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I. Introduction

In 1955, the Federal Food and Drug Administration approved the drug methylphenidate, otherwise known as Ritalin, for use in treating general childhood behavioral disorders.[1] Recently, in just under a decade, the number of Ritalin prescriptions has increased by over 500%.[2] Physicians, prompted by concerned parents and teachers, increasingly diagnosed children with behavioral problems and accordingly found that Ritalin alleviated the children's symptoms. But when do child-like, rambunctious characteristics reflect a serious medical condition? More importantly, should parents, as consumers, rely on drugs to counteract these behavioral problems?

Last year, parents of children diagnosed with Attention Deficit Disorder ("ADD") and Attention Deficit Hyperactivity Disorder ("ADHD") and who have taken Ritalin filed three class action lawsuits in California, New Jersey, and Texas against the drug's manufacturer, Ciba-Geigy/Novartis ("Ciba-Geigy").[3] Although there are significant diagnostic differences between the two disabilities, the suits involve both disorders. This article, however, will only discuss the suits with regard to ADHD. The suits specifically allege that Ciba-Geigy took steps to promote and dramatically increase the sales of Ritalin by:

1. actively promoting and supporting the concept that a significant percentage of

children suffer from a "disease" which required narcotic treatment/therapy;

2. actively promoting Ritalin as the "drug of choice" to treat children diagnosed with ADD and ADHD;

3. actively supporting groups such as Defendant Children and Adults with ADHD ("CHADD"), both financially and with other means, so that such organizations would promote and support (as a supposed neutral party) the ever-increasing implementation of ADD/ADHD diagnoses as well as directly increasing Ritalin sales;

4. distributing misleading sales and promotional literature to parents, schools, and other interested persons in a successful effort to further increase the number of diagnoses and the number of persons prescribed Ritalin.[4]

As of April 22, 2001, two of the lawsuits have been dismissed, with the third still pending. Nevertheless, these class actions demonstrate the need for an evaluation of the drug Ritalin and its administration to children for ADHD.

In order to be diagnosed with ADHD, children must meet the following criteria, as set forth by the Diagnostic and Statistical Manual of Disorders, Fourth Edition ("DSM –IV").[5] First, the child must demonstrate six or more symptoms of either inattention or hyperactivity-impulsivity.[6] Symptoms of inattention include the following:

a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities;
b) often has difficulty sustaining attention in tasks or play activities;
c) often does not seem to listen when spoken to directly;
d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions);
e) often has difficulty organizing tasks and activities;
f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
g) often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools);
h) is often easily distracted by extraneous stimuli;
i) is often forgetful in daily activities.[7]

Symptoms of hyperactivity include the following:
a) often fidgets with hands and feet or squirms in seat;
b) often leaves seat in classroom or in other situations in which remaining seated is expected;
c) often runs about or climbs excessively in situations in which it is inappropriate;
d) often has difficulty playing or engaging in leisure activities quietly;
e) is often "on the go" or often acts as if "driven by a motor";
f) often talks excessively.[8]

Lastly, symptoms of impulsivity include the following:

g) often blurts out answers before questions have been completed;
h) often has difficulty awaiting turn;
i) often interrupts or intrudes on others (e.g. butts into conversations or games).[9]

Children must exhibit these symptoms for at least six months and the impairment from the symptoms must be present in at least two different settings (in school, at home, etc.).[10] Moreover, there needs to be clear evidence of "clinically significant impairment in social, academic, or occupational functioning."[11] Lastly, the symptoms must not occur exclusively during the course of a developmental disorder, schizophrenia, or other psychotic disorder, and the symptoms should not be better accounted for by another mental disorder.[12] After a physician confirms the aforementioned symptoms in a child and diagnoses him with ADHD, the next step is to determine proper treatment.

Ritalin is a nerve stimulant drug that physicians primarily prescribe to children who suffer from ADHD.[13] The drug produces an increase in neural activity that, in most people, results in increased motor activity.[14] In hyperactive children, however, Ritalin produces the opposite result and the children become calmer.[15] Most children are then better able to concentrate and focus their attention on school. Another important advantage of Ritalin is that it is effective almost immediately.[16] Despite these advantages, the drug has a multitude of possible side effects, not limited to the following: insomnia, nervousness, loss of appetite, abdominal pain, weight loss, extensive bruising, and abnormally low red and white blood cell counts.[17] The medical evidence in *Witherspoon v. Ciba-Geigy* suggested that children could even develop Tourette's Syndrome from taking Ritalin.[18] Although most long-term side effects are unknown, one

well-known side effect is the possibility of developing an addiction to Ritalin or other similar stimulant drugs.[19] Despite the unavoidable risks of taking Ritalin, physicians continue to recommend and prescribe this drug to children diagnosed with ADHD, presumably because the benefits of the drug tend to outweigh the possible harms.[20]

For a multitude of reasons, Ritalin has been a controversial drug for nearly 30 years. Additional issues surrounding the drug include effectiveness of the drug, school administration of the drug, amount of proper dosage, and, most recently, Ritalin fraud and abuse in schools and on the street. The totality of these controversies has led to the formation of several different groups of supporters and dissenters of the drug. On the one side are those parents and professionals who do not believe that ADHD is an actual condition and, therefore, want physicians to discontinue prescribing Ritalin when children exhibit the alleged symptoms. At this extreme, these advocates want the drug taken off of the market completely. On the other side, also represented by parents and professionals, are those who believe ADHD to be a serious illness and that Ritalin is the safest, easiest, and often the only treatment for a child with ADHD. To date, neither side has prevailed in its advocacy.

This Article will explore the merits and weaknesses of each set of arguments in light of the recent class action lawsuits that plaintiffs brought against Ciba-Geigy. Specifically, this Article will present congressional testimony from various witnesses regarding the diagnosis of ADHD, as well as Ritalin treatment for the condition. Lastly, this Article will demonstrate that Congress's proposed bill relating to the prescription and administration of psycho-stimulants in children, if enacted, would be a productive step in combating the over-prescription of Ritalin.

II. Current Litigation Regarding Ritalin

Since its approval in the 1950's, Ritalin has been a topic of controversy for numerous reasons. The first controversy is whether physicians should prescribe mood-altering psychotropic medication to children. Likewise, there are a multitude of potential side effects attributable to the drug. Finally, many parents do not want their children stigmatized for having to take medication regularly. For these reasons, parents, educators, and physicians have questioned whether Ritalin is an appropriate treatment for children.

In 1986, for example, plaintiffs in *Witherspoon* brought a lawsuit against Ciba-Geigy alleging that the corporation failed to warn Ritalin users of the potential side effect of Tourette's Syndrome.[21] On appeal, the plaintiffs mistakenly argued that the trial court erred in refusing to admit the defendants' revised warning label that was issued subsequent to the child's prescription of the medication.[22] Because the plaintiffs had brought forth a strict liability claim, rather than negligence, the Tennessee Appellate Court found no error.[23] The court stated that based on the medical and scientific knowledge available at the time the child began taking the drug, the old warning label had been sufficient and it accordingly found for Ciba-Geigy.[24]

The issue in the three class action lawsuits is whether Ciba-Geigy conspired and colluded to promote the diagnosis of ADHD (as well as ADD) in an effort to expand the market for Ritalin.[25] Other named defendants include Children and Adults with Attention Deficit/Hyperactivity Disorder ("CHADD"), which allegedly accepted donations and contributions from Ciba-Geigy/Novartis so that the organization would help increase sales and use of Ritalin.[26] A third named defendant is the American Psychiatric Association due to its involvement in establishing the diagnosis of ADHD.[27] The plaintiffs additionally allege that Ciba-Geigy distributed mislead-

ing sales and promotional materials to parents, schools, and others in order to increase sales.[28]

III. Evidence to Support a Ban on Ritalin Use

In response to these lawsuits and in consideration of ongoing studies involving Ritalin and other psychiatric medications, Congress recognized a need for further investigation regarding the use of this drug. In September 2000, Congress held hearings before the Subcommittee on Oversight and Investigations, under the Committee on Education and the Workforce in the wake of the lawsuits.

A. A Physician's Perspective on Ritalin Use

Appearing before members of the Subcommittee, Dr. Peter Breggin, Director of the International Center for the Study of Psychiatry and Psychology, testified regarding the fallacy of ADHD and the over-prescription of Ritalin.[29] Dr. Breggin presented evidence illustrating the similarities between the effects of Ritalin and cocaine on the brain, thus suggesting the addictive nature of the drug.[30] Secondly, Dr. Breggin analyzed the three diagnostic categories of ADHD: hyperactivity, impulsivity, and inattention.[31] He emphasized the correlation between disruptive behavior in classrooms and these characteristics.[32] Dr. Breggin asserted that the diagnosis of ADHD was aimed at controlling disruptive, but not diseased, children in the classroom.[33] Likewise, he stated that there were no statistics to confirm a biological basis for ADHD.[34] Lastly, Dr. Breggin stated that physicians tended to prescribe stimulant drugs in general as a quick, effective alternative to examining actual problems in the child's life.[35] Instead of analyzing why a child is restless or disobedient, the parents or schools simply choose to give the child a pill so that he will be "drugged into a more compliant or submissive state."[36]

Although Dr. Breggin's views are extreme in that he believes that the ADD/ADHD diagnoses were concocted by an organization that needed a market for its new drug, he supports his conclusions with scientific evidence. First, he states that there is no known scientific evidence in the brain of ADHD, which means that the diagnosis is based entirely on behavioral characteristics.[37] Second, Dr. Breggin notes that the three different bases for diagnosis of ADHD (hyperactivity, impulsivity, and inattention) are extremely subjective because children naturally exhibit these characteristics. Physicians must therefore make the difficult determination of what is "normal" behavior and what is a medical condition.[38] Lastly, he recommends that those who actually observe these diagnostic characteristics, primarily teachers and parents, should try to be the persons who should decide what treatment is appropriate for these children.[39] Ideally, the physicians who write the prescriptions for Ritalin should be able to observe the children's behavior in order to assess whether drugs are in the best interest of the children. Instead, physicians usually spend a relatively short amount of time with the children and try to learn more about their daily behavioral characteristics from their parents and teachers. Based on these subjective observations by parents and teachers, doctors must then decide the appropriateness of prescribing Ritalin.

B. Other Harmful Effects of Ritalin

Although the Ciba-Gaigy lawsuits prompted the Congressional hearings, other topics of concern were addressed in addition to the actual validity of ADHD as a medical condition. Numerous studies indicate, for example, that between 1990 and 2000, the production and subsequent use of Ritalin has increased by 500-800%.[40] Another issue that Congress has addressed is the growing prevalence of Ritalin abuse among school-age children, as well as college students and adults. Because

Ritalin is a powerful and somewhat addictive nerve stimulant drug, the Drug Enforcement Administration ("DEA") has classified it in the Schedule II of the Controlled Substances Act ("CSA") category in 1971.[41] Other Schedule II drugs, which are classified as such due to their high abuse potential and dependence profile, include cocaine, barbiturates, and most opiates.[42] Reports show that to achieve the desired effect, abusers crush Ritalin pills into a fine powder and snort the substance; other evidence shows children dissolving the pills and injecting the liquid like heroin.[43]

Although few states or local governments have brought lawsuits regarding Ritalin abuse by children or college students, several sources verify the prevalence of abuse occurring. The DEA, for example, conducted a study in 1998-1999 that examined abuse of methylphenidate as shown by poison control data, emergency room data, and high school surveys.[44] Additionally, the DEA stated that from January 1990 to May 1995, methylphenidate ranked in the top ten most frequently reported controlled drugs stolen.[45] These statistics reflect thefts from facilities that are registered with the DEA to carry the drugs.[46] Unfortunately, the DEA does not require schools to be register and report how much Ritalin they have, even though schools often keep children's bottles for daily dosages.[47] Therefore, precise statistics identifying theft from unregistered facilities, as well as from private individuals, are impossible to ascertain.

Unfortunately, an alarming number of schoolteachers and administrators have been caught stealing Ritalin from school facilities. In March 2000, the Tennessee Court of Appeals in *Lannom v. Board of Education* affirmed the termination of a tenured teacher who was caught on videotape stealing pills from a student's prescription bottle.[48] Over the course of two years, the school experienced eight incidents in which Ritalin was missing from a student's bottle, even though the pills were stored in a locked area of a school office.[49] With help from the

local police department, the principal installed a surveillance camera in the office where the pills were kept and replaced the Ritalin with baby aspirin in order to apprehend the offender.[50] The plaintiff was thus apprehended and terminated after a hearing, with no formal charges brought against him.[51]

News reports also indicate that Ritalin abuse occurs even when interested parties do not file lawsuits.[52] In October 2000, the principal of an elementary school in Orem, Utah spent 30 days in jail for replacing a student's Ritalin with sugar pills.[53] In that situation, not only was the principal allegedly abusing the drug, but he was also endangering the treatment and health of a student by depriving the student of his medication. Likewise, in Indiana, a school nurse was fined $1,300 and ordered into treatment after stealing Ritalin and other drugs from a locked cabinet.[54] Although few cases have actually been litigated, the DEA evidence supports the contention that for every abuse instance that ends up in the news, there are numerous unreported incidents that do not become public.[55]

In response to the growing abuse of Ritalin, as well as other psycho-stimulants, Henry Hyde (R-IL), Chairman of the Committee on the Judiciary asked the General Accounting Office ("GAO") to undertake a study of Ritalin abuse in schools.[56] This request came just two weeks before Dr. Breggin's testimony on September 29, 2000. This report, however, has not yet been published and there are no news releases indicating when the report might be available. Additionally, Rep. Hyde supported legislation requiring the states to certify the existence of guidelines for prescription use of Ritalin on school premises.[57] Likewise, Representative Bob Schaeffer proposed House Resolution 459 earlier last year that among other provisions urged Congress to "exercise its oversight responsibilities and conduct hearings concerning the provision for school children of prescriptions for psychotropic drugs."[58] The Bill attracted 24 co-sponsors

and was referred to a House subcommittee, but was not enacted before the end of the last Congressional term.[59] The last section of this article will explore this proposal to greater lengths.

IV. Affirmative Support for Ritalin Use in Children

Now that Congress and some physicians are beginning to investigate and closely scrutinize whether Ritalin is appropriate for the escalating amount of children taking the drug, concerned parents and physicians are coming forth and expressing their support for the drug. The supporters first emphasize the positive effects of the drug, insisting that the medication has helped their children and patients with ADHD live more normal lives.[60] They also adamantly oppose the contention that ADHD is a condition originally created by a drug company to boost sales of a product.[61] While little biochemical evidence demonstrates why Ritalin, a nerve stimulant, helps hyperactive children slow down and focus, dissenters have a difficult time disputing the observations of grateful parents and teachers who have witnessed their children's behavioral improvements after they began taking the drug.[62]

On May 16, 2000, Ms. Mary Robertson, the past President of CHADD, submitted testimony regarding Ritalin to the Early Childhood, Youth and Families Subcommittee.[63] Robertson stated that when her son was diagnosed with ADHD, she vowed that she would not treat his condition with medication.[64] Instead, she sought evaluations from a neurologist, an allergist, a hearing specialist, an ophthalmologist, a pediatrician, and numerous psychologists and psychiatrists.[65] Her son was also exposed to various treatment therapies, such as allergy shots, dietary changes, behavior management, accommodations at school, and interventions.[66] After conservative

treatments failed and her son came home from school crying because he was always getting in trouble and not remembering how to spell, Robertson decided to put her son on Ritalin.[67] She described the change in her son as "watching a scene from Dr. Jekyll and Mr. Hyde."[68] Although she acknowledged the inherent drawbacks of the drug and recounted her son's ultimate struggle through elementary and middle school, she urged the Subcommittee not to disregard the helpful effects that Ritalin has had on millions of children.[69]

That same day, Ms. Francisca Jorgenson, a Special Educator for the Arlington County School System also testified as to the benefits of drug treatment.[70] Jorgenson emphasized that while environmental and behavioral modifications should be an integral part of treating a child with special needs, medication often needs to be part of a child's treatment.[71] She stated, that conservative treatment alone is not enough for some children and that "Ritalin is an academic and social necessity."[72] Like Robertson, Jorgenson witnessed the dramatic improvements in the numerous children with whom she has worked.[73]

While educators and schools have been among the most vehement supporters of the use of Ritalin to treat ADHD, some parents have found it necessary to take action against schools that refuse to administer the drug to their children. In *Davis v. Francis Howell School District* and *DeBord v. Board of Education of the Ferguson-Florissant School Dist.*, parents brought lawsuits against their children's schools because the school nurse refused to administer Ritalin.[74] In both cases, the nurses stated that because the daily amount of medication that the child was prescribed exceeded the recommended dosage in the Physician's Desk Reference, school policy forbade them from administering any dosages at school.[75] Although the court did not rule on the propriety of dispensing the drug at schools, it did not find that the school discriminated against the children for not dispensing the medication in

alternate ways due to the high dosage.[76] Together, the two cases collectively demonstrate that while schools generally support use of Ritalin, they do not want to face liability for any potential problems stemming from overmedication of the children.[77]

Likewise, parents often look to Ritalin for their children to avoid the stigma of attending remedial classes. This stigmatism is a valid concern for parents and their children who suffer from ADHD. For example, if a teacher gives an ADHD student the extra attention needed to help him focus in a regular class, other students may openly question the student's abilities. Additionally, the teachers are not always able to devote equal attention to other students; they must often modify their classrooms to accommodate children with special needs.[78] When choosing between transferring the child to a classroom where he can receive the attention he needs or giving the child medication, most parents would prefer to keep the child in the regular classroom and endure the inconvenience and drawbacks of medication, especially when the families have exhausted conservative treatments.[79]

V. Congressional Support for a Middle Ground Approach to Ritalin

Considering the two aforementioned extremes, those who support the use of Ritalin and those who discount its effects, a middle-ground approach consisting recognizing ADHD and strictly regulating the distribution of medication would be the most advantageous solution to the controversy. This solution would involve participation of the government, the school systems, physicians, and parents of children with ADHD. Several interested parties have expressed support for this middle ground approach, which would include greater government involvement and additional research as to the actual scientific effects of the drug.

Dr. Lawrence Diller, a behavioral pediatrician, submitted testimony on May 16, 2000, to Congress regarding the use of Ritalin.[80] Dr. Diller recognized the dramatic increase in use of the drug in the past ten years and partially attributed the increase to greater pressure put on children to achieve and be successful at earlier ages.[81] He noted, however, that the actual improvements in behavior that Ritalin causes in ADHD children are virtually the same improvements as those exhibited in any other child or adult who took the drug.[82] In other words, if Ritalin can bring about behavioral improvements in every sector of the population, then just because a child responds to the drug does not necessarily mean that he suffers from ADHD, or that Ritalin is the most appropriate treatment. Although Dr. Diller stated that stimulant drugs could be effective for "a limited number of children and adults who are compromised in any situation," he discredited the idea that improved diagnostic guidelines could help remedy the overuse of Ritalin.[83] Instead, Dr. Diller took a broader stance and concluded that parents and doctors must change the way they treat the children's behavior, personality, and performance problems.[84] Although the change in focus could dramatically decrease the amount of children on psychotropic medication, Dr. Diller offers no means of achieving these changes in the societal attitude, and his testimony falls short of a practical solution to the problems he outlines.

Congressional representatives, however, recognized the need for governmental action and recently addressed the Ritalin controversy. The House Resolution 459 ("H. Res. 459") is a good model of a preliminary effort by Congress to take a more active, educated role in the regulation of stimulant drugs used for therapeutic purposes.[85] First, the resolution proposes that Congress conduct hearings regarding the prescription of psychotropic drugs in order to gather information on how the drug is currently being used.[86] As demonstrated, Con-

gress did conduct preliminary hearings that brought forth information from various physicians, teachers, and parents; H. Res. 459 would investigate this issue even further.[87] Although the testimony presents potentially useful information, the many disparities in the various opinions illustrate the need for increased research. Accordingly, Congress's second proposition is that the National Academy of Sciences "study the effects of prescription psychotropic drugs on the academic achievement and behavior of children" to remedy the lack of scientific evidence that is currently known about the effects of the drug.[88]

Additionally, H. Res. 459 calls for the federal government to support state and local education agencies with respect to their "conclusions and resolutions" regarding the prevalence of children taking psychotropic medication.[89] Likewise, the resolution encourages school personnel to use academic and classroom management techniques to work with children who have behavioral or attention problems (essentially, symptoms of ADHD).[90] This step is crucial in reducing the number of children on Ritalin because teachers and school administrators are often the persons who most often observe the childrens' behaviors and subsequently recommend that parents should give their children Ritalin.[91]

Lastly, the proposed legislation urges increased communication among parents, educators, and medical professionals with regard to the effects of psychotropic drugs on school children, both behaviorally and academically.[92] By working together, these individuals might be able to focus more on childrens' needs and less on the differences in their points of view. More specifically, the Resolution proposes a focus on regulations pertaining to administering and prescribing the drug to schoolchildren, in the hopes of combating both over-diagnosis as well as potential abuse.[93]

H. Res. 459 is a positive, comprehensive step towards increased regulation and more careful prescrip-

tion of Ritalin, as well as any other psycho-stimulant that may replace it in the future. This piece of legislation is a good model of how government can exercise its authority over public education in a way that brings together interested parents, teachers, and physicians in an effort to help the children who suffer from behavioral disorders. Additionally, the language of the resolution is appropriate because it does not promote an outright ban on the use of medication to treat children's behavioral problems. Rather, H. Res. 459 recognizes the need for increased scientific research and general supervision of the drug, while at the same time encouraging greater use of behavioral management in classrooms. H. Res. 459 effectively seeks to reach a much-needed middle ground between those who zealously oppose drug use and those who believe that Ritalin is the best answer for children with behavioral problems.

VI. Conclusion

As major consumers of Ritalin, parents, on behalf of their children, need to be aware of the potential harms surrounding the medication. Likewise, parents should also realize that they often have options apart from medicating their children, so that their children can maintain normal lives. Parents should also be aware that more and more people are beginning to abuse Ritalin, a practice that could endanger their children as well as individuals who take the substance illegally. Most importantly, as House Resolution 459 advocates, parents must work along with teachers and physicians to insure that children receive the best treatment possible for their particular illnesses. Hopefully, with the help of the government, physicians, concerned teachers and parents, children will receive improved diagnoses and treatment for whatever behavioral problems they might have.

Endnotes

1. Shankar Vedantam, *A Symptom of the Times? ADD, Ritalin Focus of Suits*, PHIL.. INQ., Dec. 11, 2000, *available at* http://www.parkinsons-information-exchange-network-online.com/drugdb/083.htm.

2. Hearing on Ritalin Use Among Youth; Examining the Issues and Concerns, Subcommittee on Early Childhood, Youth and Families, Comm. on Education and the Workforce, 106th Cong. 109, (2000) (statement of Terrence Woodworth, Drug Enforcement Agency, Deputy Director of the Office of Diversion Control) 2000 WL 644334, *available at* http://www.dea.gov/pubs/cngrtest/ct51600.htm. [hereinafter *DEA*]. This figure reflects the increase in Ritalin use between 1990 and 2000.

3. Jennifer L. Reichart, *Class Action Suits Target* Ritalin, 36-DEC Trial 89, 89-90 (Dec. 2000). The cases were filed as follows: Vess v. Ciba-Geigy Corp., No. 00-CV-1839 (S.D.Cal. filed Sept. 13, 2000); Dawson v. Ciba-Geigy Corp., No. BER-L-7774-00 (N.J., Bergen County Super. Ct. filed Sept. 13, 2000); Hernandez v. Ciba-Geigy Corp., No. 2000-051888D (Tex., Cameron County Dist. Ct. filed May 1, 2000).

4. *Ritalin Fraud*, (2000), *available at* www.ritalinfraud.com. [hereinafter *Fraud*]. These claims specifically are those from the Texas lawsuit, but represent the general allegations of all three suits.

5. DIAGNOSTIC AND STATISTICAL MANUAL OF DISORDERS IV-R (Am. Psychiatric Ass'n et al. eds., 4th ed. 1994) [hereinafter DSM-IV].

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. James O'Leary, *An Analysis of the Legal Issues Surrounding the Forced Use of Ritalin: Protecting a Child's Right to "Just Say No"*, 27 NEW ENG. L. REV. 1173, 1178 (1993).

14. *Id.*

15. *Id.* at 1179.

16. *Id.* at 1175.

17. Therese Powers, *Race for Perfection: Children's Rights and Enhancement Drugs*, 13 J.L. & HEALTH, 141, 144 (1998-99); *See also Fraud, supra* note 4, at 1.

18. Witherspoon v. Ciba-Geigy Corp., 1986 Tenn. App. LEXIS 2773. Tourette's syndrome is a central nervous system disorder characterized by uncontrollable motor and phonic tics that wax and wane in severity. Plaintiffs alleged that their child, Kent, began exhibiting symptoms of Tourette's syndrome shortly after he began taking the drug. The symptoms subsequently ceased immediately after he discontinued taking Ritalin, which made them aware of the possible connection.

19. Powers, *supra* note 17, at 145.

20. O'Leary, *supra* note 13, at 1179.

21. *Witherspoon*, 1986 Tenn. App. LEXIS, at *2.

22. *Id.* at *4.

23. *Id.*

24. *Id.* With regard to the issue of whether Ritalin caused the Tourette's Syndrome, the Tennessee Appellate Court also held that the trial court did not err when it relied on the medical and scientific knowledge available at the time of the trial.

25. *Fraud, supra* note 4, at 1.

26. *Id.*

27. *Id.*

28 *Id.*

29. Peter R. Breggin, *Peter Breggin MD Testifies Before Congress on Ritalin*, (Sept. 29, 2000), *available at* http://www.breggin.com/congress.html. [hereinafter *Breggin*].

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. O'Leary, *supra* note 13, at 1179. This article supports Dr. Breggin's assertion that there is no scientific evidence to support the connection between Ritalin and ADHD.

35. *Id.*

36. *Id.*

37. *Id.*

38. Richard Welke, *Litigation Involving Ritalin and the Hyperactive Child*, 1990 DET. C. L. REV. 125, 134 (Spring 1990) [hereinafter *Litigation*]. This article presents the "Diagnostic Criteria for Attention Deficit Disorder with Hyperactivity" as it was listed in the 1980 Diagnostic and Statistical Manual of Mental Disorders (DSM) Third (III). These characteristics are still presently the elements of ADHD, although the DSM-IV is now the current manual.

39. *Breggin, supra* note 29.

40. Kristen L. Aggeler, *Is ADHD a "Handy Excuse"? Remedying Judicial Bias Against ADHD*, 68 UMKC L. REV. 459, 463 (Spring 2000) [hereinafter *Handy Excuse*]; *DEA, supra* note 2, at 1.

41. *DEA, supra* note 2, at 1.

42. *Id.*at 1-2.

43. *Id.*

44. *DEA, supra* note 2, at 8.

45. *Id.* at 6.

46. *Id.*

47. *Id.*

48. *Lannom v. Bd. of Educ.*, No. MI 1999-00137-COA-R3-CV, 2000 WL 243971, at *1 (Tenn. Ct. App. March 6, 2000).

49. *Id.* at *2.

50. *Id.*

51. *Id.*

52. Karen Thomas, *Stealing, Dealing and Ritalin*, USA TODAY, Nov. 27, 2000, at 3, *available at* http://www.usatoday.com/life/health/child/lhchi215.htm [hereinafter *Stealing*].

53. *Id.*

54. *Id.*

55. *DEA*, *supra* note 2, at 6.

56. News Advisory for the Committee on the Judiciary, *Hyde Wants Study of Ritalin Abuse in Schools*, (Sept. 14, 2000), *available at* http://www.house.gov/judiciary/na091400.htm. [hereinafter *Hyde*].

57. *Id.* at 1.

58. H.R. 459, 106th Cong. (2000), *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d106:.h.res.00459:html.

59. *House Hearing Highlights Extremes of Ritalin Controversy*, (Oct. 8, 2000), *available at* http://www.specialednews.com/storyarchive/1000/ritalinhearing1008.htm. [hereinafter *House Hearing*].

60. Mary Robertson, *Testimony of Mary Robertson, Lexington, KY, Respectfully Submitted to the U.S. House of Representatives Early Childhood, Youth and Families Subcommittee*, (May 16, 2000), *available at* http://edworkforce.house.gov/hearings/106th/ecyf/ritalin51600/robertson.htm. [hereinafter *Robertson*].

61. *Id.*

62. Jillene Magill-Lewis, *Psychotropics and Kids: Use of Drugs in Treating ADHD Sets Off New Debate About Finding the Right Therapy for Children*, 2000 WL 9185300 (2000) [hereinafter *Psychotropics*].

63. *Robertson*, *supra* note 59. Note that Ms. Robertson's testimony actually occurred before the California and New Jersey lawsuits had

even been filed. Congress had therefore already begun to examine the use of the drug.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. Francisca Jorgensen, *Testimony of Ms. Jorgensen*, (May 16, 2000), *available at* http://www.house.gov/ed_workforce/hearings/106th/ecyf/ritalin51600/jorgensen.htm. [hereinafter *Jorgensen*]. Again, Ms. Jorgensen's testimony came before two of the lawsuits were filed.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Davis v. Francis Howell Sch. Dist.*, 138 F.3d 754 (8th Cir. 1998); *DeBord v. Bd. of Educ. of the Ferguson-Florissant Sch. Dist.*, 126 F.3d 1102 (8th Cir. 1997).

75. *Davis*, 138 F.3d at 755; *DeBord*, 126 F.3d at 1104.

76. *Davis*, 138 F.3d at 756; *DeBord*, 126 F.3d at 1105. Note that these cases were bought forth on a Title II claim, based on alleged discrimination against the children for their disabilities.

77. *Davis*, 138 F.3d at 756; *DeBord*, 126 F.3d at 1105.

78. *Jorgensen, supra* note 69.

79. *Robertson, supra* note 62.

80. Dr. Lawrence Diller, *Testimony of Dr. Diller*, (May 16, 2000), *available at* http://www.house.gov/ed_workforce/hearings/106th/ecyf/ritalin51600/diller.htm. [hereinafter *Diller*].

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. H.R. 459, 106th Cong. (2000), *available at* http://thomas.loc.gov/cgi-bin/query/C?c106:./temp/~c1065pJMXF.

86. *Id.*

87. *See Breggin supra* note 18; *see also Robertson supra* note 51.

88. H.R. 459, 106th Cong. (2000) *available at* http://thomas.loc.gov/cgi-bin/query/C?c106:./temp/~c1065pJMXF.

89. *Id.*

90. *Id.*

91. Deborah Pryce, *Testimony of the Honorable Deborah Pryce (R-OH-15)*, (May 16, 2000), *available at* http://house.gov/ed_workforce/hearings/106th/ecyf/ritalin51600/pryce.html. [hereinafter *Pryce*].

92. *Id.*

93. *Id.*