarily committed mental patients retain liberty interests protected directly by the Constitution and that those interests are implicated by the involuntary administration of psychotropic drugs.¹⁴¹ The court noted, however, that the substantive rights guaranteed in the Federal Constitution define only a minimum protection, one that is encompassed by the state regulatory provision allowing objection to treatment.¹⁴²

In its examination of the procedural validity of the New York statute, the court looked to *Rennie* for guidance as to the appropriate standard for assessing whether the State had adequately protected an involuntarily committed individual's interest in freedom from forced medication.¹⁴³ The court, therefore, indicated that, in light of *Youngberg*, its function was to "make certain that professional judgment . . . was exercised."¹⁴⁴ This standard reflected the balance between the legitimate interests of the State and the rights of an involuntarily committed patient to be free from unreasonable chemical restraints.¹⁴⁵ Thus, it would not be appropriate for the court to ask which of several professionally acceptable choices should have been made.¹⁴⁶

Applying this standard, the court looked to the New York State regulations and noted provisions for three levels of review by medical personnel

(2)), and then to the regional director of the department, *id* (citing § 27.8(e)(3)). The objecting patient has the right to request an attorney to represent him. *Id.* (citing § 27.8(d)).

138. See *id.* at 963. In *Project Release*, a non profit patient rights advocacy group, Project Release, filed suit on behalf of Carrie Greene, a patient at Creedmoor Psychiatric Center. *Id.* at 963. The plaintiffs alleged that the standards and procedures in New York's Mental Hygiene Law violated the patient's Fourteenth Amendment rights to substantive and procedural due process. *Id.* The district court granted summary judgment for the defendants on all issues raised by the parties. See *id.* at 965 (citing *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982)).

139. *Id.* at 977.

140. *Id.*

141. *Id.* at 978-79 (citing *Mills*, 457 U.S. at 299 n.16 (1982)).

142. See *Project Release*, 722 F.2d at 979.

143. See *id.* at 979-80 (citing *Rennie v. Klein*, 653 F.2d 836 (3rd Cir. 1981) (en banc), vacated in light of *Youngberg v. Romeo*, 457 U.S. 307 (1982)).

144. *Id.* at 980.

145. *Id.* (citing *Youngberg*, 457 U.S. at 321-22).

146. *Id.* (citing *Youngberg*, 457 U.S. at 322).

other than the treating physician, as well as the right to counsel.¹⁴⁷ The court further observed that, "due process requires an opportunity to be heard and review of a decision to administer psychotropic medication."¹⁴⁸ This determination, however, need not be judicial in nature.¹⁴⁹ Therefore, the court concluded that the New York regulations satisfied both substantive and procedural due process under the Fourteenth Amendment.¹⁵⁰

IV. STATE COURTS ADVOCATE PATIENTS' RIGHTS UNDER STATE STATUTES, CONSTITUTIONS, AND THE COMMON LAW

In *Rivers v. Katz*,¹⁵¹ the Court of Appeals of New York reached a different conclusion than the Second Circuit reached in *Project Release*. New York's highest court held that, under the State's *parens patriae* power, involuntarily committed mental patients are entitled to a judicial determination of capacity prior to the forced administration of psychotropic drugs.¹⁵² In *Rivers*, three involuntarily committed patients refused the administration of psychotropic medication.¹⁵³ The county court determined that they were in need of involuntary care and treatment, and that their judgment was so impaired that they were unable to understand the need for such care and treatment.¹⁵⁴ Therefore, the administrative review procedures prescribed by the regulations of the Commissioner of Mental Health were implemented.¹⁵⁵ The objections of the patients were overruled and they were medicated with various antipsychotic drugs.¹⁵⁶ The patients then initiated a declaratory judgment proceeding against the Mental Health Commissioner and hospital, seeking to enjoin the nonconsensual administration of psychotropic drugs and to obtain a declaration of their common law and constitutional right to refuse medication.¹⁵⁷

As a preliminary matter, the court stated that the common law of New York recognizes that "every individual of adult years and sound mind has a

147. *Id.* at 980. See *supra* note 137 for a full discussion of provisions of the New York State regulations.

148. *Id.* at 981.

149. *Id.*

150. *Id.*

151. 495 N.E.2d 337 (N.Y. 1986).

152. *Id.* at 343-44. See *In re Mental Commitment of M.P.*, 500 N.E.2d 216, 221 (Ind. Ct. App. 1986) (holding that a patient had a liberty interest protected by due process in refusing medication and was entitled to judicial hearing prior to medication).

153. *Rivers*, 495 N.E.2d at 339-40.

154. *Id.* at 339.

155. *Id.*

156. *Id.* at 339-40.

157. *Id.* at 340.

right to determine what shall be done with his own body and the right to control the course of his medical treatment.”¹⁵⁸ The court noted further that these rights extend equally to the mentally ill, who should not be treated as persons of lesser status because of their illness.¹⁵⁹ In response to the Commissioner’s argument that committed mental patients are presumptively incompetent to exercise the right to refuse, the court observed that neither mental illness nor involuntary commitment constitutes a sufficient basis to conclude a lack of mental capacity.¹⁶⁰ The court concluded that mental illness does not result in a forfeiture of the patient’s civil rights, including the right to make decisions concerning one’s own body.¹⁶¹

The court recognized, however, that the right to reject treatment was not absolute and would yield to the State’s police or *parens patriae* power.¹⁶² However, it viewed the scope of the State’s police power very narrowly, holding that it only applied where the patient presented a danger to himself or other members of society and that medication could only be justified in emergent situations.¹⁶³ Regarding the State’s *parens patriae* interest, the court ruled that in order to invoke the interest the individual must be incapable of making a competent treatment decision on his own.¹⁶⁴ This involves a determination of competency, a function that the *Rivers* court found to be uniquely judicial, not medical.¹⁶⁵ Therefore, the court held that where the State’s police power is not implicated and a patient refuses psychotropic medication, due process requires a judicial determination of whether the patient has the capacity to make a reasoned decision before medication can be administered pursuant to the State’s *parens patriae* power.¹⁶⁶

The essential distinction between *Rivers* and *Project Release v. Prevost*

158. *Id.* at 341.

159. *Rivers*, 495 N.E.2d at 341 (citing Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977)).

160. *Id.* at 341-42. See also Rennie v. Klein, 653 F.2d 836, 846 (3rd Cir. 1981) (en banc), vacated by 458 U.S. 1199 (1982); Rogers v. Okin, 634 F.2d 650, 658-59 (1st Cir. 1980), vacated *sub nom.* Mills v. Rogers, 457 U.S. 291 (1982); Scott v. Plante, 532 F.2d 939, 946 (3rd Cir. 1976); Davis v. Hubbard, 506 F. Supp. 915, 935 (N.D. Ohio 1980); Rogers v. Commissioner, 458 N.E.2d 308, 314 (Mass. 1983); *In re Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981). But see Stensvad v. Reivitz, 601 F. Supp. 128, 129, 131 (W.D. Wis. 1985).

161. *Rivers*, 495 N.E.2d at 342. See generally Kathy L. Cerminara, *The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting*, 24 AM. J.L. & MED. 7 (1998).

162. See *Rivers*, 495 N.E.2d at 343.

163. *Id.*

164. *Id.*

165. *Id.* (citing Rogers v. Commissioner, 459 N.E.2d 308 (Mass. 1983); *In re Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981)).

166. *Id.* at 343-44.

is the theory under which the plaintiffs asserted a right to be free from treatment. In *Project Release*, the plaintiffs alleged violation of their rights under the Fourteenth Amendment of the Federal Constitution,¹⁶⁷ whereas in *Rivers* the plaintiffs alleged violation of their rights under the common law and the New York State Constitution.¹⁶⁸ Indeed, the different causes of action, which resulted in different outcomes, illustrate the principle articulated in *Mills v. Rogers*.¹⁶⁹ This is an area of law where state law and state constitutions provide greater protection for a patient's interest to be free from forced medications than the constitutional minimum prescribed under the Due Process Clause of the Fourteenth Amendment.

The dichotomy between decisions based on state law and those relying on the Fourteenth Amendment to the Constitution is further exemplified by *In re Orr*, where the Appellate Court of Illinois held that an involuntarily admitted patient may refuse medication unless, under the *parens patriae* doctrine, he has been adjudicated incompetent in a separate proceeding.¹⁷⁰ In that case, following a hearing, an Illinois circuit court involuntarily committed the patient, Jeffrey Orr, because of his mental illness and the court's reasonable expectation that his illness would cause him to seriously harm himself or others.¹⁷¹ The circuit court further authorized the State to administer medication.¹⁷² In response, the Guardianship and Advocacy Commission, appointed to represent Orr, filed an appeal on his behalf alleging that the court's order authorizing the State to administer medication as

167. See *Project Release v. Prevost*, 722 F.2d 960, 963 (2d Cir. 1983).

168. *Rivers*, 495 N.E.2d at 340.

169. *Mills*, 457 U.S. at 303 (noting that liberty interests found within the Constitution cannot be determined independent of state law).

170. *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. Ct. 1988). This determination was the result of the court's application of the Illinois Mental Health and Developmental Disabilities Code (Mental Health Code). See 405 ILL. COMP. STAT. 5/2-107 (2002). The relevant section of the Mental Health Code provides that:

An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.

405 Ill. Comp. Stat. 5/2-107(a).

171. *Orr*, 531 N.E.2d at 67.

172. *Id.*

part of the involuntary admission was void for want of statutory authority.¹⁷³

The Appellate Court of Illinois agreed.¹⁷⁴ Relying on Illinois statutory law, the court noted that the *parens patriae* doctrine was inapplicable because the patient had not been adjudicated incompetent under the Illinois Probate Act.¹⁷⁵ Furthermore, it noted that mere involuntary committal does not imply a lack of competency under Illinois law.¹⁷⁶ The court also looked to common law and constitutional theories to support its decision that the trial court exceeded its statutory authority when it issued the order authorizing the State to forcibly medicate Mr. Orr.¹⁷⁷

V. AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965

The other statutory solution developed by Congress and incorporated by amendment into the Older Americans Act of 1965 provides for the establishment of a long-term care ombudsman program by any state receiving federal funds under Title III of the Act.¹⁷⁸ These amendments, rather than outlining a right or providing a judicial remedy, set aside and grant federal funds to states that implement a comprehensive long-term care ombudsman program.¹⁷⁹ Thus, Congress has made the receipt of significant amounts of federal funds conditional on a state's development and adherence to a comprehensive plan in compliance with the Act.¹⁸⁰

Congress does not, however, provide for any cause of action by which a resident of a long-term care facility can assert a right to have an ombuds-

173. *Id.* at 69-71.

174. *Id.* at 71.

175. *Id.* at 73 (citing 755 ILL. COMP. STAT. 5/11a-3 (2002)).

176. *Id.* (citing 405 ILL. COMP. STAT. 5/2-101 (2002)).

177. *Orr*, 531 N.E.2d at 73-74. The court noted that informed consent and the right to refuse medical treatment were grounded in the common law right to be free of nonconsensual bodily invasions, the individual liberty interest in bodily integrity, and the right to privacy protected by both the State and Federal Constitutions. *See id.* at 74 (citing *Davis v. Hubbard*, 506 F. Supp. 915, 929-39 (N.D. Ohio 1980)). The court further looked to *Mills v. Rogers* noting that patients, even those subject to involuntary hospitalization, retain liberty interests to remain free from intrusions into body and mind. *See id.*

178. *See* 42 U.S.C. § 3021(c) (2000); 42 U.S.C. § 3027(a)(9) (2000). *See also* 42 U.S.C.A. § 3021(c) (West 2003); 42 U.S.C.A. § 3027(a)(9) (West 2003). *See supra* note 13 for an account of the legislative history of these provisions.

179. *See generally* 42 U.S.C. § 3027(a).

180. *See id.* Congress employs this method in many other areas, essentially conditioning a grant of federal funds upon the recipient state or entity's agreement to comply with regulatory framework. *See* 42 U.S.C. § 1396 (2000) (providing for the reimbursement of patient's expenses at a nursing home through Title XIX of the Social Security Act, commonly known as Medicaid).

man assist him in a refusal case.¹⁸¹ Indeed, the legislative history of the most recent amendment to this provision omits any discussion of providing either a right that might be enforced through 42 U.S.C. § 1983¹⁸² or any other distinct cause of action.¹⁸³ Thus, it seems that the principal purpose of this statute, in addition to improving the quality of care of residents in long-term care facilities, is to gather information for the purpose of further policymaking.¹⁸⁴

In order for a facility resident to bring suit under this statute, a court would need to discern an implied private cause of action in the language of the statute or its legislative history.¹⁸⁵ Neither the explicit language of the

181. See generally § 3027(a).

182. 42 U.S.C. § 1983 creates a cause of action for the "deprivation of any rights, privileges, or immunities secured by the Constitution and laws" by any person acting "under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory." 42 U.S.C. § 1983 (2000). To state a claim under § 1983, a plaintiff must allege the violation of a right secured by the Constitution and laws of the United States and must show that the alleged deprivation was committed by a person acting under color of state law. See, e.g., *West v. Atkins*, 487 U.S. 42, 48 (1988); *Parratt v. Taylor*, 451 U.S. 527, 535 (1981); *Flagg Brothers, Inc. v. Brooks*, 436 U.S. 149, 155 (1978).

183. See H.R. 782, 106th Cong., 114 Stat. 2226 (2000).

184. See S. Rep. No. 100-136, at 54-56 (1987), reprinted in 1987 U.S.C.C.A.N. 86673, 876. See also H.R. Conf. Rep. No. 100-427, at 68-70 (1987), reprinted in 1987 U.S.C.C.A.N. 932, 938-40. The 1987 Senate Report discusses diverse issues including the improvement of quality of care, availability of adequate legal counsel, conflicts of interest, the disabled elderly and data collection. See S. Rep. No. 100-136, at 54-56. The 1987 House Conference Report reflects the determinations of the House, Senate, and the Conference Committee, discusses funding, and includes the submission of a report by the Commissioner on Aging that detailed findings and recommendations of a study on the long-term care ombudsman program. Most importantly, the conference report clarifies the duties of the ombudsman to:

[R]esolve complaints by elaborating upon the nature of the complaints which are to be investigated to include complaints relating to action, inaction, or decisions of providers, or their representatives, of long-term care services, of public agencies, or of social service agencies which may adversely affect the health, safety, welfare, or rights of such residents.

H.R. Conf. Rep. No. 100-126, at 69.

185. The Supreme Court has suggested that four inquiries be made when deciding whether a private remedy may be implied in a statute that contains no express provision:

First, is the plaintiff "one of the class for whose especial benefit the statute was enacted," . . . that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Cort v. Ash, 422 U.S. 66, 78 (1975) (citations omitted). See generally *Cerminara*, *supra* note 161; *Phan*, *supra* note 17.

statute nor its legislative history reveal any congressional intent to afford judicial relief to a facility resident. However, this does not imply that relief should not be available at the state level. Indeed, to the extent that Congress has achieved its goal of persuading the states to effectuate an ombudsman program in order to advocate the rights of patients, states have enacted statutes and adjudicated the resulting cases. One such case, *In the Matter of Conroy*,¹⁸⁶ has been studied by legal commentators and has provided a subject for earnest debate regarding the appropriateness of such a program.

VI. *IN THE MATTER OF CONROY*: ONE STATE'S IMPLEMENTATION OF A LONG-TERM CARE OMBUDSMAN PROGRAM

In *Conroy*, the Supreme Court of New Jersey comprehensively addressed the circumstances under which life-sustaining treatment may be withheld or withdrawn from an incompetent, institutionalized, elderly patient with severe and permanent mental and physical impairments and a limited life expectancy.¹⁸⁷ In its analysis, the court discussed the role of the Office of Ombudsman for the Institutionalized Elderly, as created by New Jersey statute.¹⁸⁸ The provisions that the court saw as arguably implicated by a decision to withhold or withdraw treatment were those charging the ombudsman with responsibility to prevent "abuse" of elderly patients.¹⁸⁹ These

186. *In re Matter of Conroy*, 486 A.2d 1209 (N.J. 1985).

187. *Id.* at 1216. Although Ms. Conroy had been adjudicated incompetent, the court devoted significant attention to the important issues of what rights a competent patient has to accept or reject medical care. *Id.* at 1221-26. Here, Justice Schreiber examined the patient's interest in self determination from the perspective of common law tort theory and the federal constitutional right of privacy. *Id.* at 1221-23. He then discussed countervailing societal interests: preserving the particular patient's life, preserving the sanctity of all life, safeguarding the integrity of the medical profession, and protecting innocent third parties who may be harmed by the patient's treatment decision. *Id.* at 1223-25.

188. *See id.* at 1239-42. The Ombudsman Statute provides in pertinent part:

[I]t is the public policy of this State to secure for elderly patients, residents and clients of health care facilities serving their specialized needs and problems, the same civil and human rights guaranteed to all citizens; and that to this end there should be established as an agency of the State Government the Office of the Ombudsman for the Institutionalized Elderly, to receive, investigate and resolve complaints concerning certain health care facilities serving the elderly, and to initiate actions to secure, preserve and promote the health, safety and welfare, and the civil and human rights, of the elderly patients, residents and clients of such facilities.

N.J. STAT. ANN. § 52:27G-1 (West 2001).

189. *Id.* at 1239. Pursuant to a 1983 amendment, the statute was enlarged to protect patients from abuse. "Abuse" in this instance was defined as "the willful infliction of physical pain, injury or mental anguish; unreasonable confinement; or, the willful deprivation of services which are necessary to maintain a person's physical and mental health." N.J. STAT.

provisions were interpreted by the court as creating a vehicle for safeguarding the rights of elderly, institutionalized, incompetent patients both to receive medical treatment and to refuse life-sustaining medical treatment under certain circumstances.¹⁹⁰

A. The Procedural Requisites

In light of the circumstances, the issue was whether a decision to terminate life-sustaining medical treatment constituted "abuse" and thus conflicted with the intention of the Ombudsman Act.¹⁹¹ The court held that it did not, articulating the procedure necessary to justify a decision to withhold or withdraw life-sustaining treatment from an incompetent nursing home resident.¹⁹² The ombudsman plays an integral role in this process: a person who believes that withholding life-sustaining treatment would effectuate the wishes of the incompetent patient or would be in the "best interests" of the patient should notify the Office of the Ombudsman of the contemplated action.¹⁹³ Any person with reason to suspect that withholding treatment would be an abuse should likewise inform the ombudsman.¹⁹⁴

After reviewing these notification requirements, the ombudsman gathers evidence concerning the patient's condition from the attending physician and nurses.¹⁹⁵ He then consults with two physicians who are unaffiliated with the nursing home.¹⁹⁶ Based on this information and, in some instances, the concurrence of family members, the patient's guardian may withhold or withdraw life-sustaining medical treatment upon a good faith belief that it is consistent with the patient's right to self-determination.¹⁹⁷

B. Three Tests for Implementing Patient Self-Determination

In addition, the court discerned three possible tests that would substantiate this good faith belief and thus justify the withholding of life-sustaining

ANN. § 52:27G-2a (West 2001).

190. See *Conroy*, 486 A.2d at 1239.

191. *Id.* at 1240.

192. *Id.* at 1241-42.

193. *Id.* at 1241. This notification may be undertaken by the guardian of the patient or by another interested party such as a family member of an attending physician.

194. *Id.* at 1242.

195. *Id.*

196. *Conroy*, 486 A.2d at 1242.

197. *Id.* at 1240. Compliance with the wishes of the now incompetent patient can be achieved by: (1) proceeding with the course of action previously agreed upon by the then competent patient; or, (2) in instances where the patient had expressed no clear wishes, balancing the burden of the patient's continued existence with any benefits pursuant to a limited or pure objective test.

treatment. The first is a subjective test, essentially effectuating a patient's explicit intent not to receive life sustaining intervention.¹⁹⁸ This might be embodied in a living will or evidenced by an oral directive to a family member.¹⁹⁹ The second, a "limited-objective" test, provides that treatment may be withdrawn or withheld when there is some trustworthy evidence that the patient would have refused treatment and where the decision maker is satisfied that the burdens of the patient's continued life outweigh any benefits.²⁰⁰ The third, a "pure objective" test, is simply a balancing test applied in the absence of any intent, either explicit or implied, by the patient.²⁰¹

Clearly, *Conroy* addresses the somewhat unique situation in which the ombudsman attempts to discern the intent of the patient with respect to life-sustaining treatment. The Federal Long-Term Ombudsman Plan was most likely drafted to address many other situations, including refusal of various non-life-sustaining medications and other general self-determination issues. *Conroy* does, however, provide some insight into the issues raised by this type of program. Indeed, to the extent this case represents the extreme situation in which a long-term care ombudsman program would be implemented, it provides valuable information as to the issues that are implicated by such regulation. Among these are questions of economy, deference to the patient's family, and ultimately, the difficult task of creating a procedure to determine the proper course of action for the incompetent elderly patient who cannot speak for himself.

VII. RE-EVALUATING THE OMNIBUS BUDGET RECONCILIATION ACT

Despite the breadth of rights and the compliance, enforcement, and oversight measures provided for in OBRA, nursing home abuse and neglect continues to rise.²⁰² The General Accounting Office (GAO) has issued sev-

198. *Id.* at 1229.

199. *Id.*

200. *Id.* at 1232.

201. *Id.* See also Alan Meisel, *Barriers to Forgoing Nutrition and Hydration in Nursing Homes*, 21 AM. J.L. & MED. 335, 345-52 (1995) (discussing federal requirements for providing adequate nutrition and hydration under the Medicare/Medicaid programs).

202. U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO/HEHS-99-46, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS (Mar. 1999) [hereinafter ENFORCING FEDERAL QUALITY STANDARDS], available at http://www.ascp.com/public/ga/gao_report.pdf; U.S. OFFICE OF THE INSPECTOR GEN. (OIG), DHHS, PUB. NO. OEI-02-98-00331, NURSING HOME SURVEY AND CERTIFICATION: DEFICIENCY TRENDS (Mar. 1999), available at <http://oig.hhs.gov/oei/reports/oei-02-98-00331.pdf>. The Committee on Government Reform reported that the percentage of nursing home abuse violations has increased every year since 1996. In an effort to combat elder abuse, U.S. Senators John Breaux and Orrin Hatch introduced The Elder Justice Act on Feb-

eral reports on nursing home abuse and neglect since the passage and implementation of OBRA. In January 1996, the GAO reported findings of rampant fraud and abuse surrounding nursing home services and supplies.²⁰³

Since July 1998, the GAO has identified and reported four key weaknesses in OBRA. First, state surveyors understated the extent of serious care problems, which include "actual harm" to residents and the "immediate jeopardy" of residents' health, safety, and lives.²⁰⁴ This understatement issue resulted from the procedural weaknesses and predictable timing of state surveys of nursing homes.²⁰⁵ Second, complaints remained uninvestigated for weeks or months.²⁰⁶ Third, when deficiencies were in fact identified, federal and state enforcement agencies did not ensure that they were addressed and permanently fixed.²⁰⁷ Fourth, federal oversight mechanisms were limited in their range and effectiveness.²⁰⁸

In its 2000 report, the GAO concluded that measures have been taken by the federal government, the states, and the nursing home industry in an effort to alleviate OBRA shortcomings identified in the July 1998 GAO report.²⁰⁹ The report qualified these measures by recognizing the time needed to implement them and to determine their efficacy.²¹⁰ In March 2002, the GAO issued a report analyzing the adequacy of the responsiveness of the federal government, the states, and the nursing home industry, generally concluding that "nursing home residents need both stronger and more immediate protections."²¹¹

Both state and federal efforts in combating elder abuse and nursing home

ruary 10, 2003. This proposed legislation would seek to better train workers to detect abuse among senior citizens and, additionally, require FBI criminal background checks for nursing-home aides. These safeguards would enhance the long-term care ombudsman program and establish an office of adult protection services. See S. 333, 108th Cong. §§ 104-05 (2003).

203. GAO, PUB. NO. HEHS-96-18, FRAUD AND ABUSE: PROVIDERS TARGET MEDICARE PATIENTS IN NURSING FACILITIES 2 (Jan. 1996), available at <http://www.gao.gov>.

204. *Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment: Testimony Before the Senate Special Comm. on Aging*, 106th Cong. (2000) (statement of William J. Scanlon, Director, Health Financing and Public Issues, Health, Education, and Human Services, Division) (published as GAO/T-HEHS-00-209) [hereinafter Scanlon Testimony], available at <http://aging.senate.gov/events/hr61bs.pdf>.

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.* at 15.

210. Scanlon Testimony, *supra* note 204, at 15.

211. GAO, PUB. NO. GAO-02-312, NURSING HOMES: MORE CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE 26 (Mar. 2002), available at <http://www.gao.gov>.

deficiencies have proven to be inadequate.²¹² The far-sweeping federal legislation of OBRA has been downsized by procedural inadequacies. State initiatives are too limited and do not provide the national uniformity necessary to address nursing home inadequacies.²¹³ Both OBRA and various state initiatives have focused on deterrence as a method of combating elder abuse and inadequate care, but have had dismal results.²¹⁴ It is evident that there is a need to refocus on prevention of elder abuse and the inadequate treatment of the elderly by reevaluating the structure of contemporary nursing homes.²¹⁵

A. Continuing Inadequacies

Of the nation's 17,000 nursing homes, 15,000 provide Medicare-covered skilled nursing and rehabilitative care every year to 1.4 million Medicare patients who have been discharged from acute care hospitals.²¹⁶ Therefore, an increase in federal funds would dramatically impact a vast amount of nursing home facilities. Yet, the November 2002 GAO report concluded that "increasing the Medicare payment rate was not effective in raising nurse staffing."²¹⁷ These findings were based upon the 2001 and 2002 temporary increase in Medicare payment, which expired on October 1, 2002.²¹⁸ The analysis of the 2001 and 2002 data indicated that there was not a "significantly higher nursing staff time after the increase to the nursing component of Medicare's payment."²¹⁹ Regardless of this report, increases in federal funding should be reinstated. Federal funding should be provided with guidelines outlining how to appropriate the monies. It is precisely this guidance mechanism that was lacking when Congress increased funding in 2000.

212. See Scanlon Testimony, *supra* note 204, at 1-2. See generally Marie-Therese Connolly, *Federal Law Enforcement in Long Term Care*, 4 J. HEALTH CARE L. & POL'Y 230 (2001).

213. See Scanlon Testimony, *supra* note 204, at 2. See generally, Jennifer Gimler Brady, *Long-Term Care Under Fire: A Case For Rational Enforcement*, 18 J. CONTEMP. HEALTH L. & POL'Y 1 (2001).

214. See Scanlon Testimony, *supra* note 204, at 1. See also ENFORCING FEDERAL QUALITY STANDARDS, *supra* note 202, at 3.

215. See Connolly, *supra* note 212, at 238 (noting that there are "many distinct players" involved in the issue of long term care, not just law enforcement). See also Brady, *supra* note 213, at 4 (noting that the difficulties posed to nursing homes by increased regulation is compounded by an increase in litigation aimed at quality of care issues).

216. GAO, PUB. NO. GAO-03-176, SKILLED NURSING FACILITIES: AVAILABLE DATA SHOW AVERAGE NURSING STAFF TIME CHANGED LITTLE AFTER MEDICARE PAYMENT INCREASE 1 (Nov. 2002), available at <http://www.gao.gov>.

217. *Id.* at 4.

218. *Id.* at 2.

219. *Id.* at 4.

It has been reported that ninety percent of nursing homes in the United States are too under-staffed to provide basic care such as dressing, grooming, feeding, and cleaning.²²⁰ Without this basic care, nursing home residents are likely to suffer from blood-borne infections, dehydration, bed-sores, malnutrition, and pneumonia.²²¹ In addition to insufficient care, nursing home residents are suffering from abuse by staff.²²² It has been reported that approximately forty percent of nursing home staff admitted to engaging in psychological abuse, and approximately ten percent admitted to engaging in physical abuse of residents.²²³

The issues and problems of the nursing home industry are so urgent and pervasive that if not dealt with immediately, America is certain to face a crisis by 2030. The soaring elder population is on a collision course with the rising incidence of elder abuse and inadequate care in nursing home facilities. The federal government has responded by passing OBRA, which has resulted in the ineffective regulation of nursing homes, as demonstrated by the increased incidence of nursing home abuse. State governments have responded with indirect mechanisms, which have proven limited and ineffective. Federal and state efforts have focused on deterrence while ignoring the causes of mistreatment in the nursing home setting. Rather, the focus should be on prevention, with particular attention to nursing home staff and a well-balanced working environment. Nursing homes are tremendously under-staffed and lack the appropriate training necessary to provide quality care in the modern day nursing home. Increased federal funding is mandatory to deliver the quality care that this vulnerable population so desperately needs and deserves.

VIII. CONCLUSION

A. OBRA '87

A comparison of the outcomes in cases brought under state law and those brought under the Fourteenth Amendment of the Constitution sheds some light on the effect of the provision of OBRA '87, which defers the determination of competency and the concomitant right to refuse medication to state law.²²⁴ Because the Fourteenth Amendment imposes a constitutional

220. Kimberly L. Intagliata, Comment, *Improving the Quality of Care in Nursing Homes: Class Action Impact Litigation*, 73 U. COLO. L. REV. 1013, 1014 (2002). See also the proposed Elder Justice Act, *supra* note 202.

221. Intagliata, *supra* note 220, at 1014.

222. *Id.*

223. *Id.* at 1014-15.

224. See 42 U.S.C. § 1395i-3(c)(1)(C) (2000); 42 C.F.R. § 483.10(a)(3) (2003). See

minimum of substantive and procedural process that must be afforded in all situations, the OBRA '87 provision, incorporating relevant state law, certainly does not harm the interests of patients objecting to psychotropic medication. In fact, as has been illustrated in *Roger v. Okin* on remand, the Federal Due Process Clause provides procedural protection for state-created substantive liberty interests.²²⁵ Moreover, this protection extends to procedural requirements where such limitations place substantive restrictions on the actions of state officials.²²⁶

Furthermore, as illustrated by the holdings in *In re Orr*²²⁷ and *Rivers v. Katz*,²²⁸ state law and constitutional provisions provide more compelling arguments for full judicial proceedings in patient refusal cases. Thus, the deference of OBRA '87 to state law on this issue would tend to expand the substantive and procedural rights of residents in long-term care facilities to successfully refuse the administration of psychotropic medication. Granted, if OBRA '87 provided an explicit right to facility residents to refuse medication in all but the most extreme cases, the result would be a uniformly high standard. Nevertheless, as a matter of policy, there are many reasons for not doing so.

The legacy of recent right to refuse cases has been aptly characterized as a conflict in which "the law is struggling to decide whether it is better social policy to have judges make quasi-medical decisions or to have doctors make quasi-judicial ones."²²⁹ The reactions of members of the medical community have been dispassionate. Dr. Alan Stone, the former president of the American Psychiatric Association, described the ruling in *Rogers v. Okin* as "the most impossible, inappropriate, ill-considered judicial decision in the field of mental health law."²³⁰ These objections seem to be based on the concern of medical professionals about significant delay in treatment, a disservice to the welfare of the patient, and the greater time commitment required of the physician to consult with legal counsel and testify in court.²³¹ *Rivers v. Katz* has also received attention from the medical com-

also 42 U.S.C.A. § 1395i-3(c)(1)(C) (West 2003).

225. 738 F.2d 1, 5 (1st Cir. 1984).

226. *Id.* at 7 (citing *Parenti v. Ponte*, 727 F.2d 21, 24-25 (1st Cir. 1984)).

227. See 531 N.E.2d 64, 75 (Ill. 1988).

228. See *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986).

229. Loren H. Roth, *The Right to Refuse Psychiatric Treatment: Law and Medicine at the Interface*, 35 EMORY L.J. 139, 150 (1986).

230. *Id.* at 148 & n.30 (quoting NAT'L L.J., Jan. 26, 1981, at 2).

231. Marilyn J. Schmidt & Jeffrey L. Geller, *Involuntary Administration of Medication in the Community: The Judicial Opportunity*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 283, 283-84 (1989) (describing the reaction of the psychiatric community to the holding in *Rogers v. Commissioner*, 390 Mass. 489 N.E.2d 308 (1983), the Massachusetts case that provided the state law basis for the holding of *Rogers v. Okin*, as remanded by the Supreme

munity.²³² In a recent analysis of the impact of this decision, one study concluded that the rate of refusal in New York mental hospitals has actually decreased.²³³ The authors reasoned that, after *Rivers* and its "cumbersome mechanism," patients were no longer encouraged to write formal refusals, resulting in the hearing of fewer objections.²³⁴ The conclusion reached was that because of the delay of medication, the patients' welfare was eroded, thus providing no clinical or legal benefits to the patients.²³⁵

There has been little after-the-fact commentary describing the beneficial effects of according full judicial procedures to refusing patients. This may be attributed to the fact that the direct beneficiaries of the greater procedural protections—mental patients—are a less vocal group than the medical profession. Nonetheless, some benefits have been recorded in a study including patients who, under court order, were administered medication, and then released.²³⁶ The primary benefit of the court order is that, unlike less formal administrative proceedings, it ensures that the patient will continue using the medication even after release.²³⁷ *Rivers v. Katz* has also been viewed favorably as a milestone, establishing that it is the unique function of a jurist to balance a patient's constitutional protections against the interests of the State.²³⁸

The lack of consensus on the benefits of full judicial procedures versus less formal administrative procedures for refusal cases should provide some insight into the appropriateness of Congress' decision to defer similar decisions for residents in long-term care facilities to the states. To the extent OBRA '87 allows these policy determinations to be made at the state level, the rights of nursing home residents are often afforded greater protection than they would otherwise receive under the Fourteenth Amendment. Furthermore, in light of the rapidly increasing number of residents in these fa-

Court). See also Steven K. Hoges et al., *The Right to Refuse Treatment Under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 163, 168 (1987) (describing another analysis of *Roger v. Commissioner*, which concedes that the new treatment practices serve the purposes of due process well). However, the article also asks if the patients' true interests are as well served because clinical time and money are diverted from clinical care, subverting the ultimate goal: quality of care. *Id.*

232. See J. Richard Ciccone et al., *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 203, 208 (1990).

233. *Id.* at 208.

234. *Id.* at 213-14.

235. *Id.* at 214.

236. See Schmidt & Geller, *supra* note 231, at 285-86.

237. *Id.* at 286.

238. Steven Mintz, Note, *The Nightmare of Forcible Medication: The New York Court of Appeals Protects the Rights of the Mentally Ill Under the State Constitution: Rivers v. Katz*, 53 BROOK. L. REV. 885, 916 (1987).

cilities, parallel jurisdiction with state courts would share the burden of any litigation arising under state law. If Congress were to enact specific standards, all resulting litigation would have to take place in federal court, causing even greater delay and expense to litigants in the already overburdened federal courts. Most importantly, though, there is already a significant state infrastructure for the administration and funding of long-term care facilities. The states should, therefore, also make the decision as to additional substantive and procedural rights appropriate for refusal cases in these institutions.

B. The Long-Term Care Ombudsman

Reactions to the long-term care ombudsman solution have been varied. Some, citing the medical community's powerful impulse to maintain a sphere of professional influence, have advocated the medical self-determination of both competent and incompetent patients.²³⁹ They have approved and disapproved of the ombudsman procedures in *Conroy*.²⁴⁰ Others have implicitly approved of the notion of an ombudsman, advocating court-appointed guardianship in the context of non-judicial protective proceedings.²⁴¹ Still, others have characterized long-term care ombudsman programs as an overly burdensome, intrusive exercise of state power in an essentially private domain.²⁴² This view, however, does not appear to represent the prevailing one. Indeed, although expressing reservations, most approve of the ombudsman notion as a compromise solution, which avoids the expense of judicial proceedings while deferring to the rights of the patient.²⁴³

A comparison of OBRA '87 and the long-term care ombudsman program discussed in *Conroy* reveals a congressional desire to extend some protection to the rights of residents in long term care facilities. However, two important points may be inferred from these proposed solutions to the problem. Congress is unwilling to become involved in the administration of any

239. *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1655 n.97, 1676 (1990).

240. *Id.*

241. See Mark Fowler, Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 1031 (1984).

242. See Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 435 (1988); Andrew Agrawal, Note, In Re *Conroy: Forging a Path to Death with Dignity*, 67 B.U.L. REV. 365, 367, 386 (1987).

243. See Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 760, 799 (1987); Phoebe A. Haddon, *Baby Doe Cases: Compromise and Moral Dilemma*, 34 EMORY L.J. 545, 564 (1985); Suzanne Levant, Case Comment, *Natural Death: An Alternative in New Jersey*, 73 GEO. L.J. 1331, 1352-53 (1985).

comprehensive regulatory mechanism to implement this goal. Furthermore, it has limited the jurisdiction of the federal courts to hear refusal cases by deferring to the states the articulation of any right that exceeds due process. Congress has also deprived the federal courts of jurisdiction by making no explicit or implicit mention of a private cause of action under the amendments to the 1965 Act. In addition, the purpose of the ombudsman provisions seems to be to avoid either the situation where judges make medical decisions or where doctors make judicial decisions.²⁴⁴ This is a very fine line to tread, but to the extent this policy consideration is respected, it can only be hoped that a balanced solution will be achieved ultimately which promotes the rights of the patient while at the same time recognizing the necessity for a cost-effective administrative framework.²⁴⁵

244. Roth, *supra* note 229, at 150.

245. See Gelfand, *supra* note 243, at 799.