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The Relationship Between the Court and the Doctor on the Issue of an Inpatient's Refusal of Psychotropic Medication

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ABSTRACT: New procedures, tailored after such court decisions as *Rogers v. Commissioner of the Department of Mental Health,* have restricted the doctor's ability to treat psychiatric inpatients with psychotropic medication and have increased the protection of a competent patient's right to refuse. This study investigates how the relationship between the doctor and the court has adapted to these new procedures. All 40 court cases of a maximum security forensic hospital over a two-year period were reviewed. Results suggest that the new procedures have had no dramatic effect upon either the treatment patients receive or the doctor-court relationship. While abstract arguments both in favor of and against these new procedures can be drawn from the same data, the concrete relationship still remains poorly understood.

KEYWORDS: psychiatry, jurisprudence, litigation

For better or for worse, the courts have entered into the privileged doctor-patient relationship over the issue of forced medication, thus transforming the dyad into a doctor-court-patient triad. In its role of arbiter, the court has had to weigh, among other things, the apparently conflicting demands of the physician's duty to treat and the patient's right to refuse intrusions on his person. To the extent that court decisions give priority to either of these demands, they can be perceived, at least on the surface, as favoring either patient or doctor. Appelbaum [*1*] has nicely classified the many court decisions into two divergent approaches, the "treatment-driven model," which favors the doctor's priority to treat, and the "rights-driven model," which favors the patient's right to refuse medication.

Appelbaum explains that a number of decisions can be classified as treatment-driven because they make "appropriate treatment" a greater priority than patients' rights. To the extent that the doctor knows what treatment is best, these decisions seem to favor the physician. And, clinicians argue, this approach also benefits patients since it is in their best interest to be treated appropriately. For landmark decisions leading to this model, see especially *Rennie v. Klein* [*2*], *Youngberg v. Romeo* [*3*], and *Project Release v. Prevost* [*4*].

Such an approach is most commonly implemented through some sort of internal review process; when a patient refuses medication, the decision is formally reviewed by other

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clinicians or administrators or both, and it does not go to the courts. Minnesota's use of a clinical Treatment Review Panel, which is described by Zito et al. [5], is a good illustration of this type of procedure. Also, Oregon's treatment-driven procedure, described by Young et al. [6], is modeled after New Jersey's *Rennie v. Klein* decision [2], and the procedures are quite similar.

In contrast, Appelbaum explains that the rights-driven model makes the competent patient's rights to control bodily intrusions its top priority, to the possible detriment of the patient's need for treatment. In this sense, the courts take the "side" of the patient in reducing the ground of the physician to those circumstances in which the patient is incompetent. And, even then, the court also limits the ground of the physician by deciding upon competence and, in some cases, even deciding upon the appropriateness of the treatment proposed by the physician.

For instance, in the case of *Rogers v. Commissioner of the Department of Mental Health* [7], it was decided that (1) doctor-patient disputes over medication must be settled in a *formal court hearing,* (2) that the court is to determine whether the patient is *competent,* (3) that the court is to act as the patient's *substituted judgment* if the patient is found to be incompetent, and, finally, (4) that the court is to determine the *appropriateness of the medication* in the event that the substituted judgment decides in favor of medication. Inspired by *Rogers v. Commissioner* [7], the New York State Supreme Court decision, *Rivers v. Katz* [8], mandated similar procedures.

On the face of it, this radical variation of the rights-driven model severely restricts the "turf" of the physician, and this has triggered, in turn, what Appelbaum characterizes as the "greatest invective on the part of clinicians" (Ref *1,* p. 417). This emotional response is well conveyed in Gutheil's now well-known description of drug refusal as nothing more than the patients' ability to "rot with their rights on" [*9,10*]. Gutheil [*11*] went on to trace the problems of the decision to the court's bias against medications and to the "instinctive assumption that an adversary relationship must exist between physician and patient" (Ref *11,* p. 214).

In this context, it also appears that an adversarial relationship between the court and the physician has developed. As represented in Gutheil's position, physicians feel that the courts are intruding into the doctor-patient relationship in the name of the patient's best interest. But, given that the patient's best interest is the top priority of the physician's sworn duty, this confrontation with the courts may therefore come across to the physician as a "turf battle," where the patient's best interest is used as a weapon. The field of battle includes not only the issue of who is qualified to determine the mental competency of the patient, but also the issue of the courts deciding on the appropriateness of treatment, something which seems patently absurd to physicians.

Like many other physicians [*9,12*], Gutheil [*11*] predicted that these procedures would lead not only to an impeding of the physician's ability to carry out his duty to treat but, even more importantly, to the deterioration of treatment available to patients. The only solution, in his opinion, was to introduce new litigation and legislation to reverse the *Rogers v. Commissioner* [7] decision.

After several years of *Rogers* procedures, however, empirical research has failed to confirm these dire predictions.

First, the fear that a mandatory formal court hearing would result in a drastic increase in the number of petitions that would overwhelm the legal and medical systems proved to be simply unfounded. For instance, Veliz and James [*13*] and Hoge et al. [*14*] did not find any evidence that treatment refusal had spread to unmanageable proportions.

With respect to the fear that patients would remain untreated, in a more global review of the literature, Appelbaum [*1*] found that (1) the overwhelming majority of refusing patients still received treatment under rights-driven procedures and (2) there was no difference between the rates of patients treated under rights-driven procedures and the

rates of patients treated under treatment-driven procedures (the rates consistently fell in the 70 to 100% range). He concluded, therefore, that physicians simply "underestimated" the ability of the courts and their surrogates to get treatment to patients who need it.

In a particularly interesting study not covered by Appelbaum, Cournos et al. [*15*] were able to contrast the effects of the two procedures while controlling the setting to a single state psychiatric hospital. This was made possible when New York state changed from a treatment-driven procedure to a rights-driven procedure with the *Rivers v. Katz* [*8*] decision in 1986. By comparing equivalent periods of time pre- and post-*Rivers* in the same hospital, they were able to compare the specific effects of the change in procedure. They found (1) that there was an equivalent number of medication refusals and (2) that the rate of forced medication was equivalent (roughly 90%) with both types of procedures. And, incidentally, this rate of forced medication also fits well within the range (70 to 100%) reported by Appelbaum [*1*] in his review of the literature.

With respect to what seems to be the most significant encroachment, the issue of substituted judgment and determining the appropriate medication, it would seem that the courts simply do what the doctors suggest. That is, once a refusing patient has been found to be incompetent, Veliz and James [*13*] found that, in 100% of the cases, the court, acting in lieu of the patient, decided in favor of medication. In addition, Cournos et al. [*15*] found that in 95% of the cases the court agreed in full with the treatment initially proposed by the doctor.

An ironic observation of the study by Cournos et al. is that specific *therapeutic* advantages were found in rights-driven procedures. They note, "the (rights-driven) procedure offered considerably greater representation and participation (for the patient). Patients may gain a better understanding of the need for treatment through a process that offers this degree of patient involvement" (Ref *15,* p. 855). Although these observations are only anecdotal, they are consistent with the results of Hasenfeld and Grumet [*16*], who found that patients who refuse treatment and then receive it after a formal review do better after discharge than patients who comply. They suggest that, for some refusers, a formal review of their refusal develops their sense of autonomy, which is so important in coping with life outside the hospital. When generalized to review procedures, these results suggest that a rights-driven procedure may actually have certain therapeutic benefits by enhancing the patient's autonomy, which is less evident in a treatment-driven procedure.

This paper contains a descriptive study of a rights-driven procedure in New York state. As mentioned above, New York state has a procedure derived from the *Rivers v. Katz* [*8*] decision in 1986, and it follows the main points outlined by the *Rogers v. Commissioner* [*7*] decision in Massachusetts. Whenever there is a dispute over medication between patient and physician in New York state, (1) the dispute must be settled in a formal court hearing, (2) the court determines if the patient is competent, and (3) the court determines the appropriateness of the medication and the duration of the treatment in the event that the patient is found to be incompetent. The small difference between the two procedures is that the judge's *substituted judgment* is replaced by a *best interest* consideration in New York.

By looking at all of the treatment over objection cases in a New York state forensic hospital over the two-year period following the *Rivers v. Katz* [*8*] decision, 1986 and 1987, it is possible to see how the hospital system has adapted to the change to a rights-driven procedure.

Specifically, the different steps of New York state's procedure are investigated here.

1. For instance, an interesting initial observation is a record of the reasons invoked by the physicians for forced medication (they can invoke incompetence as well as dangerousness to self or others).

2. It is also possible to compare the rate of agreement between the courts and the doctors on the issue of forced medication, which includes a finding of incompetence with the added "best interest" decision. It would be expected to fall in the range found by Appelbaum [*1*], namely, 70 to 100%.

3. The final step is for the court to decide on the appropriateness of the medication proposed by the doctor and to determine the dosage, frequency, and duration of the prescription for the patient. As we move more clearly into the doctor's area of expertise, we can expect results similar to those of Cournos et al. [*15*], who reported that only in 1 out of 19 overridden refusals did the court decide on a medication different from that originally suggested by the physician.

If competence is viewed more as a legal issue and medication more as a psychiatric issue, then these steps in the procedure can be seen as a gradual transition from legal to medical "turf." This spectrum provides us with a convenient way of studying the doctor-court part of our original triad.

Regardless of the empirical findings, however, serious questions remain about how to interpret the results. Cogent arguments can be made, based on the *same* findings, for both the rights-driven and the treatment-driven positions.

Methods

All of the decisions on treatment over objection cases were recorded over a two-year period—1987 and 1988—at a maximum security forensic psychiatric hospital in New York state. All the cases that made it to court were reviewed, and the data available for the study included, for each case, the two original applications by the physicians and the final court decision, which included (1) the eventual finding of incompetence, and (2) the specific prescription decided upon.

Subjects

A total of 40 applications were reviewed by the courts over this two-year period, representing 33 patients, 6 of whom went to court twice.

The hospital consists of six wards, of which one is female, each with an approximate census of 25 patients. The patients are evenly divided between posttrial patients who were found not guilty by reason of mental disease or defect and pretrial patients who were found not competent to stand trial.

The types of cases that made it to court seem representative of the general hospital population in terms of sex ($\chi^2 = 0.502$; $P < 0.05$) and legal status ($\chi^2 = 0$; $P < 0.05$). All the diagnoses included a psychotic disorder except for one which was a paranoid personality disorder.

The ages of the patients ranged from 23 to 74 and averaged 44.2 years [standard deviation (SD) = 13.4 years]. The average length of stay at the hospital by the time the physician made the application for forced medication ranged from 20 days to 3.5 years and averaged 1 year (SD = 1 year). As might be expected, the average length of stay for patients not fit to stand trial was shorter than that for posttrial patients found not guilty by reason of mental illness or defect ($t = 2.4$ years, $P < 0.05$)

Results

Reason for Medication

All 80 reports (2 doctors were involved per case) to the court invoked the patient's incompetence as a result of his illness, and in only 25 reports was there an additional

mention of dangerousness to self or others. In 5 of the 40 applications (20%), the diagnoses and recommendations of the two doctors differed.

Finding of Incompetence—The court found 32 of the 40 patients incompetent (80%), and in all of these cases, the judge ruled that it was in the best interest of the patient to receive medication.

Decision on the Type of Medication—In 29 of the 32 approvals (91%), the court allowed the initial treatment plan recommendation of the doctors to stand untouched. This information can be broken down more specifically. In 22 of the 32 approvals (67%), the court decided exactly on a combination of the treatment plans recommended by both doctors. That is, if there was no conflict between the treatment plans of the two doctors, the court decided upon that treatment plan "as is," and if there was a conflict, the court simply put the term "or" between the two plans and let the treating doctor choose as he or she saw fit. In addition, in 6 of the 32 approvals (19%), the court offered a more liberal treatment plan than that asked for in either of the two doctors' reports. For instance, if both doctors had recommended a certain dosage of Haldol, the court decided on "Haldol or any other neuroleptic therapy." In one case, the court decided on the recommendation of one of the two doctors where it was in conflict with that of the other.

In the remaining 3 of the 32 approvals (9%), however, the court decided upon a more restrictive, or simply different, treatment plan than that initially recommended by either doctor. For instance, in one case the doctors asked for a choice between "Stelazine or any other antipsychotic medication," and the court decided on Haldol.

Discussion

Reason for Medication

It is clear that doctors do not present dangerousness as a significant issue in their applications to the courts. Dangerousness seems at best to be an afterthought, as all of their applications are geared to demonstrate incompetence. This replicates the findings of Hoge et al. [*14*]. In contrast, however, Veliz and James [*13*] found that, notwithstanding the manifest reasons for the application, what is discussed and given most attention during the court proceedings is not competence but dangerousness.

Some anecdotal observations made during this study may suggest an explanation. As the chief psychiatrist of the hospital explained, doctors have caught on to the concerns of the court and will indeed concentrate on a patient's competence in their applications. When there is a dangerousness issue on the doctor's mind, he or she may still tailor the application to address a less pressing competency issue, hoping that the court will be more receptive. Once in court, however, all additional issues such as dangerousness are given greater attention.

Rate of Agreement on Competence and Forced Medication

The 80% rate of agreement on the issue of incompetence, combined with the 100% "best interest" decisions in favor of medication, means that 80% of refusing patients ultimately get treated. This falls well within the 70 to 100% range of Appelbaum's review [*1*], thus adding weight to his conclusion that the courts do not stand in the way of patient's getting the treatment they need. Indeed, judges in the "front lines" of the judicial system must feel that it is in the "best interest" of these patients to get treated. They simply do not seem to have the bias against medication that Gutheil [*11*] seemed to find in some of the higher courts.

In addition, parallel to anecdotal observations of Cournos et al. [*15*], some patients seemed to derive therapeutic benefit from the process of going to court, which, in turn,

improved their relationship with their doctor. In one particular case, a chronically paranoid patient had previously had loud and intimidating verbal outbursts against staff and patients several times a day whenever he felt put down in any way. These outbursts would often result in fights among patients and in much frustration among the staff. When he refused his medication, the staff psychiatrist applied to the courts for forced medication. Feeling that a court-appointed attorney would be working with the hospital, the patient decided to prepare his own case *pro se*. As he poured his energy into the preparation of his case, his hypersensitivity and suspiciousness subsided and his interpersonal interactions improved. After he lost his case and was put on medication, all remaining symptoms were controlled, and he thanked his doctor for fighting him all the way to court. After having spent many years in a maximum security hospital, he was transferred to a non-secure facility just a few months after his treatment over objection case was decided.

What seems to be more problematic for a treatment team is a patient who vacillates between taking his medication when he is sick and then refusing it when he gets better and feels more confident. This does not seem to allow the type of consistent opposition between the treatment team and the patient around which the patient (and sometimes the team) can organize himself, as in the case above.

Decision on Type of Medication

In 91% (29 out of 32) of the cases where the patient was incompetent, the court clearly left the treatment plan entirely up to the doctor, even in some cases writing a blank check by recommending generically "neuroleptic medication." In 9% (3 out of 32) of the cases, however, the court decided on a different or more restrictive medication plan. Incidentally, this is approximately the same rate at which the two doctors disagreed on the diagnostic impression and treatment recommendation.

The hospital doctors have reported informally that they do not experience the court as infringing upon their treatment decisions. On the rare occasion where there is a different decision on the type of medication than the one in the initial application, anecdotal evidence suggests that it is not an arbitrary decision on the part of the judge but that it is usually a natural outcome of the court process, with the doctor agreeing. For instance, it came out in court that a patient preferred being on a different drug than that initially recommended, at which point the judge turned to the doctor to ask him for his opinion, which was favorable, and the final decision was for this different medication. Cournos et al. [*15*] found the same thing in the one instance where this occurred in their study.

It would be fair to conclude, therefore, that judges stay off the "turf" of doctors even where the procedures might allow them to do otherwise.

Conclusions

The effects of the change to a rights-driven procedure are neither dramatic nor simple. After several years of post-*Rivers* procedures, it seems clear that nothing dramatically different has occurred. Most patients still get treated; more specifically, the overwhelming majority of refusing patients still get treated. The relationship between the physician and the court has not substantially changed in the concrete; not only have the fears drawn from abstract discussion proven to be unfounded, but one could also argue that, like most turf battles, a greater understanding and clearer definition of the roles has been the outcome.

Even accepting these data, arguments can be made for both rights-driven and treatment-driven procedures. Hoge et al. [*14*], for instance, argue that since nothing much has

changed in the concrete, the extra money spent on *Rogers* procedures is wasted and could be better spent elsewhere. In contrast, Zito et al. [5] argue that since the *Rogers* procedures do not radically upset the system, they are worth the extra protection they give to the competent patients whose rights they are meant to protect. But then we seem to be drifting toward abstract considerations quite divorced from the concrete. The fact is that the dynamics and nature of the doctor-court-patient triad are still poorly understood. This poor understanding, in turn, fuels the broad generalizations and fears that are the weapons of the abstract turf battles to begin with.

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