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A Case in Two Acts in Search of a Middle Ground (United States v. Charters)

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A CASE IN TWO ACTS IN SEARCH OF A MIDDLE GROUND-*United States v. Charters*-Imagine a man in the following situation: He is walking down the street listening to a cacophony of voices. They form a vague background to his aimless wandering, but one in particular stands out. It frightens him. It says that the President of the United States is organizing a plot to kill him, and suggests--rather, insists--that he "get him first." His psychiatrist has assured him that these voices are not real. Nonetheless, he forms a vague plan to kill the President and inquires about purchasing a gun, "just in case."

He gets arrested and the prison doctors want to inject him with medication. He feels frightened, confused, and angry. Are these psychiatrists part of the plot? What will the medication do? He vaguely recalls that the last time he took it his mouth got dry and his muscles stiffened; also, they said that he was "doing much better" and discharged him from the hospital. Really, it is not so bad here on the unit. He would not mind staying. He decides not to take the medication.

What should the legal system do with him? Should it treat him as a poor, lost soul in need of treatment he does not realize he needs, or as a criminal willfully denying the government of the chance to do the one thing that might make him competent to stand trial for threatening the President? Should he be seen as a powerless person in need of protection of his right to think his own thoughts and do as he pleases with his own body, or as a danger to an ordered society? In reality, he would be all of the above, but who should decide what is to be done with him and how? What procedures would protect both him and the President?[1]

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1. This account is based on the case which is the focus of this Comment: United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (en banc) *vacating* 829 F.2d 479 (4th Cir. 1987). It is a fictionalized account based on the reported cases, some specific references in the lower court hearing, and the writer's eight-years of experience providing mental health care to the incarcerated mentally disabled.

Additionally, this account makes reference to medication, a repeated issue in the Comment. The medication referred to are antipsychotics. The earliest of these was chlorpromazine (Thorazine). It was found, by the French surgeon in Laborit, to be helpful

Nowhere is this dilemma better illustrated than in *United States v. Charters,*[2] in which a panel of the Fourth Circuit Court of Appeals answered that nothing less than a two-stage judicial hearing on the matter would satisfy the defendant's due process rights.[3] One year later, rehearing the case *en banc*, the Fourth Circuit found such judicial hearings to be unnecessary, saying the decision to medicate with antipsychotic drugs is a medical one to be made by Charter's psychiatrists.[4] The United States Supreme Court has not addressed these questions,[5] leaving the federal judiciary in a quandry.

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in decreasing certain responses to surgical stress. Delay and Deniken, in 1952, experimented with its effects on schizophrenia and news of its usefulness spread quickly. J. DAVIS, ANTI-PSYCHOTIC DRUGS, 3 COMPREHENSIVE TEXT BOOK OF PSYCHIATRY III 2557 (H. Kaplan, A. Freedman & B. Sadock eds. 1988) [hereinafter DAVIS]. Today, there are a number of compounds with similar effects: trifluoperazine (Stelazine), perphenazine (Trilafon), fluphenazine (Proxilin), thiothexene (Navane), and haloperidol (Haldol). Crane, *Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient*, 36 TRANSACTIONS N.Y. ACAD. SCI. 744, 656 n.1 (1974).

The typical symptoms which are manifested by a schizophrenic patient, which the medications are used to manage, include delusions, hallucinations, and disturbances in thought and affect. THE AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 187 (3d rev. ed. 1987) [hereinafter DSM-III-R]. For example, a person suffering from schizophrenia may be unable to "[d]istinguish categories and maintain goal-directed thinking which affects the communicative and social functions of the patient. Consensus about the relationship of person and events (which characterizes what is stable in any social system) becomes difficult or impossible." F. REDLICH & D. FREEDMAN, THE THEORY AND PRACTICE OF PSYCHIATRY 470 (1966). Specifically, in this case, the psychiatrist wished to treat Charters with Navane or Haldol; the Navane because he had responded well to it in the past, the Haldol because it is available in long-action form and can be administered on a biweekly or monthly basis. *Charters*, 863 F.2d at 302.

2. United States v. Charters, 829 F.2d 479 (4th Cir. 1988) (en banc).

3. *Id.*

4. *Charters*, 863 F.2d at 308-11.

5. *E.g.*, United States v. Charters, No. 8300239-A, slip op. at 9 (E.D. Va. 1984) ("no reported case with the precise facts of this case has been found by the court" *Id.*); *See also* Mills v. Rogers, 457 U.S. 291 (1st Cir. 1982) and Project Release v. Prevost, 772 F.2d 979 (2d Cir. 1983). The Supreme Court has stayed the *en banc* decision while deciding whether to grant Charters *certiorari* petition. *See* 57 U.S.L.W. 3545 (1989). Additionally, while the Charters Panel "express[ed] no views concerning the rights of convicted prisoners facing forcible treatment with antipsychotic drugs," the Supreme Court has granted *certiorari* on this question. *See* State v. Harper, 110 Wash. 2d 873, 759 P.2d 358 (1988), *cert.* granted 57 U.S.L.W. 3388 (1989).

I. FACTS

In late 1983, Michael Francis Charters was indicted for making threats against President Reagan.[6] Specifically, he was accused of saying that he bought the gun to kill the people that he considered to be criminals, namely, President Reagan.[7]

A hearing was held on February 1, 1984 and the district court found Charters incompetent to stand trial and committed him to a federal facility.[8] Charters' incompetence was reviewed on five separate occasions, each time with the same finding: Charters was found incompetent to stand trial.[9] He was thus recommited to the federal facility each time.[10]

On numerous occasions the district court denied the government's request to administer antipsychotic drugs to Charters against his will.[11] However, in May 1986, after modifying its finding of incompetency to stand trial into a finding that Charters was incompetent to make medical decisions, the court granted the government permission to forcibly medicate Charters.[12] The district court found that the state's duty to provide medical treatment outweighed the detainee's (Charter's) interests in freedom of thought, liberty and privacy.[13] This decision was appealed to the Fourth Circuit which overruled the district court.[14] The Fourt Circuit then reheard the case *en banc* and vacated the original decision.[15]

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6. *Charters*, 829 F.2d at 482.
7. *Charters*, 863 F.2d at 302.
8. *Charters*, 829 F.2d at 482.
9. *Id.*
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. United States v. Charters, 863 F.2d 302, 302 (4th Cir. 1988) (en banc).

II. BACKGROUND

There is unanimous agreement that a mentally ill and incompetent pretrial detainee retains a qualified right to refuse antipsychotic medications.[16] This right stems from fundamental constitutional guarantees contained in the first,[17] fourth,[18] fifth and fourteenth[19] amendments, as well as the right of privacy.[20] Having established these liberty interests, courts and commentators diverge over a wide continuum of opinion as to what procedural safeguards should to be triggered by a patient's refusal to take prescribed antipsychotic medications.[21]

During the late 1970's and early 1980's, a number of landmark cases involving the rights of civilly committed mentally disabled patients to refuse medication were decided.[22] These cases were decided with emphasis on the right to freedom of thought, the right to be free from unreasonable searches and seizures, and the right to privacy.[23] They form a clear analytic framework for decision-making in the civil

16. *See, e.g.*, Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand* 720 F.2d 266 (3d Cir. 1983); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), *modified*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom.* Rogers v. Commissioner of Dep't of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983), *on remand* 738 F.2d 1 (1st Cir. 1984); *see, e.g.*, Young, *Treatment Refusal Among Forensic Inpatients*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 5 (1987).

17. U.S. CONST. amend. I; *Charters*, 829 F.2d at 491.

18. U.S. CONST. amend. IV; *Charters*, 829 F.2d at 491.

19. U.S. CONST. amends. V, XIV; *Charters*, 829 F.2d at 491.

20. *Charters*, 829 F.2d at 490-92; *see generally* Roe v. Wade, 410 U.S. 113, 152 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972) (right of privacy is concerned with the right of the individual to be free from unwarranted governmental intrusion into fundamentally personal matters).

21. *E.g.*, Perlin, *Does Competency Matter After United States v. Charters?*, Paper presented at University of Virginia's Institute of Law, Psychiatry & Public Policy Twelfth Symposium on Mental Health and the Law, Williamsburg, Virginia, 6 (March 1989) *excerpted in* 9 Developments in Mental Health (Jan.-June 1989) [hereinafter *Does Competency Matter*].

22. *See, e.g.*, Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979).

23. Perlin, *Fourth Amendment Right of Mentally Ill Defendants to Refuse Medication Before Trial*, 15 SEARCH & SEIZURE L. REP. 9 (1988) [hereinafter *Fourth Amendment*].

area.[24] However, these constitutional issues were seldom discussed in analogous criminal cases and, when they were addressed, the holdings did not produce a cogent doctrinal direction.[25] Decisions were often in conflict with each other and, when a clear thrust could be discerned, it was in conflict with the decisions in the civil cases.[26]

A case which is illustrative of other civil cases in this area is *Mills v. Rogers*,[27] where the Supreme Court noted the district court's holding that an involuntarily committed civil patient's rights to liberty and privacy were implicated in the decision of whether to allow forced medication with antipsychotics to proceed.[28] These rights could only be abrogated in an emergency situation in which "[f]ailure to [medicate forcibly] would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution."[29] Otherwise, a court must find the patient incompetent before medication can be forcibly given.[30] The First Circuit Court of Appeals affirmed the district court's holding with regard to the constitutionally protected interests.[31] The Court found that a state may not rely on its *parens patriae* power absent a "[d]etermination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the

24. *Id.*

25. *Id.* at 9-10.

26. *Id.* at 10 (citing State v. Hayes, 389 A.2d 1379 (N.H. 1978) *and* Craig v. State, 704 S.W.2d 948 (Tex. App. 1986) (upholding forced drugging to stimulate competence to stand trial, where jury made aware of use of medication), *with* Whitehead v. Wainwright, 447 F. Supp. 898 (M.D. Fla. 1978), *vacated and remanded on other grounds*, 609 F.2d 223 (5th Cir. 1980) (due process violated where defendant rendered incompetent by overmedication) (emphasis in original text)).

27. 457 U.S. 291 (1982).

28. *Id.* at 299 n.16 (citing O'Connor v. Donaldson, 422 U.S. 563 (1975)).

29. Project Release v. Prevost, 722 F.2d 960, 977 (1983) (quoting Rogers v. Okin, 478 F. Supp. 1342, 1365 (D. Mass. 1979)).

30. Rogers v. Okin, 478 F. Supp. 1342, 1363-64 (D. Mass. 1979).

31. *Project Release*, 722 F.2d at 977 (citing Rogers v. Okin, 634 F.2d 650, 653 (1st Cir. 1980)).

drugs."[32] The Supreme Court granted certiorari but remanded the case for consideration in light of a decision of the Supreme Judicial Court of Massachusetts, *In re Guardianship of Roe*.[33] The Supreme Court noted that "[t]he substantive rights provided by the Federal Constitution define only a minimum [and] State law may recognize liberty interests more extensive than those independently protected by the Federal Constitution."[34] Thus, Rogers is crucial in at least two ways: (1) it is illustrative of the way this type of case is handled in civil context in that it secures the patient's qualified right to refuse medication barring an emergency[35] and in its clear application of procedural due process rights to the decison-making process;[36] and (2) Supreme Court implied that state courts might afford more generous protection in this area,[37] increasing the importance of state courts.[38]

As noted, however, the resolution of this issue has been far from clear in criminal cases.[39] Professor Perlin notes that there has been "a series of apparently random decisions from which almost no doctrinal threads could be extracted."[40] One case, for example, held that medication could be forcibly administered if it would make the defendant competent to stand trial and any prejudice resulting would be remedied by a limiting instruction to the jury[41] while the court in another case found that the defendant's due process rights were

32. *See id.* at 978 (quoting Rogers v. Okin, 634 F.2d 650, 657 (1st Cir. 1980) (citing Winters v. Miller, 446 F.2d 65, 71 (2d Cir. 1971)), *cert. denied*, 404 U.S. 985 (1971)).

33. 383 Mass. 415, 421 N.E.2d 40 (1981).

34. *Project Release*, 722 F.2d at 979 (quoting Mills v. Rogers, 457 U.S. 291, 300 (1982)).

35. Rogers v. Okin, 478 F. Supp. 1342, 1365 (D. Mass. 1979).

36. *Id.* at 1371. *See also* Rennie v. Klein, 462 F. Supp. 1131, 1143 (D. N.J. 1978) (due process requires "some form of notice and an opportunity to be heard").

37. *Does Competency Matter*, *supra* note 21, at 4.

38. *Id.* at 5. *See, e.g.*, Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *see generally*, Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled*, 20 LOY. L.A.L. REV. 1249 (1987).

39. *Fourth Amendment*, *supra* note 23, at 9.

40. *Id.* at 10.

41. State v. Hayes, 118 N.H. 458, 389 A.2d 1379 (1978).

violated by his overmedication.[42]

The panel decision in the *Charters* case moved the law toward a more unified thinking in this troublesome area of deciding under what circumstances and under whose discretion a mentally ill person may refuse antipsychotic medication.[43] It significantly strengthened a pretrial detainee's right to refuse medication and revived the right to privacy and freedom of thought rationales which underlay the law-reform civil cases alluded to earlier.[44]

In the process, the *Charters* panel distinguished *Youngberg v. Romeo*[45] and refused to apply its "professional judgment" standard to the question of forced antipsychotic medication.[46] The panel relied on a thoughtful combined standard for deciding whether a detainee/patient is medically competent to refuse medication[47] and outlined a clear procedure to be followed in the event that the detainee is found incompetent.[48]

Youngberg v. Romeo involved a profoundly retarded man with the mental capacity of an eighteen-month-old child[49] who had been involuntarily committed to a Pennsylvania state institution.[50] He was injured on many occasions due to his uncontrollable, violent behavior and was restrained in soft-arm restraints.[51] The Supreme Court agreed with the Court of Appeals' finding that he had a constitutionally protected liberty interest protected by the fourteenth amendment[52] that

42. Whitehead v. Wainwright, 447 F. Supp. 898 (M.D. Fla. 1978), *vacated and remanded on other grounds*, 609 F.2d 223 (5th Cir. 1980).

43. United States v. Charters, 829 F.2d 479 (4th Cir. 1987).

44. *Fourth Amendment*, *supra* note 23, at 9.

45. Youngberg v. Romeo, 457 U.S. 307 (1982).

46. *Charters*, 829 F.2d at 488.

47. *Id.* at 494-97.

48. *Id.* at 497-99.

49. *Youngberg*, 457 U.S. at 309.

50. *Id.* at 309-10.

51. *Id.* at 310. It was alleged that he suffered injuries at least 63 times (by his own violence and others' reaction to him), and on one occasion received a broken arm. *Id.*

52. *Id.* at 312-13.

must be balanced against the pertinent state interests involved.[53] In finding that Romeo's liberty interest was not violated, the Supreme Court proceeded to state that "[t]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions,"[54] and "[f]or these reasons, the decision, if made by a professional, is presumptively valid . . . ."[55]

The *Youngberg* decision has been read by commentators as a clear message that these questions are matters of state law and professional discretion.[56] Yet the Fourth Circuit panel distinguished the *Youngberg* case in three ways and proceeded to decide the case on the constitutional issues.

First, the *Charters* court noted that Romeo the (plaintiff in *Youngberg)* due to his severe handicap, was clearly unable to be involved in decisions concerning his medical treatmant.[57] Thus, the issue in *Youngberg* became: how should decisions be made for him? Citing *Bee v. Greaves*,[58] the court noted that *Youngberg* did not address the degree to which a *competent* person may make treatment decisions on his own behalf.[59] Although he was mentally ill, Charters might indeed have been competent to participate in medical care decisions.[60] The court cited *Davis v. Hubbard*,[61] in which the court noted that "[T]here is no necessary relationship which renders [the mentally ill] unable to provide informed consent to medical

53. *Id.* at 313.

54. *Id.* at 322.

55. *Id.* at 323.

56. R. MILLER, INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA 143 (1987) [hereinafter MILLER]; Project Release v. Prevost, 551 F. Supp 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983); R.A.J. v. Miller, 590 F. Supp. 1319 (W.D. Tex. 1984); Johnson v. Silvers, 742 F.2d 823 (4th Cir. 1984).

57. United States v. Charters, 829 F.2d 479, 488 (4th Cir. 1987).

58. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 499 U.S. 1214 (1985).

59. *Charters*, 829 F.2d at 488.

60. *Id.*

61. 506 F. Supp 915 (N.D. Ohio 1980).

treatment."[62]

Citing *Bee v. Greaves*,[63] *Rennie v. Klein*,[64] and *In re Guardianship of Roe*,[65] the court found a second important distinction between the instant case and *Youngberg*: the nature of the restraints.[66] In *Youngberg*, the restraints were of a temporary nature (soft-arm restraints) and there was no risk of permanent harm to the plaintiff.[67] Citing the above-mentioned cases, the court found the use of antipsychotic medication to restrain Charters to entail the risk of "serious and irreversible injury."[68] Additionally, the court saw the method involved as implicating Charters' freedom of thought and compared it to psychosurgery.[69] These findings made the Charters decision one which "[m]ay profoundly impact an interest at the core of liberty, the protection of the thought that defines individuality, an interest which was not at stake in *Youngberg*."[70] The third rationale given by the court in distinguishing *Youngberg* was that Romeo actually presented a danger to himself and others on numerous occasions.[71] The deference to professional judgment involved a medical determination of the best manner of avoiding violence.[72] By contrast, the court noted that in three years of confinement Charters had not been involved in a single violent incident.[73] Again emphasizing the risk of permanent injury resulting from antipsychotic medication, the court found that this is not a

62. *Charters*, 829 F.2d at 488 (quoting Davis v. Hubbard, 506 F. Supp. 915, 935 (N.D. Ohio 1980)).

63. 744 F.2d 1387, 1396 n.7 (10th Cir. 1984), *cert. denied*, 499 U.S. 1214 (1985).

64. 720 F.2d 266, 276 (3d Cir. 1983) (Weis, J., concurring).

65. 383 Mass. 415, 436-37, 421 N.E.2d 40, 53 (1981).

66. *Charters*, 829 F.2d at 489.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Charters*, 829 F.2d at 489.

71. *Id.* at 488.

72. *Id.* at 489.

73. *Id.*

matter soley for professional judgement.[74] The court found that a doctor may not "dictate" treatment,[75] he may only advise. Further, the court found that an evaluation of the benifits and risks must be an individualized decision and not one made exclusively based on professional judgement.[76]

Having thus distinguished *Youngberg*, the Fourth Circuit proceeded to balance Charters' interest in resisting the medication against the government's interest in administering it.

In its examination of the individual's interest, the court found that "[f]orcible medication with antipsychotics implicates individual rights to . . . freedom of thought as well as the right to privacy protected by the Constitution and the common law."[77] The common-law notions were discussed first in terms of the right to be free from unwanted touching, dating back to thirteenth-century England.[78] The Supreme Court acknowledged this right as far back as 1890,[79] and today it is encompassed in the tort of battery.[80]

III. CONSTITUTIONAL BASES FOR THE RIGHT TO REFUSE TREATMENT

The Fourth Circuit panel opinion proceeded to find "[t]he right to refuse medical treatment [to be] specifically recognized as a subject of constitutional protection."[81] In support, it cited the already-mentioned "right to refuse" cases

74. *Id.*

75. *Id.*

76. *Id.* at 490.

77. *Id.*

78. *Id.* (citing F. MAITLAND, THE FORMS OF ACTION AT COMMON LAW 40, 43, 53 (1985)).

79. *Charters*, 829 F.2d at 490-91 (citing Union Pac. Ry. v. Botsford, 141 U.S. 250, 215 (1890)).

80. *See id.* at 490 (citing W. KEATON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS 39 (5th ed. 1984)).

81. *See id.* at 491.

from the civil context,[82] fourth[83] and first[84] amendment cases, as well as the right to privacy cases.[85]

The court referred to a woman's constitutionally protected right to obtain an abortion, which was upheld in *Roe v. Wade*,[86] as a primary example of the "[r]ight to privacy contained in the notions of personal freedom which underwrote the Bill of Rights."[87]

The idea that there is a constitutionally protected right to privacy has been hinted at in Supreme Court decisions since the 1890's, but had been without a strong constitutional articulation[88] until, in *Griswold v. Connecticut*,[89] Justice Douglas located the right more precisely in the penumbras emanating from several amendments which give the Bill of Rights "life and substance."[90] These constitutionally guaranteed "zones of privacy" were derived from the first, fourth, and fifth amendments.[91] Also mentioned was the ninth amendment origin which implies that there is a natural rights aspect to the right to privacy.[92]

The 1960's (*Griswold* was decided in 1965) were a time

82. Bee v. Greaves, 744 F.2d 1387, 1393 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983); Rogers v. Okin, 634 F.2d 650, 653 (1st Cir. 1980).

83. Winston v. Lee, 470 U.S. 753 (1985); Ingraham v. Wright, 430 U.S. 651 (1977); Sibron v. New York, 392 U.S. 40 (1968); Schmerber v. California, 384 U.S. 757 (1966); U.S. CONST. amend. IV.

84. Stanley v. Georgia, 394 U.S. 557 (1969); U.S. CONST. amend. I.

85. Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1971); Griswold v. Connecticut, 381 U.S. 479 (1965).

86. Roe v. Wade, 410 U.S. 113 (1973).

87. United States v. Charters, 829 F.2d 479, 491 (4th Cir. 1987).

88. A. KELLY & W. HARBISON, THE AMERICAN CONSTITUTION: ITS ORIGINS AND DEVELOPMENT 963 (1976) [hereinafter KELLY].

89. Griswold v. Connecticut, 381 U.S. 479 (1965).

90. *Id.* at 484.

91. *Id.*

92. *See* KELLY, *supra* note 88, at 964. Justice Goldberg, in his concurring opinion, placed emphasis on this aspect. *Griswold*, 381 U.S. at 486-99. The ninth amendment was seen as protecting rights not specifically noted in the first eight amendments. *Id.* at 488. Thus, by implication, the rights of privacy in the marriage relationship were seen as fundamental ones enjoyed by people at the time of the drafting and, therefore, protected. *See* KELLY, *supra* note 88 at 963-64.

in which the public definition of the private self was thought to be repressive and in need of restructuring.[93] There was a notion that with the growth in the public sector of the economy new "safeguards" were needed to protect the rights of the individual.[94] With the loosening of societal restrictions, however, it is not surprising that a new phenomenon developed whereby people began to complain of a loss of identity or sense of self.[95]

Against this backdrop began the advent of the patient's rights movement which culminated in the "right to refuse" cases of the late 1970's and early 1980's.[96] However, while the "political liberalism" of the 1960's was being altered in the late 1970's and 1980's, the "cultural radicalism" encompassing such notions as sexual freedom was intricately woven into mainstream American culture.[97] Thus, the same people who participated in 1960's "revolution" were, in essence, becoming more conservative.[98] In this way, we should not be surprised to see the social setting for a decline of interest in the right of privacy issues which animated in the right to refuse cases.[99]

First Amendment Aspects

The *Charters* panel placed special emphasis on the freedon of thought (first amendment) aspects of the privacy right.[100] Of particular concern to the court was the possibility that antipsychotic medication may "undermine the foundation

93. J. BENSMAN & R. LILIENFELD, BETWEEN PUBLIC AND PRIVATE: LOST BOUNDARIES OF THE SELF viii (1979) [hereinafter BENSMAN].

94. Rabin, *Job Security and Due Process: Monitoring Administrative Discretion Through a Reasons Requirement*, 44 U. CHI. L. REV. 60 (1976).

95. BENSMAN, *supra* note 93, at 5 n.12 (citing V. FRANKL, THE WILL TO MEANING (1969), IDENTITY AND ANXIETY (M. Stein, A. Vidich and D. White eds. 1960)).

96. *See, e.g.*, MILLER, *supra* note 56, at 140.

97. BENSMAN, *supra* note 93, at viii.

98. *Id.*

99. *See generally* BENSMAN, *supra* note 93.

100. United States v. Charters, 829 F.2d 479, 492 (4th Cir. 1987).

of personality."[101] The vision raised is one of totalitarian mind control and the potential to allow the government to alter or control thinking and thereby destroy the independence of thought and speech so crucial to a free society.[102] This notion appears to implicate one of the American citizen's most cherished tenets, the freedom to express ideas. Certainly, if people are to express ideas freely they must be able to develop them freely.[103] As noted in *United Transportation Worker's Union v. State Bar of Michigan*,[104] a person's mental processes and the generation of ideas come within the ambit of the first amendment. The first amendment must equally protect the individual's right to generate ideas. Or as Justice Holmes stated in *Abrams v. United States*,[105] "[w]e should be eternally vigilant against attempts to check expression of opinion that we loathe and believe to be fraught with death . . . ."[106]

However, there are those who question just what freedom and what thought we are protecting in the psychotic individual.[107] By definition, the schizophrenic's thought process is plagued by disturbances involving the content and form of thought, perception, affect, sense of self, voilition, and relationship to the social and external world.[108] One commentator has asserted that the entire notion that antipsychotic drugs have a thought-controlling (in the sense of changing the content of thought) potential is mistaken.[109] The authors assert that courts tend to focus on the harmful effects

101. *Id.*

102. *Id.*

103. *Id.*

104. 401 U.S. 576 (1971).

105. 250 U.S. 616 (1919).

106. *Id.* at 630 (Holmes, J., dissenting).

107. Gutheil & Applebaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of AntiPsychotic Medication*, 12 HOFSTRA L. REV. 77 (1983) [hereinafter Gutheil].

108. DSM-III-R, *supra* note 1, at 459.

109. *See* Gutheil, *supra* note 107, at 81.

of the drugs without adequately considering their positive effects;[110] that is, to the extent that thought patterns are changed, it is in the direction of normality.[111] Courts, additionally, fail to consider that the behavior effected is the result of psychotic illness.[112] They posit that the courts believe that medication has the capacity to suppress the belief-content of thoughts, not merely the psychotic structure of thoughts.[113] Medication can, however, be seen as increasing first amendment rights as positive social interaction is often improved.[114]

Perhaps at issue is the panel's lack of trust in our society not to label as unhealthy that which is merely different. As the social scientist Robert Endleman stated, "'[h]ealthy' need not coincide with conformity to prevailing cultural norms . . . and 'sick' need not coincide with non-conformity or deviance."[115] A large body of sociological literature has developed expressing precisely this fear.[116] On the other hand, when one sees the agony which psychosis causes its sufferer, it becomes difficult to justify viewing symptoms as a manifestation of privacy or freedom of thought. It is difficult to see them as an expansion of the self in a meaningful way,

110. *Id.* at 80.

111. *Id.*

112. *Id.*

113. *Id.*

114. *See* Spohn, *Phenotiazine Effects on Psychological and Psychophysical Dysfunction in Chronic Schizophrenics*, 34 ARCHIVES GEN. PSYCHIATRY 633 (1977). One can relate Justice Holmes' concept of a "marketplace of ideas," *see* Abrams v. United States, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting), and view psychotropic medication as a way of permitting the individual to express himself in a manner consistent with permitting the individual to express himself in a manner consistent with permiting the "free trade" of ideas. *See supra* note 1 for a discussion of the way in which the psychotic process can make such communication impossible.

115. R. ENDELMAN, PSYCHE AND SOCIETY 377 (1981). For an interesting discussion of the role conformity and compliance play in the decision of whether to take medication, *see* Amarasingham, *Social and Cultural Perspective on Medication Refusal*, 137 AM. J. PSYCHIATRY 353 (1980).

116. *See, e.g.*, E. GOFFMAN, THE PRESENTATION OF SELF IN EVERYDAY LIFE (1959); E. GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); H. BECKER, OUTSIDERS 133-34 (1983); E. GOFFMAN, STIGMA (1963).

but rather one sees a "burden under which the individual must suffer."[117]

The final constitutional rationale for the right of privacy implicitly stems from the fourth amendment right to be free from unreasonable searches and seizures.[118] Citing *Ingraham v. Wright*,[119] the *Charters* court noted the right to be free from "unjustified intrusion on personal security." [120] The court cited *Winston v. Lee*,[121] and equated the surgical intrusion in *Winston* to the unwanted injection of antipsychotic medication.[122]

In *Rochin v. California*,[123] the Supreme Court delineated the standard for what constitutes an improper intrusion of the body. Such an intrusion is improper if it (1) lacks in procedural aspects; (2) contains needlessly severe procedures; (3) is too novel; (4) or is lacking in a fair measure of reciprocity.[124] One commentator has interpreted this standard to mean, in part, that the question of physical pain must be considered in addition to the permanence of possible complications.[125] The reciprocity notion is seen as an attempt to minimize the risk of an invasion being only for the good of society; that is, the individual should reap some benefit as well. [126] The *Charters* court, citing both legal and psychiatric literature, was convinced that the potential dangers of antipsychotic medications were substantial.[127]

Against the above-mentioned liberty interests, the court considered the government's interest in forced medication.[128]

117. *See* BENSMAN, *supra* note 93, at 68.

118. U.S. CONST. amend. IV.

119. 430 U.S. 651 (1971).

120. United States v. Charters, 829 F.2d 479, 491 n.18 (4th Cir. 1987) (quoting Stanley v. Georgia, 394 U.S. 557, 564 (1969)).

121. 470 U.S. 753 (1985).

122. *Charters*, 829 F.2d at 492.

123. 342 U.S. 165, 167 (1952).

124. *Id.*

125. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1333 (2d ed. 1988).

126. *Id.*

127. United States v. Charters, 829 F.2d 479, 493 (4th Cir. 1987).

128. *Id.* at 492.

The government first asserted its interest in preventing violence.[129] The court did not find this argument compelling as Charters had not been involved in a single violent incident in three years of incarceration.[130] Although the district court had found that he could not be maintained in a less restrictive environment without medication,[131] the *Charters* court of appeals panel found that the risk of violence must be "manifested," not merely hypothetical.[132] A number of studies have indicated that psychiatrists have limited success in making predictions about future violent behavior.[133] A leading expert has suggested that for predictions to be accurate they must be "context-specific,"[134] not based on "attempts to guess how someone observed in a controlled environment will behave in a very different setting."[135] This belies the district court's attempt to allow forced medication in the prison setting based on predictions of future behavior in a hospital setting.

The second interest which the state asserted was in having Charters medicated so that he might be competent to stand trial.[136] The court rejected this argument for three reasons. First, it was not convinced that Charters would become competent even if his medication were allowed.[137] Second, they found that the government's interest should not be in having a trial, per se, but in having a fair trial.[138] The court reasoned that a heavily medicated defendant may not receive a fair trial for several reasons. Once made competent, the

129. *Id.*

130. *Id.* at 493.

131. *Id.*

132. *Id.*

133. *See, e.g.*, Dershowitz, *The Law of Dangerousness: Some Fictions About Predictions*, 23 J. LEGAL EDUC. 24 (1970).

134. Monahan, *Predictions Reasearch and the Emergency Commitment of Dangerous Mentally Ill Persons*, 135 AM. J. PSYCHIATRY 198, 199, 201 (1978).

135. *Id.*

136. *Charters*, 829 F.2d at 492.

137. *Id.* at 493.

138. *Id. See also* Fentiman, *Whose Right Is It Anyway?*, 40 U. MIAMI L. REV. 1109 (1986).

next legal issue for the incompetent detainee is typically the insanity defense.[139] However, if the defendant is heavily medicated it could be difficult to convince a jury that he was "insane" at the time the crime was committed.[140] The court was also concerned with other side effects of medication, namely akinesia and akathisia.[141] Akinesia makes an individual appear uncaring and unemotional;[142] akathisia causes agitation.[143] The Fourth Circuit panel was concerned that these manifestations could mislead the jury with regard to the defendant's innocence, guilt, or attitude toward the crime or victim.[144] Finally, the court held that all of the above-mentioned concerns, notwithstanding the state's interest in a trial, "do not permit such a draconian invasion of the individual's freedom and risk of permanent physical injury."[145]

Third, the court rejected the state's previously mentioned interest in protecting the health of its citizens by stating that such an interest does not constitute a "license for the government to control individual's lives."[146] The court quoted Justice Brandeis' opinion in *Olmstead v. United States*:[147] "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficient."[148] Additionally, the court noted, the well-being of the citizen is best promoted by respecting his autonomy, absent a finding of medical incompetence.[149]

The court then addressed the question of the proper

139. *Charters*, 829 F.2d at 494.

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.* at 494.

147. 277 U.S. 438 (1928).

148. *Charters*, 829 F.2d at 494 (quoting Olmstead v. United States, 277 U.S. 438, 479 (1928)) (Brandeis, J., dissenting).

149. *See id.* at 495.

procedure for deciding if a person is medically competent. The district court relied on the testimony of Charters' psychiatrist that his refusal of medication was not in his best interest.[150] If the patient does not agree with the physician he is deemed incompetent.[151] This, as the panel court said, renders the value of individual autonomy a nullity.[152] The court noted that the question of how such a determination is properly made had not arisen frequently in litigation.[153] The appellate court instructed the district court to conclude whether Charters followed a rational process in deciding to refuse medication.[154] It warned that "rational" must be construed "broadly."[155] For example, if Charters were to fear that medication would mean discharge to a less restrictive environment or the risk of dangerous side effects, his thought process would be deemed "rational" and his refusal upheld.[156]

A factor not considered by the court in this regard is that certain types of paranoid psychotic individuals will always, due to the very nature of their illness, be able to give cogent explanations for their maladaptive actions,[157] while others, no more disturbed but less organized, will not be able to do so.[158] Are certain psychiatric diagnostic groups inherently more competent than others? Perhaps preferable, is a test which requires the person to rationally manipulate the abstract information about his condition and apply it to his particular situation.[159] This goes further toward ensuring a genuine informed consent or refusal as it requires the patient to show

150. *Id.*

151. *See* Annas, *Competence to Refuse Medical Treatment*, 15 U. TOL. L. REV. 561 (1984).

152. *Charters*, 829 F.2d at 495; *see generally* Annas, *supra* note 151.

153. *Charters*, 829 F.2d at 497.

154. *Id.* at 496.

155. *Id.*

156. *Id.* at 497.

157. *See* Annas, *supra* note 151, at 570.

158. *Id.*

159. *Id.*

an understanding of the consequences of his action.[160] Such an understanding is more important than it may appear because many psychotic persons are unable to distinguish clearly between themselves and others, reality and fantasy.[161]

Additionally, the panel dealt with the proper course of action for decision making should the defendant be found incompetent.[162] The discussion explored the various ways in which decisions could be made for an incompetent person. The court reiterated its rejection of the professional judgment standard of *Youngberg*,[163] adding that the staff in institutional settings often use medication for nontherapeutic reasons: to control behavior and reduce cost.[164]

The court discussed the substitute judgment approach,[165] a procedure that attempts to discern what the patient would do were he competent,[166] and thus avoid the negation of individual uniqueness implicit in applying a reasonable man standard.[167] The court found that this approach, while commendable, was in reality a legal fiction[168] as, according to the court, it is not feasible for a judge to decide what a mentally ill person would do were he competent.[169] Additionally, such a determination could be a subterfuge for the imposition of the staff's will upon the patient.[170] However, the court did not reject this approach outright. Noting that in cases where there is clear and convincing evidence as to what a patient's wishes would be were he competent, those wishes

160. *Id.*

161. *See* DSM-III-R, *supra* note 1, at 187-90; *see also* J. PERRY, ROOTS OF RENEWAL IN MYTH AND MADNESS ix (1976).

162. United States v. Charters, 829 F.2d 479, 497 (4th Cir. 1987).

163. *Id.* at 497.

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.* at 498.

169. *Id.*

170. *Id.*

should be respected.[171] This is usually applicable in cases where the patient has strong religious beliefs.[172] The *Charters* panel court held that absent "such clear and convincing evidence,"[173] the court should rely on the best interests of the patient approach.[174] This was viewed as the best method of protecting the patient's rights and was fully compatible with government's *parens patriae* responsibilities.[175]

The difficulty with this approach is that, to the extent a determination of "best interest" is made based upon expert psychiatric testimony, the process is brought "full circle" to a reliance on professional judgment. However, the court ameliorated this problem by stating that the decision must be made by an "independent arbitrator."[176] Thus, the court would have the benefit of differing views within the profession upon whose "judgment" it will rely. After such evidence the court could approve an overall treatment plan subject to periodic review.[177]

Thus, the Fourt Circuit panel decided the case in a way which could have been expected to play a central role in pushing the law toward a greater emphasis on the rights of confined mentally ill persons (both in hospitals and prisons) to make autonomous medication-related decisions.

IV. THE EN BANC DECISION: THE PANEL DECISION IS VACATED

In the *en banc* decision,[178] the Fourth Circuit vacated the panel's decision in virtually every significant aspect. In an

171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.*
176. *Id.* at 499.
177. *Id.* at n.28.
178. United States v. Charters, 863 F.2d 302, 302 (4th Cir. 1988) (en banc).

unispired application of the *Matthews v. Eldridge*[179] balancing approach, which fails to address a number of legal, factual, and medical issues raised by the panel, the court ruled that although Charters retained a constitutionally protected interest in not being medicated against his will, this interest was only to be protected against arbitrary and capricious actions by the government.[180] Due process was adequately guarded by the possibility of judicial review of decisions made by medical staff.[181]

Relying heavily on *Youngberg* and *Parham v. J.R.*,[182] the court dismissed the panel's approach for a variety of reasons. The court viewed the procedure imposed as awkward, time consuming, and expensive.[183] Concern was expressed that the treating psychiatrists would be reduced to mere expert witnesses whose opinions would be weighed against those of "outside expert witnesses whose testimony surely can be anticipated."[184] The court cited a number of unreported cases in which inmate/patients who were situated similarly to Charters stopped taking prescribed medication following to the panel's decision.[185]

In one of the cases the district court states: "[o]f prime importance to the court in arriving at this decision [is whether the inmate/patient in question] is competent to make this

179. 424 U.S. 319 (1976). The test articulated in Matthews, a disability benefits case, goes as follows:

> [F]irst, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitue procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requests would entail.

Id. at 335.

180. *Charters*, 863 F.2d at 308.

181. *Id.*

182. 442 U.S. 584 (1979).

183. *Charters*, 863 F.2d at 309.

184. *Id.*

185. *Id.* at n.5.

decision [to refuse medication]."[186] Although there was testimony directly to the contrary, "the court [was] unable to say that the opinion of [the other expert] outweighs the opinion of Dr. Royal."[187] In a footnote, the court noted that it is "difficult to imagine a situation in which the court could ever give the testimony of one psychiatrist such weight."[188] However, a close reading of the opinion suggests that if the district court had read the *Charters* panel decision in a less rigid manner, it could have ordered the medication if it thought it necessary.[189]

With regard to the distinction between legal and medical competence, the *en banc* court acknowledged that there "may be a difference," but essentailly found that it was too subtle and complex for a judge to fathom.[190] Thus, the court denied Charters' assertion that a judicial hearing should be held with regard to his competency, stating that judges are not better able than medical personnel to make such determinations.[191]

Similarly, the entire issue of the potential dangers of antipsychotic medication was relegated to "one element" in the "best interests" decision.[192] It viewed differences of professional opinion as to the probability and nature of possible medication-related side effects as sufficient reason to

186. United States v. James Ballard, 704 F. Supp. 620, 624 (E.D.N.C. 1987).

187. *Id.*

188. *Id.* at 9 n.1.

189. United States v. Charters, 829 F.2d 479, 496-97 (4th Cir. 1987).

> Latitude must be given in defining a 'rational reason'," supporting Charters' decision. For example, it would *not be a competent decision based on rational reasons if Charters refused medication out of a denial that he suffers from schizophrenia or out of a belief* that the drugs will have effects that no rational person could believe them to have.

Id. (emphasis added).

There was clear evidence in the district court case that Ballard (the person whom the government wished to medicate against his will) actually stated as one of his reasons for refusing medication that he did not believe that he is mentally ill." *Ballard*, 704 F. Supp. at 623.

190. United States v. Charters, 863 F.2d 302, 311 (4th Cir. 1987) (en banc).

191. *Id.*

192. *Id.*

avoid judical attempts at synthesizing the scientific data on the subject.[193]

All of the above, including the perceived judicial inability to comprehend these distinctions, was seen as further reason to view medical staff decisions as "presumptively valid."[194] The court then quotes former Chief Justice Burger in *Parham*: "[c]ommon human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."[195] Thus, the court deemed the government's plan for decision making adequate. It relied heavily on its interpretation of the *Youngberg* professional judgment standard. Importantly, this was seen as standing for the proposition that the medical decision in question need not be correct or most appropriate. The only relevant inquiry now becomes "only whether the decision was made by an appropriate professional . . . ."[196] In evaluating the decision we need only ask: "[W]as this decision reached by a process so completely out of professional . . . boundaries . . . as to make it explicable only as an arbitrary, nonprofessional one."[197]

This was the essence of the *en banc* court's argument: a inmate/patient, while retaining important liberty interests

193. *Id.* at 311-12.

> Without exhaustive analysis of the scientific literature before us documenting these side effects (of antipsychotic medications) and their statistical probability, it suffices to observe that while there is universal agreeement in the relevant professional discipline that the side effects always exist as a risk, there is wide disagreement within those disciplines as to the degree of their severity, their susceptibility to treatment, their duration and, most significantly, their probability over the run of cases.

Id. at 310-11.

The court proceeded to hold that this means that it was "[p]ersuaded that the potential for these specific side effects does not requrie substitution of the procedureal regime proposed by Charters . . . ." *Id.*

194. *Id.* at 310.

195. *Id.* (quoting Parham v. J.R., 442 U.S. 640 (1979)).

196. *See id.* at 313 (quoting Youngberg v. Romeo, 457 U.S. 307 (1982)).

197. *See id.*

concerning the decision of whether to take medication, may, nonetheless, be forcibly medicated if the ultimate decision is made by a professional.

Analysis

The *Charters en banc* decision addresses a number of legal, medical, and ethical issues in a cursory fashion and fails to address others entirely. These issues include: the informed consent doctrine,[198] the actual applicability of the *Youngberg* and *Parham* authorities,[199] the related area of the risks and benefits of psychotropic medication,[200] the proper use of the balancing test,[201] the related topic of what degree of explanation is due a person being deprived of a liberty right,[202] and what burden the regime proposed by *Charters* really entails for the government.[203]

First, both the panel and *en banc* decisions failed to adequately consider the doctrine of informed consent. At common law a physician's showing that the patient had consented to being touched was sufficient to override the patient's complaint about the type of treatment received, and the patient had no case for the tort of battery.[204] However, this developed into the requirement that the consent be "informed."[205] That is, the patient must be advised of the value and risk of a proposed treatment.[206] While the *Charters* court did not pay further attention to this aspect it might have

198. *Charters*, 863 F.2d at 304.

199. *Id.* at 305, 308.

200. *Id.* at 310-12.

201. *Id.* at 312.

202. *Id.* at 313.

203. *Id.* at 314.

204. Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 56, 77-78 (1977).

205. P. Applebaum, *Legal and Ethical Aspects of Psychopharmacologic Practice, in J. Bernstein*, CLINICAL PSYCHOPHARMACOLOGY 13-27 (2d ed. 1984).

206. *Id.* at 14.

been pivotal in this case. One must wonder what Charters' pyschiatrist told him about his condition, the prescribed medication and under what circumstances. An inadequate exploration of this process could well undermine Charters' genuine right to treatment and to informed consent.[207]

The courts and commentators have outlined three main aspects of informed consent: (1) the patient must have adequate information so that he might make an infomed choice;[208] (2) his consent must not be coerced;[209] and (3) he must be competent.[210] The question then becomes, what should the patient be told? Generally, the consensus is, what a reasonable patient would want to know and a reasonable practioner would disclose.[211] Common or very serious risks, therefore, would be discussed.[212]

Psychiatrists often rebel against these notions out of the legitimate fear that mentally ill patients frequently misinterpret the information provided.[213] Schizophrenic patients (including Charters)[214] often view mentioned risks as part of an evil plan to harm them, and thus avoid needed treatment.[215] The only satisfactory manner of balancing these concerns is for the process to be tailored to the patient with careful monitoring

207. *Id.*

208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.*

212. *Id.*

213. *See, e.g.*, Rose, *Schizophrenia, Civil Liberties, and the Law*, 14 SCHIZOPHRENIA BULL. 1, 3 (1988); *see also* B. SHULMAN, ESSAYS IN SCHIZOPHRENIA (2d ed. 1984) ("[t]he consequent loss of consensual frame of reference and need to replace it with a private logic [and] the distrust of others and their logic, and the assignation of private and secret meanings to ordinary events are typical reactions of schizophrenics to attempts to impart information." *Id.*).

214. United States v. Charters, 863 F.2d 302, 304 (4th Cir. 1988) (en banc). A number of studies document the connection between the paranoid ideas often associated with schizophrenia and medication refusal. *See, e.g.*, Wilson & Enoch, *Estimation of Drug Rejection by the Schizophrenic Patient*, 1 BRIT. MED. J. 972 (1962).

215. Applebaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patient*, 7 AM. ACAD. OF PSYCHIATRY AND THE L. 306, 310 (1976).

of his reaction by the psychiatrist.[216] Thus, informed consent should be a thoughtful part of the treatment process itself, and the patient's understanding should be explained by the psychiatrist so that misinterpretations and unrealistic fears can be addressed.[217] This process is also important in building trust between the therapist and patient as a result of the fact that patients are increasingly likely to hear about the risks of medication from others and would mistrust the psychiatrist should he not be the one to impart such important information.[218]

A willingness on the part of the patient to be treated is also crucial, particularly in an institutional setting such as a prison or psychiatric hospital.[219] There is an inherently coercive aspect to these institutions where the person is dependent on the authorities for the most basic necessities. On a more subtle level, the patient may fear withdrawal of the psychiatrist's interest should he refuse medication.[220] These factors should lead to a careful investigation of the subtleties in this type of case. The inquiry must: (1) ensure that the right to informed consent is not abridged in an overt or covert manner,[221] and (2) ensure that facial compliance by way of, for example, a signed statement, is not achieved in a manner which unfairly frightens and confuses the patient, thus robbing him of an equally important right to treatment.[222] These issues are not adequately addressed in either the panel or *en banc* decisions.

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216. *See* Applebaum, *supra* note 205, at 24.

217. *Id.* at 25.

218. Munetz & Schultz, *Minimization and Overreaction to Tardive Dyskinesia*, 12 SCHIZOPHRENIA BULL. 168, 169 (1986).

219. *See* Applebaum, *supra* note 205, at 17-18.

220. *Id.* at 18.

221. *Id.* at 13-27.

222. Rogers & Centifanti, *Madness, Myths, and Reality*, 14 SCHIZOPHRENIA BULL. 7, 8 (1988).

The *en banc* court rested squarely on *Youngberg* to support its use of the professional judgment standard.[223] Yet it did not address the panel's detailed attempt to distinguish that case on the facts.[224] First, the panel noted the difference between the plaintiff in *Youngberg* and Charters (discussed above).[225] Charters clearly had a different type of impairment and a much higher intelligence level.[226] Indeed, Dr. Sally Johnson, the treating psychiatrist in *Charters*, thought Charters was quite bright.[227] This difference, with its important ramifications, goes unnoted in the *en banc* opinion. Second, the panel noted that the *Youngberg* plaintiff (Romeo) had been violent on numerous occasions where Charters had not.[228] Charters was found to be, at most, verbally agressive.[229] This, too, is not mentioned in the *en banc* opinion. Third, the panel relied heavily on its distinction between antipsychotic medications in Charters' case (which it saw as akin to psychosurgery) and the use of temporary, soft-arm restraints on Romeo.[230] While there clearly is room for disagreement as to the proper interpretation of these medical aspects, the *en banc* court refused to engage in any discussion of these issues.

For example, the *en banc* court could have pointed to the unwarranted analogy between psychosurgery and psychotropics. Psychosurgery is an irreversible procedure which is rarely used.[231] At least one reading of the scientific data points to the view that medication is less intrusive and

223. United States v. Charters, 863 F.2d 302, 313 (4th Cir. 1988) (en banc).

224. United States v. Charters, 829 F.2d 479, 487-90 (4th Cir. 1987).

225. *Charters*, 829 F.2d at 488-90.

226. *Id.* at 489-90.

227. *Id.* at 480.

228. *Id.* at 489.

229. *Id.* at 480.

230. *Id.* at 489.

231. *See* Shevitz, *Psychosurgery: Some Current Observation*, 133 AM. J. PSYCHIATRY 266 (1976); Donnelly, *The Incidence of Psychosurgery in the Untied States*, 1971-73, 135 AM. J. PSYCHIATRY 1476 (1978).

often of great benefit to the patient.[232] Second, the panel's preference for restraints could have been challenged in a number of ways. While psychotropics do have side effects and dangers,[233] they can reduce the symptoms that make restraints necessary and, if properly used, afford a patient the possibility of leading a productive life.[234] Restraints, in contrast, are only utilized to temporarily control an out-of-control patient.[235] As stated by the American Psychiatric Association, "[t]o the extent that there is a difference between medication and restraints, it lies fundamentally in the fact that, while restraints are merely ancillary to treatment goals, the medications are themselves therapeutic."[236] But the *en banc* court did not make such an argument; instead, it ignored the issue.

The *en banc* court cited *Parham* numerous times in support of its ruling that less rigorous due process hearings would be sufficient to protect Charters' liberty interests. As noted by one commentator, however, "*Parham* dealt with the commitment of juveniles, and its holdings were premised on a very specific vision of the way parents, allegedly, make certain medical decisions for their children with their

232. *See, e.g.*, Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133, 142 (1987) ("Antipsychotic (neuroleptic) drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of this schizophrenic illness. The efficacy of medication in this context has been established in numerous double-blind, placebo-controlled trials." *Id.* at 134.). This is not to say that there are not other factors to consider in the therapeutic decision of whether to medicate, aside from the possible side effects. For example, many schizophrenics who improve on antipsychotics continue to have serious symptoms. Csernamsky, Kaplan & Hooister, *Problems in Classification of Schizophrenics as Neuroleptic Responders and Nonresponders*, 173 AM. J. PSYCHIATRY 1237-45 (1976). The point of this section is not to resolve the difficult question of which patient should be offered medication, but rather to draw attention to the fact that the *en banc* court did not address most of the relevant considerations in a serious fashion.

233. Kemna, *Current Status of Institutionalized Mental Health Patients' Right To Refuse Psychotropic Drugs*, 6 J. OF LEGAL MED. 107, 111-12 (1985). Common temporary side effects include fatigue, excitability, muscle spasms, hallucinations, parkinsonism, allergic reactions and potentially permanent tardive dyskinesia.

234. *Id.* at 111.

235. *See* Berger, *Medical Treatment of Mental Illness*, 200 SCIENCE 974 (1978).

236. *Amicus Curiae* Brief for the American Psychiatric Ass'n at 11-12, United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (en banc) (No. 86-5568).

offsprings' best interest at heart."[237] It is thus implicitly asserted by the *en banc* court that the medical staff where Charters was incarcerated would protect his interests in the same manner as would a parent. Surely, the *parens patriae* argument, despite its allusion to "parents," does not assure this degree of concern.

The deficiencies of psychiatric staff and their concomitant overreliance on medication for control purposes or administrative ease is well documented.[238] The court formed a strong foundation for the reasoning of Judge Murnaghan's panel decision[239] and his dissent from the *en banc* decision.[240] In many large, public psychiatric hospitals drugs are the only actual treatment provided.[241] Often the staff is not adequately trained or the facility is understaffed.[242] In many facilities, American-trained staff and staff members from minority groups are severely lacking. These problems have been documented in a number of federal cases.[243] Judge Murnaghan's fear that the staff in these institutions may have conflicts of interest when making medication decisions was not unfounded when expressed but went unconsidered by the *en banc* court.

The *en banc* court explicitly employed a balancing test as the framework for its decision.[244] As a general proposition, balancing has been seen as having a variety of virtues; it is

237. *See Does Competency Matter*, *supra* note 21, at 27.

238. *See, e.g.*, Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983); Miller v. Rogers, 457 U.S. 291 (1982); Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); *In re* Guardianship of Roe, 383 Mass. 415, 421 N.E.2d 40 (1981); *see also* Brooks, *The Constitutional Right to Refuse Antipsychotic Medication*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 179, 188 (1980).

239. United States v. Charters, 829 F.2d 479, 499 (4th Cir. 1987).

240. *Charters*, 863 F.2d at 313 (Murnaghan, J., dissenting).

241. *See* Rogers & Centifanti, *supra* note 222, at 7.

242. *Id.*

243. *See, e.g.*, Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983); Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); *In re* Guardianship of Roe, 383 Mass. 415, 421 N.E.2d 40 (1981).

244. *Charters*, 863 F.2d at 306-07.

simple, descriptive, and just.[245]

The balancing test has been criticized, however, as endangering "the central values" of our democratic system.[246] According to this argument, the test comes to dominate the protections it is meant to guard.[247] Laurent Frantz has said, in the first amendment context, that "[t]he balancing test assures us little, if any, more freedom of speech than we should have had if the first amendment had never been adopted."[248]

Whatever the test's virtues or problems may be in the abstract, attention to certain matters are essential for its appropriate and fair application. These have been outlined by Judge Coffin of the First Circuit Court of Appeals as follows: (1) the court should indicate the thought processes of the writer.[249] This will reduce the "effect of subjective bias";[250] (2) carefulness must be used in reasoning.[251] This includes a continuing alertness "to the temptation to rely on facile assumptions";[252] (3) it is important to develop a strong factual base for the decision;[253](4) the court must inquire not only as to the individual's right at stake, but, also evaluate "its centrality and importance";[254] and (5) in upholding the government's asserted interests the court must "[a]void relying on an official's casual and self-serving protestation without imposing a burdensome evidentiary obligation."[255] The Fourth Circuit did not fully meet these standards for a just application

245. McFadden, *The Balancing Test*, 29 B.C.L. REV. 585, 622, 625, 634 (1988).

246. *Id.* at 636.

247. *Id.*

248. *Id.*

249. Coffin, *Judicial Balancing: The Protean Scales of Justice*, 63 N.Y.U. L. REV. 16, 22 (1988).

250. *Id.* at 23.

251. *Id.*

252. *Id.* at 23-24.

253. *Id.* at 23.

254. *Id.*

255. *Id.* at 24.

of the balancing test. It did not explore a number of key issues which would have allowed it to do so.

First, the court's analysis leads to a test virtually impossible to overcome should the patient wish to refuse medication: How could a plaintiff prove that the decision to medicate was completely arbitrary and unprofessional? Short of extreme and malicious malpractice, it is hard to imagine proof which would meet such a burden. Second, while the court acknowledges, almost in passing, Charters' constitutional rights inplicated by the medication question,[256] it declines to employ a standard which adequately safeguards them. As the court noted, due process is "[f]lexible and calls for such procedural and protections as the particular situation demands."[257] As remarked by Professor Rabin, there should be a layered approach to due process.[258] Depending on the importance of the right implicated, there could be a need for protection ranging from the right to confront adverse witnesses to a fully adversarial hearing.[259] He goes on to say that if, for example, the first amendment is at issue, balancing between the individual's value and society's cost weight in favor of full hearing."[260] The Fourth Circuit denies the members of the bar and the particular plaintiff a reasoned explanation of why the fundamental rights implicated in the *Charters* case did not demand such a full hearing.

An exploration of the issue of risks and benefits of medication, crucial to a reasoned balancing of Charters' rights as against those of the state, is also lacking. Certainly, this is

256. United States v. Charters, 863 F.2d 302, 306 (4th Cir. 1988) (en banc).

257. *Id.* at 306 (quoting Morrissey v. Brewer, 408 U.S. 471, 581 (1972)).

258. Rabin, *Job Security and Due Process: Monitoring Administrative Discretion Through a Reasons Requirement*, 44. U. CHI. L. REV. 60, 79 (1976).

259. *Id.* at 79.

260. *Id.* The court, in its technical application of the balancing test, is making a tacit judgment of the importance of the rights implicated; that is, by giving them cursory treatment, the value judgment is made clear. The values, however, are not articulated. Such a mechanical application is criticized in Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in Matthews v. Eldridge: Three Factors in Search of a Theory of Value*, 44 U. CHI. L. REV. 28 (1976).

a complex matter. Important to a fair understanding of the issue is "[a] need for a rational acceptance of two facts: Neuroleptics [antipsychotics] are very helpful when used properly, and tardive dyskinesia is a genuine problem with long-term neuroleptic treatment."[261] One difficulty in assessing the usefulness of the medication is that these drugs were first seen as offering a risk-free panacea for the treatment of psychosis;[262] then, as risks became evident, there was a counter-reaction which perhaps overemphasized their potential for harm.[263]

The psychiatric literature has often remarked on the positive aspects of the medications, noting various studies showing that patients suffering from schizophrenia who when treated with medication, did significantly better than those offered only verbal psychotherapy.[264] They remind us that many patients currently treated with these medications were often incarcerated for long periods of time in hospitals, and now with medication, these same patients can lead more integrated lives in the community.[265] Furthermore, it is noted that there is no alternative treatment.[266] However, psychotropics can cause serious side effects.[267] No medication is risk free in this regard.[268] The prevalence of side effects is from 24% to 56% of long-term antipsychotic users.[269] Predictions cannot be made as to the particular effect of a

261. Munetz & Schultz, *supra* note 218 at 168 (quoting D. JESTE & R. WYATT, UNDERSTANDING AND TESTING TARDIVE DYSKINESIA 9 (1982)).

262. *See* Munetz & Schultz, *supra* note 218, at 168.

263. *Id.*

264. *See* DAVIS, *supra* note 1, at 2272.

265. *See, e.g.*, Klerman, *National Trends in Hospitalization*, 30 HOSP. & COMMUNITY PSYCHIATRY 110, 111-12 (1979); Applebaum & Gutheil, *supra* note 215 at 306 (1976); Brooks, *supra* note 238, at 182-83; *see also* Davis, *Overview: Maintenance Therapy in Psychiatry*, 132 AM. J. PSYCHIATRY 1237 (1975).

266. *See* Brief Amicus Curiae, *supra* note 236, at 12.

267. *See* J. BERNSTEIN, CLINICAL PSYCHOPHARMACOLOGY 168 (2d ed. 1984).

268. *Id.*

269. *Id.* at 165.

medication on a patient without a clinical trial.[270] A typical symptom that the average patient suffers from (tardive dyskinesia) involves abnormal mouth and body movements; this is often accompanied by excessive drooling.[271] All movement can be affected in the more extreme conditions.[272] There have been cases reported following short-term use,[273] but they are rare.[274]

The counter-arguments to the above-mentioned data, aside from citing the general efficacy of these medications in treating psychosis, include the assertion that lowering dosages or stopping treatment can usually control most side effects.[275] Additionally there are studies which indicate that most patients who are afflicted with tardive dyskinesia have mild symptoms.[276] All of this provides support for an argument in favor of an acceptable cost/risk ratio.[277]

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270. *Id.*

271. Kemna, *supra* note 233.

272. Appleton, *Fourth Psychoactive Drug Usage Guide*, 43 J. CLINICAL PSYCHIATRY 12 (1982).

273. *See*, Bernstein, *supra* note 267, at 170.

274. *Id.* However, many potentially serious conditions go unreported due to confusion in diagnosis. *See, e.g.*, Ananth & Edelmath, *Meige's Syndrome Associated with Neuroleptic Treatment*, 145 AM. J. PSYCHIATRY 513 (1983), in which a serious condition (Meige's syndrome) is reported as being confused with tardive dyskinesia. *Id.* In a recent study, three physicians concluded that neuroleptic malignant syndrome, which can be fatal, may be more common than is thought. Popoe & Keck, *Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital*, 143 AM. J. PSYCHIATRY 1227 (1986). Clinicians also often confuse another side effect, akanthisia, with tardive dykinesia due to their failure to question patients about their subjective feelings of distress. Munetz & Cornes, *Distinguishing Akathisia and Tardive Dyskinesia: A Review of the Literature*, 3 J. CLINICAL PSYCHOPHARMACOLOGY 343 (1983). An additional cause for alarm is that the incidence of certain side effects seems to be rising. *See, e.g.*, Juste & Wyatt, *Changing Epidemiology of Tardive Dykinesia: An Overview*, 138 AM. J. PSYCHIATRY 177 (1980). There are also reports of increasing prevalence of medication-induced catatonia. Fricchione, Cassem, Hoberman & Hobson, *Intravenous Lorasepam in Neuroleptic-Induced Catatonia*, 3 J. CLINICAL PSCHOPHARMACOLOGY 338 (1983); Ayd, *Neuroleptic-Induced Catatonia: A Further Report*, 18 INT'L DRUG THERAPY NEWS 9 (1983).

275. AMERICAN PSYCHIATRIC ASS'N, TASK FORCE REPORT 18: TARDIVE DYSKINESIA 123, 145 (1980).

276. *See* Applebaum & Gutheil, *supra* note 215, at 309.

277. *Id.*

All of the above may indeed fundamentally be part of the "best interest" analysis as the *en banc* court asserts,[278] but the real question is: Who is given the authority to decide what is in a particular patient's best interest at any given time? The *en banc* court would strip an individual of his right to decide and place it in the hands of the treating doctor, ignoring Justice Cardozo's statement in *Schloendorff v. Society of New York Hospital*[279] that "every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."[280]

Furthermore, a less mechanical reading of the balancing test would have considered all of the components as a whole, not compartmentalized each section as if it had no relation to the other. It must be noted that, even taking all of the suggested benefits of medication at face value, it is never asserted that they are properly administered to patients who are not receiving adequate care in all other aspects of their treatment. They are not a substitute for verbal psychotherapy or medical monitoring, but merely a major element of good treatment.[281] Seen in this light, one must ask how a decision to give forced medication will affect a patient who might very well be receiving substandard care in other regards.[282] This issue was not addressed by the *en banc* court.

In evaluating the government interest side of the equation, the Fourth Circuit could have considered data with regard to the actual cost burden of judicial hearings. Studies on how many patients actually refuse medication and the context and consequences of such refusals could have been considered.

As noted in the panel opinion a very small number of patients utilize due process procedures when they are in

278. United States v. Charters, 863 F.2d 302, 309 (4th Cir. 1988) (en banc).

279. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

280. *Id.* at 129, 105 N.E. at 93.

281. DAVIS, *supra* note 1, at 2272.

282. *Id.*

place.[283] Additionally, even after court rulings finding a right to refuse medication, relatively few patients in these jurisdictions decide to so refuse.[284]

Following the *Rennie* decision, the psychiatric community feared massive medication refusals, but this has not occurred. This fear overshadowed, at least in some psychiatric circles, the positive aspects of allowing refusal: the increase in a patient's self-esteem, and the strengthening of the doctor-patient therapeutic alliance that is so necessary to proper treatment. In short, the *en banc* court did not avail itself of the data which would have allowed it to look beyond the self-serving assertions of the government's personnel.

V. CONCLUSION

In conclusion, it may safely be said that the *Charters* case clearly illustrates two divergent manners of approaching the question of patient autonomy with regard to the right to refuse antipsychotic medications. The panel decision is a clear example of a case in which the court gave thoughtful attention to detail and made appropriate use of the balancing test, while the *en banc* decision is illustrative of the way in which the balancing test can be used to circumvent a consideration of the scientific data presented by this type of situation. One cannot say, however, that the *en banc* decision will not become an example of the way that a majority of these cases are approached.

Just as the 1960's set the social tone for an increased interest in the liberty and privacy rights of the individual,[285] the

283. *Id. See also* Brooks, *supra* note 238, at 179, 188, 206.

284. United States v. Charters, 829 F.2d 479, 499 n.28 (4th Cir. 1987) (citing Brushwood & Fink, *Right to Refuse Treatment with Antisychotic Drugs*, 42 AM. J. HOSP. PHARMACY 2709 (1985)).

285. *See, e.g.*, Linde, *Justice Douglas on Freedom in the Welfare State Constitutional Rights in the Public Sector*, 39 WASH. L. REV. 4 (1964).

conservative backlash of the 1980's[286] has set the stage for a withdrawal of the courts from a vigorous enforement of such rights. Nowhere is this more clearly seen than in the section of the court's decision which emphasized the cost of hearings. American society in the 1980's, in general, has reacted to the gains of racial minorities and other groups empowered during the 1960's and 1970's by removing the financial support which made such gains possible.[287] As the Supreme Court becomes more clearly a court in keeping with the majoritarian attitudes of the current political climate,[288] there is no reason to believe that the lower federal courts will not continue their withdrawal in this and other important areas of protection. In this small part of the overall picture the original panel decision in *Charters* may be seen as the last stand of a federal judicial element still concerned with individual liberties to the extent that it was willing to engage in a difficult, thoughtful analysis in an area that makes many judges uncomfortable.[289]

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286. J. BENSMAN & A. VIDICH, AMERICAN SOCIETY: THE WELFARE STATE AND BEYOND 231 (1987).

287. *Id.* at 165.

> Ultimately the money [to support social programs] is understood [by the middle class] to come from the taxes of the affluent white middle and upper classes. At this point, white middle-class liberalism becomes expensive and produces the most dangerous form of racism, a racism which is not expressed by conscious racial attitudes but by budgetary and fiscal selfishness and conservatism which prevent manifest solutions to racial problems.

Id.

288. *See Does Competency Matter, supra* note 21, at 41.

289. *Id.* at 34 (quoting Judge Bazelon):

> Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine bioligists. For some reason, however, many people seem to accept judicial scrutiney of, say, the effect of a proposed dam on fish life, while they reject a similiar scrutiny of the effect of psychiatric treatment on human lives . . . . It can hardly be that we are more concerned for the salmon than the schizophrenic.

Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 743 (1969).