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Michael L. Perlin

*New York Law School*, [michael.perlin@nyls.edu](mailto:michael.perlin@nyls.edu)

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# Are Courts Competent to Decide Competency Questions?: Stripping the Facade from *United States v. Charters*\*

Michael L. Perlin\*\*

## I. INTRODUCTION

One of the most remarkable developments in constitutional law of the past decade has been the proliferation of cases and scholarship concerning the right of institutionalized mentally disabled individuals to refuse the administration of psychotropic medication.<sup>1</sup> Since publication of the trial courts' opinions in *Rennie v. Klein*<sup>2</sup> and *Rogers v. Okin*,<sup>3</sup> the courts in at least five circuits and fifteen states have agreed that such persons have at least a qualified right to refuse such treatment and that procedural due process attaches to any decision-making process designed to override this right.<sup>4</sup> At the same time, at least three small cottage industries of

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\*\* Professor of Law and Director, Federal Litigation Clinic, New York Law School. A.B., Rutgers University, J.D., Columbia University School of Law. The author wishes to thank Audrey Drucker, Susan Sheppard and Demetrios Stratis for their helpful research assistance, Tony Alfieri and Dr. Stephen Rachlin for their insightful comments on an earlier draft, and Karen Powell Hill for her first-rate administrative support.

1. See, e.g., Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339 (1987); Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L.J. 1725 (1984); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977). For a comprehensive bibliography, see Brooks, *supra*, at 340-41 n.2; see generally 2 M. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, §§ 5.01-.69 (1989).

2. 462 F. Supp. 1131 (D.N.J. 1978), *supplemental opinion*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983) (involuntarily committed patients have a qualified right to refuse medication; due process attaches to medication decision making).

3. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated*, 457 U.S. 291 (1982), *on remand*, 738 F.2d 1 (1st Cir. 1984) (same).

4. See, e.g., *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291 (8th Cir. 1987); *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 467 U.S. 1244 (1985); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984); *Project Release v. Provost*, 722 F.2d 960, 977-80 (2d Cir. 1983); *Clark v. Taylor*, 710 F.2d 4, 8 (1st Cir. 1983) (quoting *Rogers v. Okin*, 634

commentary have emerged, focusing variously on the theoretical justifications for the right,<sup>5</sup> the psychiatric objections to the right,<sup>6</sup> and the empirical analyses of what happens when the right is implemented judicially and administratively.<sup>7</sup>

The emergence of this case law coincided with public scrutiny of public institutions in the late 1970s. The strategic impetus for this litigation flowed from earlier decisions that had repudiated

F.2d 650, 653 (1st Cir. 1980), *vacated*, 457 U.S. 291 (1982), *on remand*, 738 F.2d 1 (1st Cir. 1984)); *Nolen v. Peterson*, 544 So. 2d 863, 866-67 (Ala. 1989); *Riese v. St. Mary's Hosp. & Medical Center*, 209 Cal. App. 3d 1303, 243 Cal. Rptr. 241 (1987), *appeal dismissed*, 774 P.2d 698, 259 Cal. Rptr. 669 (1989); *People v. Medina*, 705 P.2d 961 (Colo.), *aff'd*, 705 P.2d 961 (Colo. 1985); *In re Boyd*, 403 A.2d 744 (D.C. Ct. App. 1979); *In re Mental Commitment of M.P.*, 500 N.E.2d 216 (Ind. Ct. App. 1986), *vacated on other grounds*, 510 N.E.2d 645 (Ind. 1987); *Clites v. State*, 322 N.W.2d 917, 921-23 (Iowa Ct. App. 1982); *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Jarvis v. Levine*, 403 N.W.2d 298 (Minn. Ct. App. 1987), *aff'd in part and rev'd in part*, 418 N.W.2d 139 (1988); *Opinion of Justices*, 123 N.H. 554, 465 A.2d 484 (1983); *In re Sanders*, 108 N.M. 434, 773 P.2d 1241 (Ct. App. 1989); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *In re Mental Health of K.K.B.*, 609 P.2d 747 (Okla. 1980); *In re Boyer*, 636 P.2d 1085 (Utah 1981); *In re G.K.*, 514 A.2d 1031 (Vt. 1986); *State ex rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 733-47, 416 N.W.2d 883, 892-98 (1987).

5. See, e.g., Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 180-200 (1980); Brooks, *supra* note 1; Gelman, *supra* note 1; Plotkin, *supra* note 1; Winick, *Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1 (1989). For a list of the most important sources, see A.B.A. COMM'N ON MENTALLY DISABLED, *THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION* 101-10 (1986) (annotated bibliography).

6. Although some legal commentators have criticized the expansion of the right, see, e.g., Comment, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 OHIO ST. L.J. 1133 (1987), the most significant opposition has come from practicing and academic psychiatrists, see, e.g., Gutheil, *The Right to Refuse Treatment: Paradox, Pendulum and the Quality of Care*, 4 BEHAV. SCI. & L. 265 (1986); Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medicine*, 12 HOFSTRA L. REV. 77 (1983); Rachlin, *One Right Too Many*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975).

7. See, e.g., Hoge, Gutheil & Kaplan, *The Right to Refuse Treatment Under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 163 (1987); Young, Bloom, Faulkner, Rogers & Pati, *Treatment Refusals Among Forensic Inpatients*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 5 (1987); Zito, Routt, Mitchell & Roerig, *Clinical Characteristics of Hospitalized Psychotic Patients Who Refuse Antipsychotic Drug Therapy*, 142 AM. J. PSYCHIATRY 822 (1985).

For a discussion of the courts' teleologic interpretation of all social science data of this sort, see Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning* 113-14 (1990) (manuscript to be published in 67 NEB. L. REV.) (discussing Appelbaum, *The Empirical Jurisprudence of the United States Supreme Court*, 13 AM. J.L. & MED. 335 (1987)).

the "hands-off" doctrine<sup>8</sup> in a wide variety of cases that broadened the applicability of procedural and substantive due process protections to institutionalized individuals.<sup>9</sup> Although this litigation initially arose in the state prison and jail settings,<sup>10</sup> lawyers representing the mentally disabled, a historically "hidden" and disenfranchised group,<sup>11</sup> began to turn to the federal courts for vindication of fundamental constitutional and civil rights.<sup>12</sup>

Originally, the courts did not merely reject the "hands-off" rubric; they eagerly buried it. In cases involving shocking disclosures of patient brutality, mistreatment, and abuse,<sup>13</sup> judges such

8. See, e.g., *Banning v. Looney*, 213 F.2d 771 (10th Cir.), *cert. denied*, 348 U.S. 859 (1954); *Siegel v. Ragan*, 180 F.2d 785, 788 (7th Cir.), *cert. denied*, 339 U.S. 990 (1950); see generally, Note, *Beyond the Ken of the Courts: A Critique of Judicial Refusal to Review the Complaints of Convicts*, 72 YALE L.J. 506 (1963).

9. See generally 1 M. PERLIN, *supra* note 1, § 1.03, at 5-9 and sources cited therein; Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A.L. REV. 1249, 1249-52 (1987) and sources cited therein.

10. See Alexander, *The New Prison Administrators and the Court: New Directions in Prison Law*, 56 TEX. L. REV. 963, 964-65 (1978). Important early cases include *Holt v. Sarver*, 309 F. Supp. 362 (E.D. Ark. 1970), *aff'd*, 442 F.2d 304 (8th Cir. 1971) (right to freedom from cruel and unusual punishment); *Hamilton v. Love*, 328 F. Supp. 1182 (E.D. Ark. 1971), *later proceeding*, 358 F. Supp. 338, *supplemental opinion*, 361 F. Supp. 1235 (E.D. Ark. 1973) (establishing minimum standards of care in county jail); *Rhem v. Malcolm*, 527 F.2d 1041 (2d Cir. 1975) (right of pretrial detainees to contact visits).

11. See, e.g., *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 461-64 (1985) (Marshall, J., concurring in part and dissenting in part) (mentally retarded individuals have been subject to a "lengthy and tragic history" of segregation and discrimination that can only be called grotesque," *id.* at 461 (quoting *University of Cal. Regents v. Bakke*, 438 U.S. 265, 303 (1978) (citation omitted))); see generally *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152-53 n.4 (1938).

12. 1 M. PERLIN, *supra* note 1, § 1.03, at 8; Perlin, *supra* note 9, at 1251. The seminal article explaining the courts' role in such litigation remains Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281 (1976).

13. See, e.g., *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974):

One [Alabama state hospital patient] died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administration of drugs which had been inadequately secured.

*Id.* at 1311 n.6; *New York State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752, 755-56 (E.D.N.Y. 1973).

The chairman of the legal action committee of the National Association of Retarded Children characterized the Pennhurst facility in suburban Philadelphia, the subject of litigation in *Youngberg v. Romeo*, 457 U.S. 307 (1982), and *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981), as "Dachau, without ovens." L. LIPPMANN & I. GOLDBERG, *THE RIGHTS TO EDUCATION: ANATOMY OF THE PENNSYLVANIA CASE AND ITS IMPLICATION FOR EXCEPTIONAL CHILDREN* 17 (1973).

as Frank Johnson<sup>14</sup> overtly embraced an activist model that "almost single-handedly, as a *tour de force*, transfigured institutional care of the mentally ill of the nation."<sup>15</sup> District of Columbia Court of Appeals Judge David Bazelon placed the issue in the unique perspective of the population in question:

Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject a similar scrutiny of the effect of psychiatric treatment on human lives. . . . [I]t can hardly be said that we are more concerned for the salmon than the schizophrenic. . . .<sup>16</sup>

When the litigation had shifted focus from the right to treatment to the right to *refuse* treatment, some recession from this position became noticeable.<sup>17</sup> Refusal-of-treatment litigation challenged the autonomy and the authority of state hospital doctors to provide what had been considered "standard" treatment: the administration of psychotropic medication to institutionalized, mentally ill patients.<sup>18</sup> On its surface, this appeared to be distinct from the type of "shock the conscience" physical brutality in the prototypic

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14. Judge Johnson was the trial judge in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala.), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala.), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). See *supra* note 13; *infra* note 15.

15. Heller, *Extension of Wyatt to Ohio Forensic Patients*, in *WYATT V. STICKNEY: Retrospect and Prospect* 161, 172 (L. Jones & R. Parlour eds. 1981) [hereinafter *WYATT Retrospect*]. One commentator has stated flatly that without Judge Johnson's involvement, "there would have been no substantial change at the institution." Brant, Pennhurst, Romeo, and Rogers: *The Burger Court and Mental Health Law Reform Litigation*, 4 J. LEGAL MED. 323, 325 (1983).

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

17. This recession did not affect the earliest right-to-refuse cases that had involved the forcible administration of drugs for purely punitive purposes. See, e.g., *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973) (involuntary administration of vomit-inducing drug apomorphine as an "aversive stimuli," *id.* at 1137, violated the eighth amendment's cruel and unusual punishment clause); *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) (if proven, allegations of involuntary administration of "breath stopping and paralyzing," *id.* at 8, drug succinylcholine would violate the first amendment right to be free from "impermissible tinkering," *id.* at 878, with patient's mental processes or the eighth amendment's cruel and unusual punishment clause).

18. For a discussion of the way that the use of psychiatric drugs "revolutionized state mental hospital systems," see Gelman, *supra* note 1, at 1725-27; Comment, *Pathway Through the Psychotropic Jungle: The Right to Refuse Psychotropic Drugs in Illinois*, 18 J. MARSHALL L. REV. 407, 408, 410-11 (1985); see generally 2 M. PERLIN, *supra* note 1, § 5.02.

right-to-treatment case *Wyatt v. Stickney*.<sup>19</sup> Thus, even in one of the broadest, most scholarly, and most sensitive of the first generation of right-to-refuse-treatment cases, Judge Stanley Brotman noted, "A little knowledge can be dangerous, and this court is hesitant to diagnose mental illness and prescribe medication."<sup>20</sup>

More typical, perhaps, were the concerns of the First Circuit in *Rogers* and the Third Circuit in its original modification of Judge Brotman's decision in *Rennie v. Klein*.<sup>21</sup> Although these courts affirmed much of the substantive bases of the trial court decisions, they toned down the trial courts' rhetoric and limited the substantive and procedural sweep of the protections. Thus, in its recalibration of the "least restrictive alternative" aspect of *Rennie*,<sup>22</sup> the Third Circuit warned about excessive intrusion into the daily

19. See *supra* note 13; see also, e.g., *Wyatt v. Stickney*, 344 F. Supp. 387, 393-94 n.13 (M.D. Ala. 1972); see also Drake, *The Development of Wyatt in the Courtroom*, in *WYATT Retrospect*, *supra* note 15, at 35, 36 (characterizing the "horror" of pre-*Wyatt* institutions in Alabama). As the right-to-refuse-treatment litigation developed, it became clear that this dichotomy was, in many circumstances, illusory. See, e.g., *Rennie v. Klein*, 476 F. Supp. 1294, 1302 (D.N.J. 1979) (hospital staff increased patient's medication regimen as "reprisal" for his decision to contact an attorney), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982); see also, *infra* note 171. The potential side effects from the administration of psychotropic medication are discussed comprehensively in *United States v. Charters*, 829 F.2d 479, 483 n.2 (4th Cir. 1987), *on reh'g*, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 110 S. Ct. 1317 (1990). The drugs that are usually the centerpiece of such litigation are discussed in Crane, *Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient*, 36 TRANSACTIONS N.Y. ACAD. SCI. 644, 656 (1974); Denber, *Tranquilizers in Psychiatry*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1251 (A. Freedman & H. Kaplan eds. 1967).

20. *Rennie v. Klein*, 462 F. Supp. 1131, 1140 (D.N.J. 1978), *supplemental opinion*, 476 F. Supp. 1294, 1302 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982). The question in *Rennie*, Judge Brotman found, tracked the question that Judge Bazelon asked rhetorically in another law review article: "[H]ow real is the promise of individual autonomy for a confused person set adrift in a hostile world?" *Id.* at 1146 (quoting Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975)).

21. 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982).

22. The *Rennie* trial court had extended the doctrine of the "least restrictive alternative," which had been regularly applied in mental health litigation to questions of *custodial* settings, see, e.g., *Eubanks v. Clarke*, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977); *Welsch v. Likins*, 373 F. Supp. 487, 501-02 (D. Minn. 1974), *supplemental opinion*, 68 F.R.D. 589 (D. Minn. 1975), *aff'd*, 525 F.2d 987 (8th Cir. 1975), to medication choices. See *Rennie*, 462 F. Supp. at 1146 (quoting Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 AM. B. FOUND. RES. J. 769, 813 (patient "may challenge the forced administration of drugs on the basis that alternative treatment methods should be tried before a more intrusive technique like psychotropic medication is used")); see generally 2 M. PERLIN, *supra* note 1, § 5.14; Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 400-05, 423-26 (1980-81).

operation of mental institutions: "This is not to say that the least intrusive means requires hourly or daily judicial oversight. Obviously that would be an unworkable standard. Rather, what is reviewable is whether the choice of a course of treatment strikes a proper balance between efficacy and intrusiveness."<sup>23</sup> These concerns mirrored the tension that characterized this first generation of right-to-refuse-treatment cases: a willingness to grant at least some claims for relief in right-to-refuse cases, combined with a palpable uneasiness in dealing with the underlying subject matter.<sup>24</sup>

A well-developed and fairly coherent body of law has evolved in the right-to-refuse-treatment cases primarily involving patients in the *civil* context.<sup>25</sup> In contrast, the issue of the pretrial criminal detainee's right to refuse similar medication, which almost always arises in the context of an incompetency-to-stand-trial ("IST") determination,<sup>26</sup> was litigated in a series of individual and obscure cases that generally escaped the attention of commentators.<sup>27</sup> This

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23. *Rennie*, 653 F.2d at 847; see also *Rogers v. Okin*, 634 F.2d 650, 656-57 (1st Cir. 1980), *vacated*, 457 U.S. 291 (1982):

In sum, we hold that the district court should not attempt to fashion a single "more-likely-than-not" standard as a substitute for an individualized balancing of the varying interests of particular patients in refusing antipsychotic medication against the equally varying interests of the patients—and the state—in preventing violence. Because we recognize the legitimacy of both of these interests, we conclude that neither should be allowed necessarily to override the other in a blanket fashion.

24. See, e.g., *Perry & Melton, Precedential Value of Judicial Notice of Social Facts: Parham as an Example*, 22 J. FAM. L. 633, 675 n.188 (1983-84) ("It is well established that legal fact finders' judgments are substantially affected by their biases and their style of processing information.").

25. See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980), *discussed in* 2 M. PERLIN, *supra* note 1, § 5.39, at 328-32. The composition of the *Davis* class is described in *Davis v. Watkins*, 384 F. Supp. 1196, 1200-02 (N.D. Ohio 1974).

26. But see *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) (case involving right of pretrial detainee who was not IST to refuse treatment), *cert. denied*, 469 U.S. 1214 (1985), *discussed in* Perlin, *Can Mental Health Professionals Predict Judicial Decisionmaking? Constitutional and Tort Liability Aspects of the Institutionalized Mentally Disabled to Refuse Treatment: On the Cutting Edge*, 3 *TOURO L. REV.* 13, 29-31 (1986)); see generally Bunn, *More Meaningful Protection for the Right to Refuse Antipsychotic Drugs*, 62 *CHI.-KENT L. REV.* 323 (1985); Comment, *Bee v. Greaves: A Pretrial Detainee's Constitutional Right to Refuse Antipsychotic Drugs Under the First and Fourteenth Amendments*, 63 *DEN. U.L. REV.* 273 (1986).

27. But compare Fentiman, *Whose Right Is It Anyway?: Rethinking Competency to Stand Trial in Light of the Synthetically Sane Insanity Defendant*, 40 *U. MIAMI L. REV.* 1109 (1986) (supporting the criminal defendant's right to refuse treatment) with Gutheil & Appelbaum, *supra* note 6 (dealing with psychiatric objections to the right to refuse treatment); see also, for a recent empirical analysis on the interplay between use of

case law resulted in a series of apparently random decisions from which almost no doctrinal threads could be extracted.<sup>28</sup> Although most courts sanctioned the forced drugging of criminal detainees,<sup>29</sup> several courts prohibited such practices where it appeared likely that inappropriate medication might exacerbate the detainee's incompetency.<sup>30</sup> The courts made little effort to distinguish, harmonize, or analyze decisions with conflicting holdings.<sup>31</sup> Thus, there has been significant and genuine confusion<sup>32</sup> in determining what rights detainees have to refuse such medication.<sup>33</sup>

It was not until the case of *United States v. Charters*<sup>34</sup> that these divergent streams of case law appeared to come together. The

medication and competency to stand trial findings, Beckham, Annis & Bein, *Don't Pass Go: Predicting Who Returns from Court as Remaining Incompetent for Trial*, 13 CRIM. JUST. & BEHAV. 99 (1986).

28. Compare, e.g., *State v. Hayes*, 118 N.H. 458, 389 A.2d 1379 (1978) (upholding forced drugging to stimulate competence to stand trial where jury was made aware of use of medication) and *Craig v. State*, 704 S.W.2d 948 (Tex. Ct. App. 1986) (same) with *Whitehead v. Wainwright*, 447 F. Supp. 898 (M.D. Fla. 1978) (due process violated where defendant was rendered incompetent by overmedication), *vacated on other grounds*, 609 F.2d 223 (5th Cir. 1980); see generally 3 M. PERLIN, *supra* note 1, § 14.09.

29. See, e.g., *State v. Lover*, 41 Wash. App. 685, 690, 707 P.2d 1351, 1354 (1985) (quoting *State v. Maryott*, 6 Wash. App. 96, 103, 492 P.2d 239, 243 (1971) (use of such drugs is "fundamental to a scheme of ordered liberty"); *State v. Jojola*, 89 N.M. 489, 492, 553 P.2d 1296, 1299 (1976) (quoting an expert witness: "Thorazine [a psychotropic drug] allows the mind to operate as it might were there not some organic or other type of illness affecting the mind"); *State v. Hampton*, 253 La. 399, 403, 218 So. 2d 311, 312 (1969) (that defendant's competency arose from such medication was of "no legal consequence").

30. See, e.g., *Whitehead*, 447 F. Supp. 898 (overmedication); *State v. Maryott*, 6 Wash. App. 96, 492 P.2d 239 (1971) (defendant was improperly medicated by jailers, not pursuant to court order).

31. But see, *Lover*, 41 Wash. App. at 688-89, 707 P.2d at 1353 (noting *Jojola's* distinction of *Maryott*); *Jojola*, 89 N.M. at 491-92, 553 P.2d at 1298-99 (distinguishing *Maryott* and *State v. Hancock*, 247 Or. 21, 426 P.2d 872 (1967)).

32. See Gutheil & Appelbaum, *supra* note 6.

33. The incompetency to stand trial determination remains a significant one. See, e.g., H. STEADMAN, BEATING A RAP?: DEFENDANTS FOUND INCOMPETENT TO STAND TRIAL 3-4 (1979) (36,000 defendants evaluated per year on incompetency question); see also Winick, *Restructuring Competency to Stand Trial*, 32 U.C.L.A. L. REV. 921, 922-23 n.3 (1985); see generally 3 M. PERLIN, *supra* note 1, § 14.02, at 206-09.

The standard incompetency test is found in *Dusky v. United States*, 362 U.S. 402, 402 (1960) (whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as a factual understanding of the proceedings against him"). For more detailed tests see, e.g., N.J. STAT. ANN. § 2C:4-4 (West 1982); *People v. Picozzi*, 106 A.D.2d 413, 414, 482 N.Y.S.2d 335, 337 (1984); see generally 3 M. PERLIN, *supra* note 1, § 14.03, at 209-15; Bennett, *A Guided Tour Through Selected ABA Standards Relating to Incompetence to Stand Trial*, 53 GEO. WASH. L. REV. 375, 377-78 (1985).

34. 829 F.2d 479 (4th Cir. 1987) (*Charters I*), *on reh'g*, 863 F.2d 302 (4th Cir. 1988) (en banc) (*Charters II*), *cert. denied*, 110 S. Ct. 1317 (1990).



Fourth Circuit's initial panel decision in *Charters* ("*Charters I*"), a case involving an institutionalized federal pretrial detainee, was perhaps the furthest reaching *federal* right-to-refuse-treatment case since the United States Supreme Court remanded *Rennie* and *Rogers* in 1982.<sup>35</sup> The panel decision in *Charters I*<sup>36</sup> (1) squarely rejected the notion that the "exercise of professional judgment

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35. When it finally decided a right-to-refuse case in 1982, the Supreme Court gave the lower tribunals little guidance. In *Mills v. Rogers*, 457 U.S. 291 (1982), the Court avoided the constitutional issues by remanding the case to the First Circuit for consideration of the effect of a 1981 Massachusetts state court decision that had held that a *noninstitutionalized incompetent* patient had a right to a prior judicial hearing to assert his desire to refuse antipsychotic drug treatment. *Id.* at 306 (relying on *Guardianship of Roe*, 383 Mass. 415, 433-36, 421 N.E.2d 40, 51-52 (1981)). For discussion of the way that *Mills* "skirted" the constitutional issues, see 2 M. PERLIN, *supra* note 1, § 5.33; Wexler, *Seclusion and Restraint: Lessons From Law, Psychiatry, and Psychology*, 5 INT'L J.L. & PSYCHIATRY 285, 290 (1982). The Supreme Court remanded *Rennie* in light of its decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982), in which it had established a minimal right to training in a case involving an incompetent, severely retarded, institutionalized individual. *Rennie v. Klein*, 458 U.S. 1119 (1982); see 2 M. PERLIN, *supra* note 1, §§ 4.31-41. On remand, a sharply divided Third Circuit reiterated its earlier holding that involuntarily admitted patients have a qualified right to refuse the administration of psychotropic drugs but that state administrative procedures satisfied due process requirements. *Rennie v. Klein*, 720 F.2d 266, 269-70 (3d Cir. 1983); see 2 M. PERLIN, *supra* note 1, § 5.36.

In the wake of *Rogers* and the Third Circuit's second *Rennie* remand decision, the focus of litigation turned swiftly to state courts, and state constitutional law became an increasingly important vehicle through which right-to-refuse claims were assessed. See, e.g., *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986) (concluding that state constitutions afforded "involuntarily committed mental patients a *fundamental* right to refuse medication," *id.* at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78 (emphasis added), and holding that "neither mental illness nor institutionalization per se can stand as a justification for overriding an individual's fundamental right to refuse antipsychotic medication on either police power or *parens patriae* grounds," *id.* at 498, 495 N.E.2d at 344, 504 N.Y.S.2d at 81)); see generally 2 M. PERLIN, *supra* note 1, §§ 5.42-43A. In state cases such as *Rivers*, the courts rejected arguments that involuntarily committed patients were "presumptively incompetent" because of their institutionalization, reasoning that without more, neither the fact of mental illness nor the fact of commitment "constitutes a sufficient basis to conclude that [such patients] lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being." *Rivers*, 67 N.Y.2d at 494, 495 N.E.2d at 341-42, 504 N.Y.S.2d at 79. Thus, in the case of a competent patient, the right "to determine what shall be done with [one's] body," *id.* at 492, 495 N.E.2d at 341, 504 N.Y.S.2d at 78 (quoting *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (overruled on other grounds by *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957))), must be honored "even though the recommended treatment may be beneficial or even necessary to preserve the patient's life." *Id.*

By 1987, it appeared that the federal forum was merely a forum of the past for the adjudication of right-to-refuse-treatment cases. See Perlin, *supra* note 9, at 1265 ("the use of state constitutions and state statutes in state courts may be the last frontier for the mentally disabled").

36. *Charters I*, 829 F.2d 479.

standard”<sup>37</sup> applied to antipsychotic medication cases; (2) resurrected right-to-privacy and freedom-of-thought-process arguments that had been generally abandoned in post-*Rennie* and -*Rogers* decision making;<sup>38</sup> (3) re-established the right to be free from unwanted physical intrusions as an integral part of an individual’s constitutional freedoms; (4) articulated a detailed substituted judgment-best interests methodology to be used in right-to-refuse cases; and (5) most startlingly, did all of this in the context of a case involving a criminal defendant who had been found IST on numerous prior occasions.<sup>39</sup>

The Fourth Circuit, sitting en banc, subsequently vacated that decision in an opinion (“*Charters II*”)<sup>40</sup> suggesting that the panel was wrong about almost everything. Although the court agreed that the defendant possessed a constitutionally retained interest in freedom from bodily restraint that was implicated by the forcible administration of psychotropic drugs<sup>41</sup> and was protected “against arbitrary and capricious actions by government officials,”<sup>42</sup> it recast the issue in dispute: “[W]hat procedural protection is constitutionally required to protect the interest in freedom from bodily intrusion that is retained by an involuntarily-committed individual after a prior due process proceeding that significantly curtails his basic liberty interest.”<sup>43</sup> The court found that the informal administrative procedures in place at the facility in question were adequate and thus no further due process protections were necessary.<sup>44</sup>

*Charters II* is significant for two entirely distinct reasons. First, in its formulation of a sterile, minimalistic, and apparently nearly

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37. See *Youngberg*, 457 U.S. at 323 (“liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment”).

38. See, e.g., *Rogers v. Okin*, 478 F. Supp. 1342, 1367 (D. Mass. 1979) (“At stake is the more fundamental question as to whether the state may impose once again on the privacy of a person, already deprived of freedom through commitment, by forcibly injecting mind-altering drugs into his system in a non-emergency situation.”), *aff’d in part and rev’d in part*, 634 F.2d 650 (1st Cir. 1980), *vacated*, 457 U.S. 291 (1982).

39. For contrasting views on the panel decision in *Charters*, compare Perlin, *Fourth Amendment Right of Mentally Ill Defendants to Refuse Medication Before Trial*, 15 SEARCH & SEIZURE L. REP. 9 (1988) (approving of decision) with Leong & Silva, *The Right to Refuse Treatment: An Uncertain Future*, 59 PSYCHIATRY Q. 284, 288-90 (1988) (criticizing decision).

40. *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc) (*Charters II*), *cert. denied*, 110 S. Ct. 1317 (1990).

41. See *id.* at 305 (quoting *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984)).

42. *Id.* at 306.

43. *Id.*

44. *Id.* at 312-14.

impregnable "arbitrariness" test,<sup>45</sup> it silently rejected the rationale of all state-law-based cases after *Rogers*. Second, by its own language and rhetoric, the opinion revealed the court's apprehensiveness about dealing with underlying social, psychodynamic, and political issues that form the overt and hidden agendas in any right-to-refuse case.

This second aspect of *Charters II* is especially important. By its language, its use of heuristic reasoning,<sup>46</sup> its retreat into its conception of "ordinary common sense,"<sup>47</sup> and its reliance on myth,<sup>48</sup> the court backpedals from the issue that remains at the core of the right-to-refuse-treatment inquiry. This issue is the competency of the institutionalized mentally disabled to retain autonomy in the most basic decision making that affects their mental and physical health and their potential length of stay in the institution. Until *this* aspect of the court's decision receives serious attention, it is impossible to understand why right-to-refuse-treatment litigation has developed as it has and why the debate over the right remains so contentious.<sup>49</sup>

The thesis of this Article is that although the court's ultimate *legal* holding in *Charters II* is erroneous, of even greater concern is the court's skewed vision of the mentally disabled, of their

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45. The en banc court culled this test from its readings of *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Parham v. J.R.*, 442 U.S. 584 (1979); *Mathews v. Eldridge*, 424 U.S. 319 (1976). See *infra* text accompanying notes 116-47.

46. See Perlin, *supra* note 7, at 15-19. For these purposes, "heuristics" refers to the principles that individuals use to simplify complex information-processing tasks, leading to distorted and systematically erroneous decisions and causing decision makers "to ignore or misuse items of rationally useful information." Carroll & Payne, *The Psychology of the Parole Decision Process: A Joint Application of Attribution Theory and Information-Processing Psychology*, in *COGNITION AND SOCIAL BEHAVIOR* 13, 21 (J. Carroll & J. Payne eds. 1976); see generally Saks & Kidd, *Human Information Processing and Adjudication: Trial by Heuristics*, 15 *LAW & SOC'Y REV.* 123 (1980-81). For a comprehensive one-volume survey, see *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* (D. Kahneman, P. Slovic & A. Tversky eds. 1982).

47. See generally Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in the Law of Confessions*, 136 *U. PA. L. REV.* 729, 737 (1988) ("ordinary common sense" is a "prereflective attitude" exemplified by the attitude of "[w]hat I know is 'self-evident'; it is 'what everybody knows'").

48. For a discussion of courts' reliance on myth in the analogous area of insanity defense, see Perlin, *Unpacking the Myths: The Symbolism of Insanity Defense Mythology* (1990) (manuscript to be published in 40 *CASE W. RES. L. REV.*).

49. See Gelman, *Mental Hospital Drugging—Atomistic and Structural Remedies*, 32 *CLEV. ST. L. REV.* 221, 222 (1983-84) (right-to-refuse-treatment suits are "unusually contentious"); see also Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 *INT'L J.L. & PSYCHIATRY* 219, 234 (1981) (criticizing "extravagant rhetoric"). For a sampling of the contentious rhetoric in the titles of the literature, see sources cited in 2 M. PERLIN, *supra* note 1, § 5.02, at 226 n.27.

rights, and of its own assessment of the judiciary's ability to weigh and to assess the extent of these rights. Stripped of its facade of minimalistic constitutional analysis, *Charters II* says simply that the court is apprehensive about deciding these cases. This fear raises a profound question that goes beyond the literal legal issue before the court: whether pretrial detainees are competent to refuse the administration of psychotropic medication designed to restore their competency to stand trial (or, at least, whether they have the right to a counseled pre-administration judicial hearing on their right to refusal).

"Competency" is not a unitary status that can be defined or explained by a single formula.<sup>50</sup> In the thirteen years since Dr. Loren Roth and his colleagues suggested that "the search for a single test of competency is a search for a Holy Grail,"<sup>51</sup> a flood of judicial opinions has deconstructed<sup>52</sup> competency from every potential perspective: competency to stand trial,<sup>53</sup> competency to plead guilty,<sup>54</sup> competency to confess,<sup>55</sup> competency to waive counsel,<sup>56</sup> competency to be executed,<sup>57</sup> competency to testify,<sup>58</sup> competency to waive a jury trial,<sup>59</sup> and competency to resist imposition of the insanity defense,<sup>60</sup> among others.<sup>61</sup> *Charters II* reveals that

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50. See generally Nagel, *The Formulaic Constitution*, 84 MICH. L. REV. 165 (1985).

51. Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 283 (1977).

52. See, e.g., Balkin, *Deconstructive Practice and Legal Theory*, 96 YALE L.J. 743 (1987); see generally Comment, *Philosophical Hermeneutics: Toward an Alternative View of Adjudication*, 1984 B.Y.U. L. REV. 323.

53. See, e.g., *Drope v. Missouri*, 420 U.S. 162 (1975).

54. Compare, e.g., *Malinauskas v. United States*, 505 F.2d 649 (5th Cir. 1974) (same test as competency to stand trial) with *Sieling v. Eyman*, 478 F.2d 211 (9th Cir. 1973) (different test).

55. See, e.g., *Colorado v. Connelly*, 479 U.S. 157 (1986).

56. See, e.g., *People v. Kessler*, 113 Ill. App. 3d 354, 447 N.E.2d 495 (1983).

57. See, e.g., *Ford v. Wainwright*, 477 U.S. 399 (1986).

58. See, e.g., *Sinclair v. Wainwright*, 814 F.2d 1516, 1522-23 (11th Cir. 1987); see also *Shuler v. Wainwright*, 491 F.2d 1213, 1223-24 (5th Cir. 1974).

59. See, e.g., *State v. Cameron*, 146 Ariz. 210, 704 P.2d 1355 (1985).

60. See, e.g., *State v. Khan*, 175 N.J. Super. 72, 417 A.2d 585 (App. Div. 1980).

61. See, e.g., *United States ex rel. Phillips v. Lane*, 580 F. Supp. 839 (N.D. Ill. 1984) (competency to participate in suppression hearing), *aff'd in part and rev'd in part*, 787 F.2d 208 (7th Cir.), *cert. denied*, 479 U.S. 873 (1986); *Pruett v. Barry*, 696 P.2d 789 (Colo. 1985) (competency to challenge extradition); see also *Sailer v. Gunn*, 548 F.2d 271 (9th Cir. 1977) (competency to participate in probation hearing); *People ex rel. Newcomb v. Metz*, 64 A.D.2d 219, 409 N.Y.S.2d 554 (1978) (competency to participate in parole revocation hearing). For a discussion of assessing the competency of the physically ill, see Mahler & Perry, *Assessing Competency in the Physically Ill: Guidelines for Psychiatric Consultants*, 39 HOSP. & COMMUNITY PSYCHIATRY 856 (1988).

this list merely skims the surface.<sup>62</sup>

To fully understand the significance of *Charters II*, it is necessary to engage in some additional modest deconstruction. It is also necessary to consider three other "competencies" that the opinion calls into question: The competency of treatment staffs to engage in the type of professional judgment that the Supreme Court has taken as a base-line expectation since its decision in *Youngberg v. Romeo*,<sup>63</sup> the competency of counsel to provide representation to pretrial detainees in cases involving the issue before the court in *Charters II*, and the competency of courts to render decisions in such cases.

The courts' competency to render decisions in these cases includes "jurisdictional competency" and "judicial competency." "Jurisdictional competency" involves the courts' willingness to even consider the merits of cases such as the one before the Fourth Circuit in *Charters*. "Judicial competency" involves judges' abilities to interpret social science data, to render thoughtful decisions in areas that cause them a significant amount of personal discomfort, and to have the capacity to further "unpack"<sup>64</sup> their own decision-making processes.

Part II of this Article discusses the panel's original decision in *Charters I*, and Part III examines the holding and the language of *Charters II*. Part IV attempts to sketch out the lurking hidden agendas that appear to have animated the *Charters II* decision, and Part V analyzes the other questions of competency raised by *Charters II*. The conclusion places *Charters II* in historical perspective and speculates on its ultimate impact on the substantive law.

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62. For a discussion of other types of competencies, see generally Mezer & Rheingold, *Mental Capacity and Incompetency: A Psycho-Legal Problem*, 118 AM. J. PSYCHIATRY 827 (1962); for a specific application, see Lipsett, Lelos & McGarry, *Competency for Trial: A Screening Instrument*, 128 AM. J. PSYCHIATRY 105 (1971).

63. 457 U.S. 307, 319 (1982) (involuntarily confined mentally retarded individuals have constitutional rights to "minimally adequate or reasonable training to ensure safety and freedom from undue restraint"); see also *id.* at 327 (Blackmun, J. concurring) (holding should be expanded to include the right to "such training as is reasonably necessary to prevent a person's pre-existing self-care skills from *deteriorating* because of his commitment" (emphasis in original)).

64. For an explanation of the methodology of "unpacking" in an analogous context (insanity defense jurisprudence), see Perlin, *supra* note 48, at 3-6. This process attempts to determine whether the ordinary common sense that judges profess to employ is, indeed, commonsensical and to see to what degree judges employ the same sort of heuristic devices—the vividness effect, attribution theory, and others—in their decision making that legislators and jurors use. See generally Perlin, *supra* note 7.

## II. CHARTERS I: THE PANEL DECISION

*United States v. Charters*<sup>65</sup> involved a criminal defendant who was indicted for threatening the President of the United States. The district court found the defendant incompetent to stand trial and ordered, under the federal incompetency determination procedures in place at that time,<sup>66</sup> that he be confined to the Federal Correctional Institution at Butner, North Carolina.<sup>67</sup> The district court reviewed the defendant's commitment five times, finding every time that the defendant remained "dangerous and incompetent to stand trial."<sup>68</sup> About seven months after the last of this series of reviews, the court granted the government's motion to permit the medical staff at the institution to forcibly medicate the defendant with antipsychotic drugs. The court primarily reasoned that "the state's 'duty' to treat the medical needs of pretrial detainees"<sup>69</sup> outweighed the defendant's interests in "liberty and privacy protected by the Due Process Clause of the Fifth Amendment and freedom of thought protected by the First Amendment."<sup>70</sup> In concluding that the defendant was incompetent to make decisions about his medical care, it "equated competence to stand trial (legal competence) with competence to make personal health care decisions (medical competence)."<sup>71</sup>

The Fourth Circuit panel began its analysis of the medication issue by distinguishing *Youngberg v. Romeo*,<sup>72</sup> where the Supreme Court had applied the professional judgment standard.<sup>73</sup> Because of the "profundity" of the *Youngberg* plaintiff's handicap (severe mental retardation) he "was completely unable to participate in decisions concerning his medical treatment."<sup>74</sup> Mentally ill patients like Charters, however, might be competent to make some decisions about their medical care.<sup>75</sup> Also, the *Youngberg* plaintiff had been

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65. 829 F.2d 479, 482 (4th Cir. 1987) (*Charters I*), on reh'g, 863 F.2d 502 (1988) (en banc), cert. denied, 110 S. Ct. 1317 (1990).

66. See 18 U.S.C. §§ 4241-47 (1982); cf. *id.* (Supp. V 1987 & West Supp. 1990) (current procedures).

67. *Charters I*, 829 F.2d at 482; 2 M. PERLIN, *supra* note 1, § 5.64, at 414-415; Perlin, *supra* note 39, at 10; Perlin, *United States v. Charters: Right of Pretrial Detainees to Refuse Medication*, 13 NEWSL. AM. ACAD. PSYCHIATRY & L. 4, 5 (1987).

68. *Charters I*, 829 F.2d at 482.

69. *Id.* at 483.

70. *Id.*

71. *Id.*

72. 457 U.S. 307 (1982).

73. 2 M. PERLIN, *supra* note 1, § 5.64, at 415-16; Perlin, *supra* note 39, at 12; Perlin, *supra* note 67, at 5.

74. *Charters I*, 829 F.2d at 482.

75. *Id.* at 488.

restrained with temporary soft arm restraints, which "posed no threat of distressing or permanent side effects."<sup>76</sup> On the other hand, the court noted that forcible administration of antipsychotic drugs "may well cause serious and irreversible injury."<sup>77</sup> In addition, in contrast to the physical restraints in *Youngberg*, antipsychotic medication had a potential impact on freedom of thought, a core liberty interest.<sup>78</sup> Finally, the *Youngberg* plaintiff had been injured many times, and if left unrestrained, he may have posed a threat to himself or to other patients. In *Charters*, where the defendant had "no history of injury," the threat of "permanent injury" from treatment with antipsychotic medication was "substantial."<sup>79</sup>

Based upon these distinctions, the panel rejected the use of the professional judgment standard here.<sup>80</sup> The court noted that the decision to forcibly administer antipsychotic drugs to Charters was "not exclusively a professional judgment" because "the decision also involve[d] an evaluation of the personal risks and benefits of undertaking the proposed course of treatment that goes beyond medical expertise."<sup>81</sup> Because treatment choices are "individualized," physicians have no particular ability to determine whether, from the *patient's* perspective, a treatment's hazards outweigh its benefits.<sup>82</sup>

The government claimed three countervailing interests: "(1) protecting society and other inmates from a dangerous individual; (2) ensuring the defendant's competence to stand trial; and (3) providing proper care and treatment for its citizens."<sup>83</sup> The court

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76. *Id.* at 489.

77. *Id.*

78. *Id.*

79. *Id.* (emphasis in original).

80. 2 M. PERLIN, *supra* note 1, § 5.64, at 416; Perlin, *supra* note 39, at 12; Perlin, *supra* note 67, at 5.

81. *Charters I*, 829 F.2d at 489.

82. *Id.* at 490. For a discussion of the court's analysis of privacy precedents in balancing the patient's interests against the government's interests, see 2 M. PERLIN, *supra* note 1, § 5.64, at 416-17; Perlin, *supra* note 39, at 12; Perlin, *supra* note 67, at 5-6. See, e.g., Aleinikoff, *Constitutional Law in the Age of Balancing*, 96 YALE L.J. 943 (1987); Coffin, *Judicial Balancing: The Protean Scales of Justice*, 63 N.Y.U. L. REV. 16 (1988); Kahn, *The Court, the Community and the Judicial Balance: The Jurisprudence of Justice Powell*, 97 YALE L.J. 1 (1987); McFadden, *The Balancing Test*, 29 B.C.L. REV. 585 (1988), for recent perspectives on the United States Supreme Court's "balancing" methodology; see also Rubinfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 761 (1989) ("There is nothing like a good balancing test for avoiding rigorous argument.").

83. *Charters I*, 829 F.2d at 482-83; 2 M. PERLIN, *supra* note 1, § 5.64, at 417; Perlin, *supra* note 39, at 12; Perlin, *supra* note 67, at 6.

rejected the government's arguments regarding each of these interests.

To establish an interest in preventing violence, the government must show that the patient poses an "immediate threat of violence that cannot be avoided through the use of less restrictive alternatives."<sup>84</sup> The government failed to show this in the present case because it was "not at all clear from the record that Charters pose[d] any threat of violence."<sup>85</sup> The court also rejected the insuring-trial-competency argument<sup>86</sup> because (1) it could not be determined from the facts of the case that antipsychotic medication *would* render Charters competent;<sup>87</sup> (2) it was unclear whether the defendant would receive a fair trial because a heavily medicated defendant might give the jury a "false impression of the defendant's mental state at the time of the crime" and because the possible akinesia-akathisia side effects of the drugs might mislead the jury by making the defendant appear either apathetic and unemotional or agitated and restless;<sup>88</sup> and (3) even if these problems were eliminated, the government's interest would still "not permit such a draconian invasion of the individual's freedom and the risk of permanent physical injury."<sup>89</sup> Finally, the court rejected the government's argument that it must provide *parens patriae* protection of its citizens' health and well-being because this rationale was "not a license for the government to control individual lives in the name of helping its citizens."<sup>90</sup>

The panel held that where a patient is medically competent, the government's *parens patriae* interest is realized "by allowing the greatest latitude to the decisions of the individual patient."<sup>91</sup> The court also emphasized that an IST finding is not dispositive of the question of medical competence, nor is it enough to override "the presumption that [Charters] is medically competent until such time

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84. *Charters I*, 829 F.2d at 493; see 2 M. PERLIN, *supra* note 1, § 5.64, at 417-18; Perlin, *supra* note 39, at 12; Perlin, *supra* note 67, at 6.

85. *Charters I*, 829 F.2d at 492. Unmedicated, Charters had not been involved in a violent incident during the three years of his confinement.

86. 2 M. PERLIN, *supra* note 1, § 5.64, at 418; Perlin, *supra* note 39, at 12-13; Perlin, *supra* note 67, at 6.

87. *Charters I*, 829 F.2d at 493.

88. *Id.* at 494. Although the Supreme Court had previously granted certiorari on a similar question, it ultimately decided that case on unrelated grounds, declining to address that claim. See *Ake v. Oklahoma*, 470 U.S. 68, 74 n.2 (1985).

89. *Charters I*, 829 F.2d at 494.

90. *Id.*; see also 2 M. PERLIN, *supra* note 1, § 5.64, at 418; Perlin, *supra* note 39, at 13; Perlin, *supra* note 67, at 6.

91. *Charters I*, 829 F.2d at 494; see 2 M. PERLIN, *supra* note 1, § 5.64, at 418-19; Perlin, *supra* note 39, at 13; Perlin, *supra* note 67, at 6.



as his incompetency is properly adjudicated.”<sup>92</sup> It relied on case law and scholarly commentary to establish this distinction.<sup>93</sup> The panel criticized the district court’s determination of Charters’s medical incompetency, stating that “if a person can be declared incompetent based on disagreement with a medical choice he has made, the right to make personalized and individual decisions concerning one’s own body would become a nullity.”<sup>94</sup> The court remanded the case and ordered the district court to examine “whether Charters has followed a rational process in deciding to refuse antipsychotic medication and [whether he] can give rational reasons for the choices he has made.”<sup>95</sup> The definition of “rational reason” must be broad:<sup>96</sup>

[I]t 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. However, Charters’ fear that if medicated he, though by no means cured, would be discharged into a less protective environment, as well as the indisputable risk that he may suffer substantial and irreversible harm, may each provide a rational basis for refusing the medication if supported by the facts. Indeed, should Charters refuse antipsychotic medication because he believes that the risks of side effects and the possibility of permanent injury outweigh the possible benefits of that medication to him, it will be difficult for him to be found incompetent by virtue of that judgment.<sup>97</sup>

Having rejected *Youngberg*’s professional judgment standard, the panel considered applying the “substituted judgment” and the “best interests” standards for making judgments on Charters’s behalf if he were found to be medically incompetent.<sup>98</sup> Under the substituted judgment standard, the decision maker must determine what patients would have done if they had been competent. The court stated that this standard was “commendable,” but that case law and commentaries had raised substantial criticisms of this

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92. *Charters I*, 829 F.2d at 495.

93. *Id.* at 495 & n.23 (citing, among other sources, the Massachusetts state court remand decision, *Rogers v. Commissioner of Dep’t of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983) and Freedman, *Competence, Marginal and Otherwise: Concepts and Ethics*, 4 INT’L J.L. & PSYCHIATRY 53, 56 (1981) (quoting Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977))).

94. *Id.*; see 2 M. PERLIN, *supra* note 1, § 5.64, at 419-20; Perlin, *supra* note 39, at 13; Perlin, *supra* note 67, at 6.

95. *Charters I*, 829 F.2d at 496.

96. *Id.*

97. *Id.* at 496-97.

98. 2 M. PERLIN, *supra* note 1, § 5.64, at 420-21; Perlin, *supra* note 39, at 13-14; Perlin, *supra* note 67, at 6.

standard.<sup>99</sup> It concluded that the substituted judgment standard should be applied only when there was "clear and convincing evidence of what the patient's choice would have been."<sup>100</sup>

The court ultimately adopted the "best-interests-of-the-patient" standard for cases in which there is not clear and convincing evidence to support the application of substituted judgment.<sup>101</sup> Under the best interests standard, the decision maker presumes that an incompetent individual would choose a treatment in the same way as "others in the same circumstance and opt for what is in his best interests."<sup>102</sup> Although the panel recognized that requiring a prior judicial hearing arguably "imposes a needless and unwieldy obstacle to proper and prompt treatment,"<sup>103</sup> it stated that other factors required that the decision to forcibly medicate "be made by an independent arbitrator such as a federal court (aided by an impartial guardian or custodian)."<sup>104</sup> Such other factors included possible conflicts of interest that would interfere with institutional officials' assessments of the patient's need for treatment, and the potential for use of antipsychotic medication as a form of institutional control or as a means of easing institutional budgets. In addition, the court noted that empirical studies showed (1) judicial oversight need not be burdensome, (2) few patients actually refuse medication, and (3) court involvement does not unduly impair institutional resources.<sup>105</sup>

Finally, the court limited its ruling to the facts of *Charters*.<sup>106</sup> Where violence could only be prevented by forcibly administering

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99. *Charters I*, 829 F.2d at 497.

Criticisms of the substituted judgment doctrine have pointed out that it is a legal fiction. Substituted judgment imagines that it is possible to predict what a person would do if competent, often in cases where the person has never in his life been competent. Furthermore, instead of protecting a patient, substituted judgment may camouflage the basis of a decision whether or not to treat, putting the patient at substantially greater risk of an incorrect decision than he would have been had the inquiry focused directly on his best interests.

*Id.* at 498 (footnote omitted) (citing, among other sources, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 934-37, 936 n.11 (1978)).

100. *Charters I*, 829 F.2d at 498. The court cited the example of a patient who is "a very observant member of a religious order that does not condone medical treatment." *Id.*

101. 2 M. PERLIN, *supra* note 1, § 5.64, at 420-21; Perlin, *supra* note 39, at 14; Perlin, *supra* note 67, at 6-7.

102. *Charters I*, 829 F.2d at 498.

103. *Id.* at 499.

104. *Id.* (footnotes omitted).

105. *Id.* & n.28.

106. *Id.*; see 2 M. PERLIN, *supra* note 1, § 5.64, at 421; Perlin, *supra* note 39, at 14; Perlin, *supra* note 67, at 7.

antipsychotic medication or where a patient could suffer "a severe, immediate and irreversible deterioration" without treatment, the panel stated that forcible medication might be justified because the government's interest would be "increased" or "more urgent."<sup>107</sup> The panel also limited its ruling to "the unconvicted defendant," expressing no opinions on comparable rights of convicted prisoners.<sup>108</sup>

### III. CHARTERS II: THE EN BANC DECISION

The en banc court disagreed. Although it acknowledged Charters's possession of a constitutionally retained interest in freedom from bodily restraint, which forcible drugging implicated,<sup>109</sup> the court dramatically shifted perspectives by focusing on Charters's status as "an . . . individual [involuntarily committed] after a prior due process proceeding that significantly curtail[ed] his basic liberty interest."<sup>110</sup>

The court rationalized the shift in focus by stating that because Charters "came legally into the custody of the United States," the current limitations on his liberty interest were constitutionally acceptable and thus his interest in freedom from bodily intrusion must "yield to the legitimate incidents of his institutionalization."<sup>111</sup>

Before it embarked upon its own analysis, the en banc court criticized the language of the panel that had cited the potentially mind-altering quality of drug treatment,<sup>112</sup> characterizing this phrase as rife with "all the images that evokes of the use by totalitarian states of 'mind-controlling' psychiatric techniques specifically to curtail individual liberty."<sup>113</sup> In a footnote, the court pointed out that tardive dyskinesia was the principal potential side effect and

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107. *Charters I*, 829 F.2d at 499.

108. *Id.* n.30. *But see* Washington v. Harper, 110 S. Ct. 1028 (1990) (minimal application of due process clause in right-to-refuse case involving convicted state prisoner).

109. United States v. Charters, 863 F.2d 302, 305-06 (4th Cir. 1988) (en banc) (*Charters II*) (quoting in part Mills v. Rogers, 457 U.S. 291, 299 n.16 (1982)), *cert. denied*, 110 S. Ct. 1317 (1990).

110. *Id.* at 306.

111. *Id.* For a sensitive and careful reading of the two *Charters* opinions, see Dlugacz, *A Case In Two Acts in Search of a Middle Ground: United States v. Charters*, 7 N.Y.L. SCH. J. HUM. RTS. 311 (1989).

112. *Charters II*, 863 F.2d at 307; *see Charters I*, 829 F.2d at 489: "[A]ntipsychotic medication has the potential to infringe upon an individual's freedom of thought. . . . Although the effects of mind altering antipsychotic medication may not . . . immediately arouse Orwellian visions, the effects of the drug at issue here can be comparable [to the effects of psychosurgery such as lobotomy]."

113. *Charters II*, 863 F.2d at 307.

that its pathology, its probability, its susceptibility to treatment, and its durability "probably cannot be more pessimistically and vividly described than [by the] *selected items* from the legal and medical literature" in the panel's initial opinion.<sup>114</sup> The court also stated that "a much less drastic appraisal of the risk-potential . . . is made by responsible elements in the relevant scientific communities."<sup>115</sup>

The court then analyzed the case before it by employing a strict *Mathews v. Eldridge*<sup>116</sup> balancing test. Under this test, the court determines due process requirements by balancing (1) the private interest to be affected by the official action; (2) the risk of an erroneous deprivation of such interest through the procedures used and the probable value of additional or substituted procedural safeguards; and (3) the government's interest, including fiscal or administrative burdens.<sup>117</sup> The court relied on *Youngberg* and *Parham v. J.R.*<sup>118</sup> in concluding that committing "the base-line governmental decision to medicate [to] the appropriate medical personnel of the custodial institution," subject to judicial review for "arbitrariness," comported fully with due process, even where the exercise of professional judgment "necessarily involves some interpretation of the disputable 'meaning' of clinical 'facts.'"<sup>119</sup>

Although the court conceded that both *Parham* and *Youngberg* involved "somewhat different types of medical decisions," it stated that "their general approval of the basic regime proposed by the government balancing here is plain."<sup>120</sup> Concluding that such a regime may comport with procedural due process requirements "notwithstanding the absence of any adversarial adjudicative element,"<sup>121</sup> the court placed particular emphasis on the acknowledgement in *Parham* that "while medical and psychiatric diagnosis obviously was fallible, there was no reason to suppose that it was

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114. *Id.* at 307 n.3 (emphasis added).

115. *Id.* No effort was made to determine what criteria the court employed to decide what the "relevant scientific communities" were or which elements in those communities were the "responsible" ones. For a discussion of the teleological way that the courts apply social science evidence, see Perlin, *supra* note 7, at 110-29; Appelbaum, *The Empirical Jurisprudence of the United States Supreme Court*, 13 AM. J.L. & MED. 335 (1987).

116. 424 U.S. 319 (1976).

117. *Id.* at 335.

118. 442 U.S. 584 (1979) (concluding that counseled procedural due process hearing was not constitutionally mandated in civil commitment cases involving juveniles).

119. *Charters II*, 863 F.2d at 307-08 (citing, among other sources, *Parham v. J.R.*, 442 U.S. 584, 609 (1979)).

120. *Id.* at 308.

121. *Id.* at 309.

more so than would be the comparable diagnosis of a judge or hearing officer."<sup>122</sup>

The court rejected Charters's proposal for several reasons. First, the court believed that his proposed regime would bring with it "all the cumbersomeness, expense, and delay incident to judicial proceedings."<sup>123</sup> Under such a scheme, institutional medical personnel would become "expert witnesses defending their opinions in judicial proceedings rather than . . . base-line decision makers [, and] their opinions . . . would be entitled to no greater deference than the conflicting opinions of the outside expert witnesses *whose testimony surely can be anticipated*."<sup>124</sup> To support this proposition, the court recounted several unreported cases in which inmates of the Federal Correctional Institution at Butner, North Carolina, withdrew earlier consent to medication in the wake of *Charters I*.<sup>125</sup> The court noted that in each of these cases, "[c]onfronted with directly conflicting opinions by two professionally qualified experts," the district court found the inmates competent to refuse medication and thus "accord[ed] less rather than more deference to the decisions of institutional professionals than to the conflicting opinions of outside expert witnesses."<sup>126</sup>

The court also found Charters's proposal apparently reflective of a "greater confidence in the ability of judges and adversarial adjudicative processes than in the capacity of medical professionals subject to judicial review."<sup>127</sup> This directly contradicted earlier Supreme Court teachings that the courts should treat this type of decision by institutional personnel as "presumptively valid."<sup>128</sup> The court found support in former Chief Justice Burger's *Parham* opinion: "Common 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."<sup>129</sup>

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122. *Id.* at 308 (citing *Parham v. J.R.*, 442 U.S. 584, 609 (1979)).

123. *Id.* at 309. The court cited no authority for this proposition.

124. *Id.* (emphasis added).

125. *Id.* at 309 n.5. Outside expert testimony supported these withdrawals of consent. *Id.*

126. *Id.* On this point, the en banc court sympathetically recounted the testimony of Dr. Johnson of the Butner staff questioning the validity of "any factual inquiry into the competency of schizophrenic patients to make such decisions at particular points in time." *Id.* (emphasis added).

127. *Id.* at 309.

128. *Id.* at 310 (quoting, in part, *Youngberg v. Romeo*, 457 U.S. 307, 323 & n.30 (1982)).

129. *Id.* (quoting *Parham v. J.R.*, 442 U.S. 584, 609 (1979)).

Finally, the court reasoned that requiring a preliminary factual determination of a patient's competency to make medical decisions would pose "an unavoidable risk of completely anomalous, perhaps flatly inconsistent, determinations of mental competence by different judicial tribunals."<sup>130</sup> Charters had already been declared IST, a "solemn judicial adjudication [that] still stands."<sup>131</sup> Although the court conceded that "there *may* be a difference" between competency to stand trial and competency to engage in medical decision making, it concluded that such a distinction "must certainly be one *of such subtlety and complexity* as to tax perception by the most skilled medical or psychiatric professionals"<sup>132</sup> and that:

To suppose that it is a distinction that can be fairly discerned and applied by even the most skilled judges on the basis of an adversarial fact-finding proceeding taxes credulity. The resulting threat of wholly inconsistent or highly anomalous adjudications is palpable, and poses high risks to the integrity and trustworthiness of the courts' *already perilous involvement*—out of necessity—in the adjudication of complex states of mental pathology.<sup>133</sup>

In addition, although the court acknowledged that side effects "introduce[d] an element in the risk of error that require[d] special concern," it recast the question as whether this risk was "so unique" that it required "skewing the basically approved regime for insuring due process in making 'medical decisions'" and concluded that it did not.<sup>134</sup> "[W]ide disagreement . . . as to the degree of their severity, their susceptibility to treatment, their duration, and . . . their probability over the run of cases"—a disagreement reflected in this case through the dramatically contrasting amicus briefs of the American Psychiatric Association and the American Psychological Association<sup>135</sup>—emphasized to the court that the side effects questions were "simply and unavoidably" an element of the "best interests" decision.<sup>136</sup> Stressing that "[n]o scientific opinion is advanced that these side-effects are so highly probable, so severe, and so unmanageable that the antipsychotic medication

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130. *Id.*

131. *Id.*

132. *Id.* (emphasis added).

133. *Id.* (emphasis added).

134. *Id.*

135. *Id.* at 310-11. Here, the court basically side stepped the social science controversy, concluding that there was "no reconciling, nor *any* possible basis for judicial choice between" the scientific positions advanced by the two opposing amici. *Id.* at 311 n.6 (emphasis added).

136. *Id.* at 311.

simply should *never* be administered . . . even with patient consent," the court concluded that the side effects threat "can better be assessed and reviewed within the government's proposed regime than by an adversarial adjudicative process."<sup>137</sup>

Turning to the government's stake, the court stressed that the government's role "here is not that of punitive custodian of a fully competent inmate, but *benign custodian of one legally committed to it for medical care and treatment*."<sup>138</sup> To accept Charters's proposed regime "would effectively stymie the government's ability to proceed with the treatment—certainly for an interval that might make it no longer efficacious, and probably indefinitely."<sup>139</sup> The court thus concluded that the government's proposed regime was constitutionally adequate.

The court then addressed how the government's regime should be administered. Relying again on *Parham* for the proposition that an "internal adversarial hearing" was not required,<sup>140</sup> the court concluded that an acceptable professional decision<sup>141</sup> may be based upon "accepted medical practices in diagnosis, treatment and prognosis, with the aid of such technical tools and consultative techniques as are appropriate in the profession."<sup>142</sup> This includes "the patient's general history and present condition, the specific need for medication, its possible side-effects, any previous reaction to the same or comparable medication, the prognosis, [and] the duration of any previous medication," all of which must be supported by "adequate documentation."<sup>143</sup>

The professional judgment standard, the court underscored, was *not* whether the treatment decision was "the medically correct or most appropriate one," but "only whether the decision was made by an appropriate professional."<sup>144</sup> Under this test, there will be

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137. *Id.* (emphasis added). Similarly, the court dismissed Charters's claim that his competency must be determined by a neutral factfinder because it was not convinced that giving this determination to "non-specialist judges . . . offers a better protection against error than would leaving it to responsible medical professionals." *Id.* The patient's competence to make an informed judgment, like the potential for side effects, was "simply another factor in the ultimate medical decision." *Id.* at 311-12.

138. *Id.* at 312 (emphasis added).

139. *Id.*

140. *Id.* (citing *Parham v. J.R.*, 442 U.S. 584, 607 (1979)).

141. The court here referred to the *Youngberg* "professional judgment" standard, the requirement that professional judgment must be exercised by institutional personnel making medical decisions. *Id.* (citing *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

142. *Id.*

143. *Id.* at 312-13.

144. *Id.* at 313. The court quoted *verbatim* *Youngberg*'s definition of a "professional." *Id.* at 313 n.8 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323 n.30 (1982)).

a denial of due process only where the decision is such a "substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."<sup>145</sup> Thus, experts will be asked *only one question* in any proceeding stemming from a medication decision: "[W]as this decision reached by a process so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one?"<sup>146</sup> Such a standard, the court concluded, "appropriately defers to the necessarily subjective aspects of the decisional process of institutional medical professionals," according them "the presumption of validity due them."<sup>147</sup>

Applying the reasoning to the facts of the case before it, the en banc court found that the district court conducted its inquiry properly: "Significantly, no evidence was offered that the decision lay completely beyond the bounds of tolerable professional judgment. This undoubtedly reflects the fact that no such evidence was available."<sup>148</sup> To support this point, the court cited two recent scholarly medical articles that had concluded that antipsychotic drugs were the "cornerstone" and the "primary modality" in the management of acute mental illnesses.<sup>149</sup> Finally, in outlining the limits of its ordered remand, the court concluded by "assum[ing] that medical professionals, now aware of the standard to which they are held, may be as willing to proceed without prior judicial approval as are other governmental officials such as those on prison disciplinary committees, civil service boards and the like."<sup>150</sup>

#### IV. STRIPPING THE FACADE: HIDDEN AGENDAS?

The *Charters II* court glossed over serious legal issues with cursory quotations from off-point precedent, evaded important

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145. *Id.* at 313 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982)).

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.* (quoting respectively Baldessarini & Lipinski, *Risks of Antipsychotic Drugs Overemphasized*, 305 NEW ENG. J. MED. 588 (1982); Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133, 134 (1987)).

150. *Id.* at 314. In a brief dissent, Judge Murnaghan, the author of the now-vacated panel opinion, stressed the potential for conflicts of interest, suggesting that the prospect that the views of the governmental medical officials who administer the Butner institution "may be inclined to coincide with" those of their "fellow employees," the federal prosecutors, was "not remote." *Id.* at 315 (Murnaghan, J., dissenting). He concluded that fairness required the "assurance of an unbiased decision," and that "[o]ne side effectively unopposed is not enough." *Id.*



underlying issues of social science and empiricism, and relied on heuristic reasoning devices<sup>151</sup> and an unarticulated notion of "ordinary common sense"<sup>152</sup> in reaching its decision. The court thus revealed several "hidden agendas" that must be illuminated if the psychodynamics of its reasoning are to be fully understood.<sup>153</sup>

The court's reliance on *Youngberg* reveals two significant errors of omission. The en banc court failed to confront the way that the *Charters I* court had carefully distinguished *Youngberg* based upon some fundamental factual differences between the two cases.<sup>154</sup> Importantly, in a significant textual reference to *Youngberg*, the *Charters II* court characterized the plaintiff there as an "institutionalized mental patient."<sup>155</sup> This reference is incorrect; the *Youngberg* plaintiff was a severely mentally retarded resident of a state school for the retarded.<sup>156</sup> Although the *Charters I* panel had noted the significance of this distinction by stating that *Youngberg* "did not consider the rights of a competent patient to determine the course of his medical treatment,"<sup>157</sup> the en banc court ignored this on rehearing.<sup>158</sup>

Perhaps even more curious is the court's failure to refer to, to distinguish, or even to recognize the existence of *Thomas S. v. Morrow*.<sup>159</sup> That case involved a mentally handicapped young adult who had been shuffled through forty foster homes and institutions after having been given up for adoption at birth.<sup>160</sup> Substantially affirming a district court decision that the plaintiff had a right to treatment in a suitable community residence, the Fourth Circuit stressed that *Youngberg* "did not allow the professionals free

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151. See *supra* note 46.

152. See *supra* note 47.

153. See Perlin, *supra* note 48 (discussing significance of psychodynamic explanations of jurisprudential developments).

154. See *supra* notes 72-79 and accompanying text.

155. *United States v. Charters*, 863 F. 2d 302, 308 (4th Cir. 1988) (en banc) (*Charters II*), *cert. denied*, 110 S. Ct. 1317 (1990).

156. *Youngberg v. Romeo*, 457 U.S. 307, 309 (1982) (plaintiff was "profoundly retarded [with] the mental capacity of an 18-month-old child").

157. *United States v. Charters*, 829 F.2d 479, 488 (4th Cir. 1987) (*Charters I*), *on reh'g*, 863 F.2d 302, 308 (4th Cir. 1988) (en banc), *cert. denied*, 110 S. Ct. 1317 (1990).

158. For a discussion of how competency questions and other issues in criminal proceedings must be considered in light of whether the defendant's specific disabling condition is mental illness or mental retardation, see Ellis & Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414 (1985).

159. 781 F.2d 367 (4th Cir.), *cert. denied*, 476 U.S. 1124, 479 U.S. 869 (1986).

160. See *Thomas S. v. Morrow*, 601 F. Supp. 1055, 1056-57 (W.D.N.C. 1985), *aff'd in part and modified in part*, 781 F.2d 367 (4th Cir.), *cert. denied*, 476 U.S. 1124, 479 U.S. 869 (1986).

rein.”<sup>161</sup> Paradoxically, in *Thomas S.*, the treatment that the institutional defendants provided to the plaintiff conflicted with professional judgment; the district court pointed out that the plaintiff’s treatment had been modified “to conform to the *available* treatment, rather than to the *appropriate* treatment, for plaintiff’s condition.”<sup>162</sup>

Furthermore, the en banc court’s repeated reliance on *Parham* for the proposition that more relaxed due process procedures might be appropriate is puzzling. *Parham* dealt with committing juveniles, and the Court premised its holdings specifically on the assumption that parents make certain medical decisions for their children with their offsprings’ best interests at heart. For instance, former Chief Justice Burger wrote:

Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. . . . The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically, it has recognized that natural bonds of affection lead parents to act in the best interests of their children.<sup>163</sup>

Aside from the universal criticism of these assumptions as lacking an empirical or scientific basis,<sup>164</sup> it strains credulity that the same paternalistic impulses motivate federal correctional institutional officials in their dealings with pretrial detainees.<sup>165</sup> Similarly, the *Charters II* court’s citation to *Parham*’s invocation of “[c]ommon human experience” that suggests that the “supposed protections of an adversary proceeding . . . may well be more illusory than

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161. *Id.* at 1057-60; *Thomas S.*, 781 F.2d at 375, 379.

162. *Thomas S.*, 601 F. Supp. at 1059 (emphasis in original).

163. *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (citations omitted). For a recent, careful analysis of the history of the political and governmental regulation of family life, see Dingwall & Eekelaar, *Families and the State: An Historical Perspective on the Public Regulation of Private Conduct*, 10 LAW & POL’Y 341 (1988).

164. See, e.g., 1 M. PERLIN, *supra* note 1, § 3.72, at 428 (“No modern U.S. Supreme Court civil case dealing with the rights of the mentally handicapped has been criticized as consistently or as thoroughly as [has] been *Parham* . . . .”); sources cited *id.* at 428-30 nn.1220-26; see also Melton, *Family and Mental Hospital as Myths: Civil Commitment of Minors*, in CHILDREN, MENTAL HEALTH AND THE LAW 151 (1984); Perry & Melton, *supra* note 24, at 634-35, 645-65.

165. See *United States v. Charters*, 863 F.2d 302, 312 (4th Cir. 1988) (en banc) (*Charters II*) (quoting *Parham v. J.R.*, 442 U.S. 584, 607 (1979)), *cert. denied*, 110 S. Ct. 1317 (1990): “Making an acceptable professional judgment of the sort here in issue does not require any internal adversarial hearing. *Parham*, 442 U.S. at 607 . . . (‘not necessary that the deciding physician conduct a formal or quasi-formal hearing’).”

real"<sup>166</sup> simply ignores the entire body of post-*Parham* social science literature rebutting the Supreme Court's allegedly common-sense reading.<sup>167</sup>

An important decade has passed since the *Parham* Court concluded that there was no reason to expect that courts could add to the diagnostic work that mental health professionals have done in public hospitals. During that period there has been ample development, both in the case law and in the social science literature, of the realities of drug management in such facilities. The trial records of cases such as *Rennie v. Klein*,<sup>168</sup> *Rogers v. Okin*,<sup>169</sup> and *Davis v. Hubbard*<sup>170</sup> are eloquent testimony to the sad reality that, unpoliced, a significant number of such hospitals have engaged in patterns and practices of serious misuse of psychotropic drugs on a regular basis.<sup>171</sup>

166. *Id.* at 310 (quoting *Parham v. J.R.*, 442 U.S. 584, 609 (1979)). For a discussion of the traps and the pitfalls of the rhetoric of "ordinary common sense" ("OCS"), see Perlin, *supra* note 7; Sherwin, *supra* note 47.

167. See, e.g., Perry & Melton, *supra* note 24, at 645:

The *Parham* case is an example of the Supreme Court's taking advantage of the free rein on social facts to promulgate a dozen or so of its own by employing one tentacle of the judicial notice doctrine. The Court's opinion is filled with social facts of questionable veracity, accompanied by the authority to propel these facts into subsequent case law, and, therefore, a spiral of less than rational legal policy making.

See also D. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT 3-22 (1990); Schmidt, *Considerations of Social Science in a Reconsideration of Parham v. J.R. and the Commitment of Children to Public Mental Institutions*, 13 J. PSYCHIATRY & L. 339 (1985). For the most recent survey, see Schmidt & Otto, *A Legal and Behavioral Science Analysis of Statutory Guidelines for Children's Mental Health and Substance Abuse Services: The Florida Case*, 16 J. PSYCHIATRY & L. 9 (1988).

168. 462 F. Supp. 1131 (D.N.J. 1978), *supplemental opinion*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

169. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated*, *Mills v. Rogers*, 457 U.S. 291 (1982), *on remand*, 738 F.2d 1 (1st Cir. 1984).

170. 506 F. Supp. 915 (N.D. Ohio 1980).

171. See, e.g., *Rennie*, 476 F. Supp. at 1299-1302. The trial record indicated that psychotropic drugs were the "be all and end all" of state psychiatric hospitals, *id.* at 1299; the defendant state hospital medical director conceded that medication was used "as a form of control and as a substitute for treatment," *id.*; hospital doctors regularly failed to diagnose tardive dyskinesia and other neurological side effects present in 35-50% of all state hospital patients, *id.* at 1300; and "unjustified polypharmacy" was common, *id.* The district court emphasized that the defendant state officials exhibited "conscious and deliberate indifference to breaches of patients' rights by hospital personnel." *Id.* at 1309; see also *Davis*, 506 F. Supp. at 926 ("testimony at trial established that the prevalent use of drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of staff and for punishment"); 2 M. PERLIN, *supra* note 1, § 5.02, at 220-21, § 5.19.

The en banc court's reference to the "cumbersomeness, expense, and delay incident to judicial proceedings"<sup>172</sup> tellingly is without citation. This bare conclusion has no basis in empirical fact. As noted in the vacated panel opinion, few patients actually avail themselves of the due process protections available.<sup>173</sup> The reference further ignores the burgeoning database of empirical studies that has begun to examine what actually happens when a right-to-refuse-treatment order is entered. These studies address such questions as "to what extent the hospital staff complies with court orders; how many patients actually wish to refuse antipsychotic medication; to what extent they are representative of all patients; [and] the impact the refusal has on treatment."<sup>174</sup> The studies<sup>175</sup> virtually unanimously belie the fear of creating an expensive, time-consuming, counterproductive layer of due process hearings.<sup>176</sup>

For example, Dr. Julie Zito and her associates' comprehensive study of the implementation of *Rivers v. Katz*<sup>177</sup> at Rockland Psychiatric Center, a New York state psychiatric facility, revealed that (1) numerically, the percentage of drug refusers whose cases

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172. *United States v. Charters*, 863 F.2d 302, 309 (4th Cir. 1988) (en banc) (*Charters II*), cert. denied, 110 S. Ct. 1317 (1990).

173. *United States v. Charters*, 829 F.2d 479, 499 n.28 (4th Cir. 1987) (*Charters I*) (citing Brushwood & Fink, *Right to Refuse Treatment with Antipsychotic Drugs*, 42 AM. J. HOSP. PHARMACY 2709 (1985)), on reh'g, 863 F.2d 302 (4th Cir. 1988) (en banc), cert. denied, 110 S. Ct. 1317 (1990); see generally, 2 M. PERLIN, *supra* note 1, § 5.49 and sources cited therein. One empirical study has concluded that, on at least one scale, length of time out of the hospital prior to re-admission, drug refusers appeared to fare better than a control group perhaps as a result of their "healthy skepticism about doctors, medicine, and psychiatry and some sense of themselves as not without power and control over their lives." Hassenfeld & Grumet, *A Study of the Right to Refuse Treatment*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 65, 72 (1984).

174. 2 M. PERLIN, *supra* note 1, § 5.47 (footnote omitted).

175. For a comprehensive, recent survey of the empirical data on the characteristics of drug refusers, see Appelbaum & Hoge, *The Right to Refuse Treatment: What the Research Reveals*, 4 BEHAV. SCI. & L. 279 (1986); see also, Rachlin, *Rethinking the Right To Refuse Treatment*, 19 PSYCHIATRIC ANN. 213 (1989) (surveying empirical and anecdotal data since 1986).

176. See 2 M. PERLIN, *supra* note 1, § 5.28; Brooks, *supra* note 5, at 201-02; see also Hickman, Resnick & Olson, *Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal*, 6 MENTAL DISABILITY L. REP. 122, 129-30 (1982) (Ohio State hospital's compliance with *Davis* decision created "no significant administrative burden"); Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. LEO. MED. 107, 119 (1985) (implementation of due process procedures has cost little and has resulted in unexpected savings). But see, Bloom *et al.*, *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, 7 INT'L J.L. & PSYCHIATRY 315, 327 (1984) (because refusers were hospitalized longer than nonrefusers, hospital incurred "substantial expenditures" for these patients' additional stays).

177. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

went to court was tiny (1.3% of the involuntary patients, 0.6% of the total population); (2) requests to medicate objecting patients were granted in thirteen of fifteen cases, but drug refusers had shorter hospital stays (to a degree approaching statistical significance); and (3) remarkably, patients *never* cited their legal rights as a reason for refusing.<sup>178</sup> Concluding that the meritorious refusals were probably an "unnecessary burden on the court," Dr. Zito and her colleagues<sup>179</sup> apparently suggest that staff doctors' passive-aggressiveness<sup>180</sup> was partially to blame:

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178. Zito, Haimowitz, Wanderling & Menta, *One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility* 7, 11-12, 18 (1989) (manuscript to be published in INT'L. J.L. & PSYCHIATRY) [hereinafter Zito]; accord Rachlin, *supra* note 175, at 215-16 (1.9% at Nassau County Medical Center, East Meadow, New York). To some extent, these data conflict with some of the studies examined by Appelbaum and Hoge, *supra* note 175, at 281 (refusers range from 1% to 15% with a mean of 10%). Zito suggests that this difference may simply reflect different populations, different definitions of refusal, and different settings in which the refusal process operates. Zito, *supra*, at 12-13.

Dr. Rachlin has subsequently raised the important question of whether *failure* to prescribe antipsychotic drugs might rise to the level of malpractice. Personal communication from Dr. Rachlin (Nov. 8, 1989). There is some case law supporting this proposition. See *Whitree v. State*, 56 Misc. 2d 693, 707, 290 N.Y.S.2d 486, 501 (Ct. Cl. 1968) (finding state liable for malpractice, criticizing state hospital for not treating patient with "modern tranquilizing drugs," and characterizing as "illogical, unprofessional and not consonant with prevailing medical standards" the hospital's defense that plaintiff refused the drugs in question); see also Wettstein, *Tardive Dyskinesia and Malpractice*, 1 BEHAV. SCI. & L. 85, 89 (1983) (psychiatrist may be liable for "prescription of the wrong dosage [or] prescription of medication for inappropriately short or long time periods").

It is necessary, however, to carefully distinguish between failure to *recommend* treatment, and imposition of *unwanted* treatment, especially given the pattern of constitutional litigation flowing from public hospitals' use of such drugs. See *supra* note 4. It has been suggested that fear of litigation may prevent psychiatrists "from effectively practicing their profession." Taub, *Psychiatric Malpractice in the 1980s: A Look at Some Areas of Concern*, 11 LAW MED. & HEALTH CARE 97, 103 (1983). This potential fear, however, cannot be seen as an excuse upon which treating physicians can rely to justify treatment decisions or nondecisions. See *infra* note 211.

179. Zito, *supra*, note 178, at 18. Dr. Zito's colleagues included an attorney for the New York State Office of Mental Health and a staff doctor at the studied facility.

180. See J. PAGE, PSYCHOPATHOLOGY 316-17 (1971) (passive aggressive personalities exhibit "covert styles of expressing resentment and hostility"). For an example of such passive-aggressive behavior in the context of right-to-treatment litigation, see Leaf, Wyatt v. Stickney: *Assessing the Impact in Alabama*, 28 HOSP. & COMMUNITY PSYCHIATRY 351, 354 (1977) (discussing the "overreaction" of Alabama state hospital staff to the court's decision in that case (see *supra* notes 14-16 and accompanying text)):

Misinformation about the operationalization of many of the [court-ordered] standards was rampant, and some staff believed that all patients had to be placed on open wards and given the freedom to engage in almost any activity that they desired. Aides in particular became very fearful of giving patients any negative feedback. Situations that required refusing even unreasonable requests by patients caused a great deal of stress for staff.

Clinical approaches which overcome these problems are typically found in everyday practice. If these cases reflect a simplistic interpretation of the court decisions or an inability to engage patients in treatment, then the judicially-mandated program could be subverted by a lack of understanding of when to use the courts and when to work with the patient until a mutually satisfactory solution emerges.<sup>181</sup>

Dr. Stephen Rachlin has suggested that, prior to seeking a court-ordered refusal "override," the doctor should attempt "all other psychotherapeutic measures," including "a negotiation process with the patient."<sup>182</sup> Quoting Professor Brooks's observation that the right-to-refuse litigation has had a "heuristic" value, he concludes, "If we have learned some principles of law that will help patients and if some improper prescribing practices have been altered, this is to the good."<sup>183</sup> The disaster scenario that the *Charters II* court predicted is simply unrealistic.

The opinion also ignores the advantages that may flow from due process protections. A modest body of literature developed over the past decade suggests that involuntary civil commitment hearings have a therapeutic potential.<sup>184</sup> A recent study conducted by Dr. Francine Cournos and her associates at Manhattan Psychiatric Center, another New York public hospital under the *Rivers* order, concluded that the new procedures offered patients "considerably greater representation and participation" because it gave them "the opportunity to hear a detailed discussion of their physician's reasoning and to present their own views."<sup>185</sup> This perhaps enabled them to "gain a better understanding of the need for treatment through a process that offers this degree of patient involvement."<sup>186</sup> To some extent, such procedures appear to respond directly to Dr. Van Putten and Dr. May's observation that Judge Brotman quoted in the *Rennie* trial: "[S]chizophrenics have

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181. Zito, *supra* note 178, at 18.

182. Rachlin, *supra* note 175, at 221. For Dr. Rachlin's views on the appropriate scope of the right to refuse treatment, see Rachlin, *supra* note 6 (arguing that the right to refuse is antithetical to the right to treatment, and there should be no right to refuse standard, well-accepted treatment).

183. Rachlin, *supra* note 175, at 222 (quoting in part Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339, 374 (1987)).

184. See D. WEXLER, *supra* note 167; Ensminger & Liguori, *The Therapeutic Significance of Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978).

185. Cournos, McKinnon & Adams, *A Comparison of Clinical and Judicial Procedures for Reviewing Requests for Involuntary Medication in New York*, 39 HOSP. & COMMUNITY PSYCHIATRY 851, 855 (1988).

186. *Id.*; see also Appelbaum & Hoge, *supra* note 175, at 283 (studies suggest that "the more persistent refusers may retain a greater sense of control over their lives").

been asked every question except, 'How does the medication agree with you?' Their response is worth listening to."<sup>187</sup>

The *Charters II* court's fear of time-consuming "battles of the experts"<sup>188</sup> is similarly unfounded. It reflects a failure to evaluate studies of the impact of similar decisions elsewhere. Such studies include the developing database in *Rivers*, revealing "quicker decisions" in drug refusal cases, which "should benefit all concerned."<sup>189</sup> The Cournos study at Manhattan Psychiatric Center concluded that adopting more stringent legal procedures "did not delay or diminish requests for or approval of involuntary treatment."<sup>190</sup>

To buttress its argument on this point, the *Charters II* court engaged in selective docket reading, citing an unreported case to support its assertion that under the panel's due process formulation, medication refusals will be routinely upheld.<sup>191</sup> Inexplicably, the court fails to note that the one *reported* post-*Charters I* case granted the government's motion to forcibly medicate under the terms of the *Charters I* opinion.<sup>192</sup>

The *Charters II* opinion also reflects inappropriate heuristic thinking in a variety of contexts.<sup>193</sup> It uses such distorting devices as availability,<sup>194</sup> typification,<sup>195</sup> the myth of particularistic

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187. *Rennie v. Klein*, 476 F. Supp. 1294, 1306 (D.N.J. 1979) (quoting Van Putten & May, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 ARCH. GEN. PSYCHIATRY 477, 480 (1978)), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983); see *supra* notes 2, 171.

188. *United States v. Charters*, 863 F.2d 302, 309 n.5 (4th Cir. 1988) (en banc) (*Charters II*), *cert. denied*, 110 S. Ct. 1317 (1990). For a comprehensive response to the feared "battle of the experts" scenario in insanity defense cases, see *United States v. Lyons*, 739 F.2d 994, 996-99 (5th Cir. 1984) (Rubin, J., dissenting), *cert. denied*, 469 U.S. 930 (1984).

189. Zito, *supra* note 178, at 21.

190. Cournos, McKinnon & Adams, *supra* note 185, at 855.

191. *Charters II*, 863 F.2d at 309 n.5 (citing *United States v. Ballard*, No. 87-525-HC (E.D.N.C. Nov. 19, 1987) (Westlaw, ALLFEDS file)). For a discussion of how this reading reflects "attribution theory," see *infra* note 200 and accompanying text; Doob & Roberts, *Social Psychology, Social Attitudes and Attitudes Toward Sentencing*, 16 CAN. J. BEHAV. SCI. 269, 279 (1984) (citing Snyder & Swann, *Hypothesis-Testing Processes in Social Interaction*, 36 J. PERSONAL. & SOC. PSYCHOLOGY 1202 (1978) (discussing the well-documented tendency for people to seek information that confirms rather than disconfirms their beliefs)).

192. See *United States v. Waddell*, 687 F. Supp. 208, 210 (M.D.N.C. 1988).

193. See generally Perlin, *supra* note 7; Saks & Kidd, *supra* note 46.

194. "Availability" refers to the theory that "people are likely to judge the probability or frequency of an event based upon the ease with which they can recall instances or occurrences of the event." Perlin, *supra* note 7, at 21 (quoting Saks & Kidd, *Human Information Processing and Adjudication: Trial by Heuristics*, LAW & SOC'Y REV. 123, 137 (1980-81)).

195. See Van Zandt, *Common Sense Reasoning, Social Change, and the Law*, 81 NW. U.L. REV. 894, 913-14 (1987) ("characterizing a current experience as a familiar type of experience" drawing on our core of accumulated knowledge, especially when attempting to understand deviant behavior).

proofs,<sup>196</sup> and the "vividness effect"<sup>197</sup> in its broad-brush characterization of Dr. Johnson's<sup>198</sup> "poignant testimony" as to whether "any factual inquiry" into the competency of "schizophrenic patients" might ever be valid.<sup>199</sup> The opinion's attempts to simplify one of the most complex problems facing decision makers, assessing mentally disabled individuals' capacity to retain some autonomous decision-making power, further reflects the pernicious effect of the heuristic of attribution theory.<sup>200</sup>

In its apparent inability to differentiate between competency to stand trial and competency to accept medication,<sup>201</sup> a distinction that the panel<sup>202</sup> and the other courts that stand "in uniform

196. The "myth of particularistic proofs" is the epistemological erroneous assumption that "case-specific [anecdotal evidence] information is qualitatively different from base-rate [statistical] information." Saks & Kidd, *supra* note 46, at 151.

197. The "vividness effect" is the phenomenon through which concrete and vivid information about a specific case overwhelms the abstract data upon which rational choices should be based. Rosenham, *Psychological Realities and Judicial Policy*, 19 STAN. LAW. 10, 13 (1984).

198. Dr. Johnson was a psychiatrist and director of forensic services at Butner. See *United States v. Charters*, 829 F.2d 479, 483 (4th Cir. 1987) (*Charters I*), on reh'g, 863 F.2d 302 (4th Cir. 1988) (en banc), cert. denied, 110 S. Ct. 1317 (1990).

199. *United States v. Charters*, 863 F.2d 302, 309 n.5 (4th Cir. 1988) (en banc) (*Charters II*), cert. denied, 110 S. Ct. 1317 (1990); see also, e.g., Dawes, *Representative Thinking in Clinical Judgment*, 6 CLINICAL PSYCHOLOGY REV. 425 (1986) (on representativeness heuristic); Tversky & Kahneman, *Extensional Versus Intuitive Reasoning: The Conjunction Fallacy in Probability Judgment*, 90 PSYCHOLOGY BULL. 293 (1983) (on heuristic errors in assessment of probability judgments).

200. See Snyder, Tanke & Berscheid, *Social Perception and Interpersonal Behavior: On the Self-Fulfilling Nature of Social Stereotypes*, 35 J. PERS. & SOC. PSYCHOLOGY 656, 657 (1977) (once a stereotype is adopted, a wide variety of evidence can be read to support that stereotype, including events that could equally support the opposite interpretation); see generally Zadny & Gerard, *Attributed Intentions and Informational Selectivity*, 10 J. EXPER. & SOC. PSYCHOLOGY 34 (1974). "Attribution theory" refers to the "propensity to remember the strengths of confirming evidence but the weaknesses of disconfirming evidence, to judge confirming evidence as relevant and reliable but disconfirming evidence as irrelevant and unreliable, and to accept confirming evidence at face value while scrutinizing disconfirming evidence hypocritically." Lord, Ross & Lepper, *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37 J. PERS. & SOC. PSYCHOLOGY 2098, 2099 (1979).

201. *Charters II*, 863 F.2d at 310.

202. *Charters I*, 829 F.2d at 488:

The balance of individual and governmental interests is quite different where a mentally ill patient such as Charters is concerned. Mentally ill patients, though incapacitated for particular purposes, can be competent to make decisions concerning their medical care and thus treatment decisions involving mentally ill individuals raise difficult questions about the deference which must be accorded a potentially competent patient's desires—questions [Youngberg] did not in any way address.

In support of this proposition, the *Charters I* court quoted with approval *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980) ("[T]here is no necessary relationship between mental illness and incompetency which renders [the mentally ill] unable to provide informed consent to medical treatment"). *Charters I*, 829 F.2d at 488 n.11.



agreement that incompetency to stand trial is not defined in terms of mental illness"<sup>203</sup> had made, the *Charters II* court engaged in what may be labeled as passive-aggressive behavior.<sup>204</sup> Scholars have patiently clarified the difference between these concepts and have warned of the "serious consequences" that may befall the adjudicator who falls prey to this "simplistic equation."<sup>205</sup> The courts have also underscored that incompetency to engage in medication decision making cannot be presumed from the fact of institutionalization (or even civil commitment).<sup>206</sup> In addition, empirical scientists have begun studying the connections between acceptance of medication and criminal trial incompetency,<sup>207</sup> and the critics have assumed that any linkage between the two had "finally been abandoned by both the courts and the medical profession."<sup>208</sup> The *Charters II* court, however, resurrected this merger with neither doctrinal, empirical, nor scientific grounding.

This passive-aggressive style surfaces elsewhere in the opinion as well. By suggesting that because medical professionals will "now [be] aware of the [appropriate] standard," they "may be as willing to proceed without prior judicial approval as" other bureaucrats and civil servants in the federal prison system,<sup>209</sup> the court implies an acknowledging acceptance of passive-aggressive behavior by the very doctors whose professional judgments it seeks to insulate from scrutiny. This expectation of resistance was ably responded to a decade ago by Professor Brooks:

It is hypothesized that some treating physicians will be reluctant to participate in a "hearing" because of unwillingness to be challenged, fear of examination and cross-examination, unwillingness to prepare or spend the time, and the like. Treating psychiatrists may in a passive-aggressive manner concede and accede, perhaps against their better judgment, to the patient's asserted wishes in order to avoid participation

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203. *Martin v. Dugger*, 686 F. Supp. 1523, 1572 (S.D. Fla. 1988); see generally 3 M. PERLIN, *supra* note 1, § 14.09, at 236 and cases cited nn.173-77.

204. See *supra* note 180; see also Teicher, *Personality Disorders*, in 2 A. FREEDMAN, H. KAPLAN & B. SADOCK, *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY—II* § 39.4a, at 2176, 2182 (2d ed. 1975).

205. Fentiman, *supra* note 27, at 1119; see generally *id.* at 1118-20.

206. See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978), *supplemental opinion*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982).

207. See *Beckham, Annis & Bein*, *supra* note 27, at 107-08; cf. *Appelbaum & Hoge*, *supra* note 175, at 290 ("unclear if most [patients who seek to refuse medication] are legally incompetent").

208. Note, *State Mental Health Patients' Right to Refuse Forcible Administration of Medication Narrowly Construed*, 11 SETON HALL L. REV. 796, 807 (1981).

209. *United States v. Charters*, 863 F.2d 302, 314 (4th Cir. 1988) (en banc) (*Charters II*), *cert. denied*, 110 S. Ct. 1317 (1990).

in such procedures. But experience with thousands of civil commitment proceedings indicates that in the relatively few cases in which negotiation fails, psychiatrists have been willing to participate in legal proceedings that are more formal and time consuming than those now proposed in *Rennie*.<sup>210</sup>

Concerning the veiled suggestion that a contrary decision would have hastened the exodus from public facilities, Brooks noted further that this argument replicated others previously advanced every time due process protections were expanded and that, empirically, there was "no significant evidence . . . that this has happened or will happen."<sup>211</sup>

The *Charters II* court's reliance on these reasoning devices reflects the unconscious turmoil that cases involving mentally disabled criminal defendants cause.<sup>212</sup> The court professes an institutional inability to sort out "opposing scientific assessments,"<sup>213</sup> notwithstanding the many recent scholarly and thoughtful contributions to this area on how courts can and should interpret and weigh social science data.<sup>214</sup>

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210. Brooks, *supra* note 5, at 207.

211. *Id.* at 211; see also Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, in *REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS* 56, 66 (A. Doudera & J. Swazey eds. 1979) (hospital unit director conceded that most of the "deleterious effects caused in his unit, allegedly by the [original trial court order in *Rogers v. Okin*], were caused by the defendants' own conduct"); see generally 2 M. PERLIN, *supra* note 1, § 5.48, at 368 & nn.922-26.

Stanley Brodsky has recently suggested that disproportionate reactions by mental health professionals responding to their fears of being sued have reached phobic proportions, see Brodsky, *Fear of Litigation in Mental Health Professionals*, 15 CRIM. JUST. & BEHAV. 492, 497 (1988), and has characterized their behavior as "litigaphobia," which he defines as "the excessive and irrational fear of litigation," *id.* (citing Brodsky, *A Case Report of Litigaphobic Release from an Involuntary Commitment*, 2 PUB. SERV. PSYCHOLOGY 11 (No. 3 1983)); see also Breslin, Taylor & Brodsky, *Development of a Litigaphobia Scale: Measurement of Excessive Fear of Litigation*, 58 PSYCHOLOGY REP. 547 (1986); McDaniel, Book Review, 39 HOSP. & COMMUNITY PSYCHIATRY 999 (1988) (reviewing R. SIMON, *CLINICAL PSYCHIATRY AND THE LAW* (1987)): "My problem, on completion of this text, was the gripping realization of how endless were the possibilities of being a defendant [in malpractice litigation], regardless of the outcome. I had a momentary impulse to retire prematurely from practice;" *cf.* *Francois v. Henderson*, 850 F.2d 231, 234 (5th Cir. 1988) (testifying doctor in post-insanity acquittal release hearing conceded he may have "hedged" in earlier testimony "because he did not want to be criticized should [the defendant] be released and then commit a criminal act").

212. See, e.g., Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, and Symbolic Values: Random Decisions, Hidden Rationales, or 'Doctrinal Abyss'?*, 29 ARIZ. L. REV. 1, 97-98 (1987).

213. *Charters II*, 863 F.2d at 311 n.6. Indeed, the court suggests that these are utterly irreconcilable and that there is not "any possible basis for judicial choice between" varying positions on such issues as the perniciousness of drug side effects. *Id.*

214. The most notable contributions are by John Monahan and Laurens Walker. See,

The court's criticism of the panel for relying on "selected items in the legal and medical literature" is also baffling.<sup>215</sup> The panel had cited extensively to standard medical works as well as to survey articles summarizing the important scientific developments in this area over the past two decades.<sup>216</sup> A reading of the law review articles that the panel cited illuminates these sources' general reliance for their data on standard medical journals and medical texts, and on other law review articles by acknowledged medical experts.<sup>217</sup>

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e.g., Monahan & Walker, *Social Authority: Obtaining, Evaluating and Establishing Social Science in Law*, 134 U. PA. L. REV. 477 (1986); Walker & Monahan, *Social Frameworks: A New Use of Social Science in Law*, 73 VA. L. REV. 559 (1987); Walker & Monahan, *Social Facts: Scientific Methodology as Legal Precedent*, 76 CALIF. L. REV. 877 (1988). The importance of Monahan and Walker's work in this area is discussed in Perlin, *supra* note 7.

215. *Charters II*, 863 F.2d at 307 n.3. Dr. Rachlin has questioned whether this analysis does justice to the separate set of questions posed in instances of short-term use of such drugs. Personal communication from Dr. Rachlin (Nov. 9, 1989). Although there are clearly important differences in short-term and long-term reactions to such drugs, there is a growing body of evidence that suggests that short-term drug reactions may pose important risks as well. See, e.g., *Riese v. St. Mary's Hosp. & Medical Center*, 209 Cal. App. 3d 1303, 1310, 243 Cal. Rptr. 241, 244-45 (1987) (citing Jennings & Schultz, *Psychopharmacologic Treatment of Schizophrenia: Developing a Dosing Strategy*, 21 HOSP. FORMULARY 332 (1986)), *appeal dismissed*, 774 P.2d 698, 259 Cal. Rptr. 669 (1989); *id.* at 1312, 243 Cal. Rptr. at 246 (citing Mann, *Early Onset of Severe Dyskinesia Following Lithium-Haloperidol Treatment*, 140 AM. J. PSYCHIATRY 1385-86 (1983)); Appleton, *Fourth Psychoactive Drug Usage Guide*, 43 J. CLINICAL PSYCHIATRY 12 (1982); see also Csernansky, Prosser & Hollister, *Problems in Treating Chronic Schizophrenics with Neuroleptics*, 19 HOSP. FORMULARY 584 (1984); Kane, Woerner, Brenstein, Wegner & Lieberman, *Integrating Incidence and Prevalence of Tardive Dyskinesia*, 22 PSYCHOPHARMACOLOGICAL BULL. 254 (1986); Yesavage, Tanke & Shiekh, *Tardive Dyskinesia and Steady-State Serum Levels of Thiothixene*, 44 ARCHIVES GEN'L PSYCHOLOGY 913 (1987).

216. See *United States v. Charters*, 829 F.2d 477, 483 n.2 (4th Cir. 1987) (*Charters I*) (citing G. BURROWS, T. NORMAN & B. DAVIES, *DRUGS IN PSYCHIATRY: ANTIPSYCHOTICS* (1985); Kane & Smith, *Tardive Dyskinesia: Prevalence and Risk Factors, 1959-1979*, 39 ARCHIVES GEN. PSYCHIATRY 473 (1982)), *on reh'g*, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 110 S. Ct. 1317 (1990).

217. See, e.g., Fentiman, *supra* note 27, at 1110 n.2 (citing, among other sources, Guthell & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medicine*, 12 HOFSTRA L. REV. 77 (1983)); *id.* at 1129 n.98 (citing Van Putten, *Why Do Schizophrenic Patients Refuse To Take Their Drugs?*, 31 ARCHIVES GEN. PSYCHIATRY 67 (1974)); *id.* at 1129 nn.103-04 (citing R. BALDESSARINI, *CHEMOTHERAPY IN PSYCHIATRY* (1977)).

Although at least one of the sources that the panel relied upon in the same footnote, Plotkin, *supra* note 1, has been criticized for its "highly selective review of the pharmacological literature," see Guthell & Appelbaum, *supra* note 6, at 88 n.57, there is no indication that the criticism that Guthell and Appelbaum have leveled at the Plotkin article focused in any way on any of the principles for which the *Charters I* court cited it. Tellingly, the *Charters II* court makes no reference to which of the sources were inappro-

By characterizing judicial involvement in this area as "already perilous,"<sup>218</sup> the *Charters II* court reveals the depth of its apprehensions. This rhetoric is not accidental; it reflects the court's almost palpable discomfort in having to confront the questions before it. The court's refusal to even *weigh* the side effects evidence leaves the nonexpert reader in a quandary: Are there two equal bodies of studies that simply cancel each other out? Are there differences in the methodologies that somehow tip the scales in one way or another? Should all of the values under consideration be given equal weight? Are there new scientific breakthroughs that are "just over the horizon"?

The court's refusal to engage in scholarly discourse offers no clues to the answers to these questions<sup>219</sup> and no insight into the new and important developments in "neuroleptic malignant syndrome"<sup>220</sup> and other topics of significance to serious researchers in this area.<sup>221</sup> For instance, the court quotes Dr. Baldessarini,<sup>222</sup> but ignores more *recent* qualifications by the same author that (1) chronic patients respond least satisfactorily to *any* treatment (including psychopharmacology); (2) the optimal role of such drugs in long-term treatment "remains a matter of investigation;" (3) antipsychotic agents are of "uncertain benefit[] in some conditions" and their use "is compromised by common and character-

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priately selective or to which *other* sources (not cited in *Charters I* but assumedly available to the *Charters II* court) might have provided a more balanced view. For a survey of the most recent literature in the area, see 2 M. PERLIN, *supra* note 1, § 5.02, at 218-24 and sources cited at nn.1-24.

218. *Charters II*, 863 F.2d at 310.

219. Cf. Woolhandler, *Rethinking the Judicial Reception of Legislative Facts*, 41 VAND. L. REV. 111, 125 n.84 (1988) (quoting D. HOROWITZ, *THE COURTS AND SOCIAL POLICY* 284 (1977) (social science may introduce "complexities that shake the judge's confidence in imposed solutions")).

220. "Neuroleptic malignant syndrome is an uncommon but potentially fatal reaction to [antipsychotic medication], characterized by muscular rigidity, fever, autonomic dysfunction, and altered consciousness." Levenson, *Neuroleptic Malignant Syndrome*, 142 AM. J. PSYCHIATRY 1137, 1137 (1985); for an earlier review, see Caroff, *The Neuroleptic Malignant Syndrome*, 41 J. CLINICAL PSYCHIATRY 79 (1980).

221. See, e.g., Baldessarini, Cohen & Teicher, *Significance of Neuroleptic Dose and Plasma Levels in the Pharmacological Treatment of Psychoses*, 45 ARCHIVES GEN. PSYCHIATRY 79 (1988); Friedman, Weinrauch & O'Elia, *Metoclopramide-Induced Neuroleptic Malignant Syndrome*, 147 ARCHIVES INTERNAL MED. 1495 (1987); Levenson, *supra* note 220. For the most recent survey of the full literature in a court opinion see *Riese v. St. Mary's Hospital*, 209 Cal. App. 3d 1303, 1310-12, 243 Cal. Rptr. 241, 244-46 (1987), *appeal dismissed*, 774 P.2d 698, 259 Cal. Rptr. 669 (1989).

222. See *Charters II*, 863 F.2d at 313 ("the use of available antipsychotic agents continues to be the cornerstone of management for these serious and disabling mental illnesses").

istic forms of early and late-onset neurological side-effects;" and (4) "all of the antipsychotic agents" currently in use "exact some unwanted effects on the central nervous system."<sup>223</sup> Again, the reader has no sense of this, partly because the court abdicates its obligation to weigh, analyze, and apply the best available social science data to the case before it.

Other curiosities in the opinion also reflect the court's discomfort. For example, the court's incantation of *Parham v. J.R.*'s<sup>224</sup> language regarding the use of "accepted medical practices in diagnosis, treatment and prognosis"<sup>225</sup> assumes that such practices are actually employed in public psychiatric institutions. This assumption is belied by nearly two decades of litigation that flows from a scandalous abdication of such professional responsibility in facilities across the nation.<sup>226</sup> The court's conclusion that Charters's failure to offer evidence that the initial drugging decision lay "completely beyond the bounds of tolerable professional judgment. . . . undoubtedly reflects the fact that no such evidence was available"<sup>227</sup> suggests a picture totally at odds with history. Without making any reference to the specific level of counsel available to Charters in this case, it can be said without fear of contradiction that counsel generally provided to involuntarily confined mental patients is grossly inadequate.<sup>228</sup> This inadequacy is magnified in cases involving mentally disabled criminal defendants,<sup>229</sup> and the situation is further exacerbated by the general lack of funds available to indigent criminal defendants to pay for expert witnesses in cases that do not fall strictly within the holding of *Ake v. Oklahoma*.<sup>230</sup> The Fourth Circuit majority was surely aware of this reality.

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223. Baldessarini, Cohen & Teicher, *supra* note 221, at 79.

224. 442 U.S. 584 (1979).

225. *Charters II*, 863 F.2d at 312 (citing *Parham v. J.R.*, 442 U.S. 584, 607-08) (1979)).

226. See, e.g., Gelman, *supra* note 1, at 1765 n.213 (New Jersey state "doctors at every level—including the Department of Mental Health directorate—ignored and subverted the rules").

227. *Charters II*, 863 F.2d at 313 (emphasis added).

228. See Perlin & Sadoff, *Ethical Issues on the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161, 161 (Summer 1982).

229. See President's Commission's Task Panel on Legal & Ethical Issues, *Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues*, 20 ARIZ. L. REV. 49, 55 (1978) [hereinafter Task Panel Rep.].

230. 470 U.S. 68, 83 (1985) (where indigent defendant makes preliminary showing that his sanity at the time of the offense is likely to be a "significant factor" at trial, he has a right to access to psychiatric assistance); see generally 2 M. PERLIN, *supra* note 1, § 8.32; 3 *id.*, § 17.16.

Finally, by applying the most minimalist perspective to *Youngberg v. Romeo*<sup>231</sup> and *Parham v. J.R.*<sup>232</sup> in the sterile context of the *Mathews v. Eldridge*<sup>233</sup> "balancing" calculus, the court creates a standard that apparently is virtually impregnable: a sole test of whether the decision-making process was "so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one."<sup>234</sup> How could this standard be violated? Some examples of actions that might meet this test include (1) intentionally medicating a patient into a coma to amorously pursue the patient's spouse; (2) in a drunken stupor, injecting the wrong medicine into the patient's vein; (3) taking a bribe from a patient's business competitor to insure the patient's long-term institutionalization; or (4) even merely posing as a doctor.<sup>235</sup> For the type of drugging scenario typically found in public hospitals, however, the standard appears to be a nonstandard.

The acid test by which to assess the *Charters II* standard would be to apply it to the trial record in *Rennie*.<sup>236</sup> There, the defendants' medical directors agreed that drugs were used for control and "as a substitute for treatment."<sup>237</sup> In addition, the medical directors' "questionable judgment in failing to acknowledge" overt physical manifestations of tardive dyskinesia was because of "institutional self-interest."<sup>238</sup> It is not at all clear that a literal reading of the *Charters II* test would find a violation in this behavior.<sup>239</sup>

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231. 457 U.S. 307 (1982). See *infra* note 251 (discussing broad and narrow readings of *Youngberg*).

232. 442 U.S. 584 (1979). See *supra* notes 164, 167 (discussing virtually unanimous criticisms of *Parham*).

233. 424 U.S. 319, 335 (1976).

234. *United States v. Charters*, 863 F.2d 302, 313 (4th Cir. 1988) (en banc) (*Charters II*), cert. denied, 110 S. Ct. 1317 (1990).

235. These examples would all meet tests for medical malpractice and delicensure and may violate criminal statutes as well. Cf., e.g., *Stephen v. Drew*, 359 F. Supp. 746, 748 (E.D. Va. 1973) (improper civil commitment tort claim stated where psychiatrist was allegedly involved in conspiracy to deprive plaintiff of his constitutional rights). For a discussion of the different grounds upon which a tardive dyskinesia malpractice suit might be premised, see Wettstein, *Tardive Dyskinesia and Malpractice*, 1 BEHAV. SCI. & L. 85, 88-89 (1983).

236. *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3d Cir. 1981), vacated, 458 U.S. 1119 (1982).

237. *Id.* at 1299.

238. *Id.* at 1302.

239. Perhaps what the Fourth Circuit has done is to engraft the "shock the sensibilities" test used in confession suppression assessments, see *Moran v. Burbine*, 475 U.S. 412, 433-34 (1986), on to civil rights law. Under this calculus, although the actions described in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala.), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala.), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* *Wyatt*

## V. OTHER COMPETENCY READINGS

What does the decision in *Charters II* mean? At the outset, the state-federal split in right-to-refuse-treatment litigation now appears to be final.<sup>240</sup> *Charters II* may signal the death knell for the litigation of right-to-refuse-treatment issues in the federal forum.<sup>241</sup> Although *Charters* had no choice regarding where to litigate because of his pretrial detention on federal charges, civil patients will continue to exercise the option to pursue remedies in state courts.<sup>242</sup> Because state appellate courts have proved to be robustly independent in analyzing right-to-refuse issues, *Charters II* may have surprisingly little impact on litigants who can pursue state remedies.<sup>243</sup>

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v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), *see supra* note 13, would certainly meet the "shock" standard and the actions in *Rennie*, 476 F. Supp. 1294 *see supra* note 171, might meet this standard, those in *Charters* most likely would not. Cf. Benner, *Requiem for Miranda: The Rehnquist Court's Voluntariness Doctrine in Historical Perspective*, 67 WASH. U.L.Q. 59, 131 (1989) (suggesting, in discussing *Colorado v. Connelly*, 479 U.S. 157, 167 (1986) (absent police coercion, defendant's mental disability was irrelevant in determination of *Miranda* waiver question), that the consciences of a majority of the Supreme Court were not "sufficiently pricked by the prospect of convicting a mental patient upon the basis of a confession made with a delusional mind").

240. *See* Perlman, *supra* note 9, at 1283-92.

Given the shift in attitude in the United States Supreme Court on cases involving institutional reform and its concomitant emphasis on professional deference, and the general renaissance of state constitutional law as a source of rights in matters involving civil liberties, the broad articulation of a state constitutional right in *Rivers [v. Katz]*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986) may reasonably be expected to have an impact both beyond the geographic borders of New York and beyond the subject-matter confines of the question of the right of the institutionalized mentally disabled to refuse treatment.

*Id.* at 1291-92 (footnotes omitted).

241. Cf. *Washington v. Harper*, 110 S. Ct. 1028, 1038-44 (1990) (limited reading of right-to-refuse doctrine under federal constitution in case of convicted state prisoner).

242. This trend continues unabated. *See, e.g., Riese v. St. Mary's Hosp.*, 209 Cal. App. 3d 1303, 243 Cal. Rptr. 241 (1987), *appeal dismissed*, 774 P.2d 698, 259 Cal. Rptr. 669 (1989); *People v. Gilliland*, 769 P.2d 477 (Colo. 1989); *In re Commitment of M.P.*, 510 N.E.2d 645 (Ind. 1987); *Williams v. Wilzack*, Docket #140 (Md. Ct. App. 1989) (awaiting decision); *In re Jarvis*, 433 N.W.2d 120 (Minn. Ct. App. 1988); *In re Sanders*, 108 N.M. 434, 773 P.2d 1241 (Ct. App. 1989); *State ex rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 416 N.W.2d 883 (1987).

243. The *coup de grace* as to the federal forum may have been delivered recently in *Harper*, 110 S. Ct. 1028 (sharply limiting the right of convicted state prisoners to refuse the administration of antipsychotic drugs). The Washington State Supreme Court decision in *Harper* is discussed in Note, *Protecting the Inmate's Right to Refuse Antipsychotic Drugs*, 64 WASH. L. REV. 459 (1989). *But see Large v. Superior Ct.*, 148 Ariz. 229, 714 P.2d 399 (1986) (state constitution was source of prisoners' right to refuse); *Keyhea v. Rushen*, 178 Cal. App. 3d 526, 223 Cal. Rptr. 747 (1986) (same); *see also Gilliland*, 769 P.2d 477 (standard for determining right-to-refuse claim same in cases involving insanity acquittees as in cases involving patients involuntarily civilly committed).

This conclusion in no way ends the inquiry into *Charters II*'s importance in attempting to answer competency questions. Competency encompasses more than just patients' ability to make their own medication decisions.<sup>244</sup> It is necessary to consider some of the *other* competency questions that *Charters* raises and the extent to which they still matter after *Charters*.

### A. The Competency of Treatment Staffs

*Charters II* clarifies that the Fourth Circuit is willing to engage in what criminal law text writers characterize as "willful blindness"<sup>245</sup> regarding whether professional judgment is actually employed in large public psychiatric hospitals. This is especially curious in light of the bold and courageous record of the District Court for the Western District of North Carolina, which is within the Fourth Circuit, in the ongoing *Thomas S. ex rel Brooks v. Flaherty*<sup>246</sup> litigation. That court continues to look beyond the presumption of staff competency and to explore exactly what happens in similar large, public institutions.<sup>247</sup> There are some important factual dis-

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

245. The classic policy debate is found in *United States v. Jewell*, 532 F.2d 697 (9th Cir.) (en banc), *cert. denied*, 426 U.S. 951 (1976).

246. 699 F. Supp. 1178 (W.D.N.C. 1988).

247. In a comprehensive and thoughtful opinion issued less than three weeks prior to *Charters II*, the district court ruled that the conditions of administration of antipsychotic drugs at all state psychiatric hospitals in North Carolina were "such a substantial departure from accepted professional judgment, practice and standards as to demonstrate that the decision is not a function of independent professional judgment within the meaning of *Youngberg*." *Id.* at 1202. In that case, the trial court entered fact findings eerily like those in *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated*, 457 U.S. 291 (1982); and *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980):

Class members have been seriously endangered and injured by the inappropriate use of antipsychotic drugs . . . .

. . . .

[According to one pharmacological expert,] eighty-eight percent [of class members at Hospital A] manifested symptoms of adverse [side]effects; forty percent showed such symptoms at [Hospital B]; and thirty-three percent showed such symptoms at [Hospital C] . . . .

. . . .

One of the ways [defendant] has most endangered [nonmentally ill] plaintiffs is by the long-term use of antipsychotic drugs for the purported purpose of controlling behavior disorders . . . .

. . . .

[W]hen chemical restraints are authorized "PRN," they are overused and



tinctions between the recent *Thomas S.* opinion (involving a class of mentally retarded civil patients housed in state psychiatric hospitals)<sup>248</sup> and *Charters* (a single incompetent-to-stand-trial criminal defendant). These distinctions, however, do not explain the absolute methodological differences between an opinion that confronts certain issues (the quality of treatment available to patients at risk) and one that utterly ignores them.<sup>249</sup> *Charters* indicates to staffs and administrators of public psychiatric facilities that the long-discarded "hands-off" doctrine<sup>250</sup> has been resurrected.<sup>251</sup>

### B. *The Competency of Counsel*

The adequacy of counsel available to individuals facing involuntary civil commitment (and to those already so committed) is generally scandalous.<sup>252</sup> This scandal is exacerbated in the cases of mentally disabled individuals facing criminal trials.<sup>253</sup> Nothing in *Charters II* recognizes this reality.

represent a substantial departure from the professional judgment of a qualified treating professional.

*Thomas S.*, 699 F. Supp. at 1186-88.

248. *Id.* at 1182.

249. See also, e.g., *Johnson ex rel. Johnson v. Brelje*, 701 F.2d 1201, 1209 n.9 (7th Cir. 1983) (decision will not be characterized as "professional" where "it is not based on a view as to how best to operate" a mental health facility).

250. See *supra* text accompanying note 8.

251. Post-*Youngberg* cases have read *Youngberg's* professional judgment standard in significantly different ways. Compare, e.g., *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984) (expansive reading) with *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983) (restrictive reading). Broad and narrow readings of the *Youngberg* standard are discussed in 2 M. PERLIN, *supra* note 1, §§ 4.43-44.

252. See, e.g., Perlin & Sadoff, *supra* note 228, at 164:

[T]raditional, sporadically-appointed counsel in mental health cases [were] unwilling to pursue necessary investigations, lack[ed] . . . expertise in dealing with mental health problems, and . . . suffered from "rolelessness," stemming from near-total capitulation to experts, hazily defined concept[s] of success/failure, inability to generate professional or personal interest in [the] patient's dilemma, and lack of [a] clear definition of [the] proper advocacy function. As a result, counsel . . . functioned "as no more than a clerk, ratifying the events that transpire[d], rather than influencing them."

253. See, e.g., Task Panel Rep., *supra* note 229; see generally *Henderson v. United States*, 360 F.2d 514, 515-20 (D.C. Cir. 1966) (Bazelon, C.J., concurring); see also D. BAZELON, *QUESTIONING AUTHORITY: JUSTICE AND CRIMINAL LAW* 49 (1988) (criticizing level of representation provided by counsel in insanity cases for failing to "dig beneath the experts' boilerplate"). The determination whether to present an insanity defense is "probably . . . the most demanding task of the defense lawyer." Kwall, *The Use of Expert Services by Privately Retained Criminal Defense Attorneys*, 13 LOY. U. CHI. L.J. 1, 17 (1981).

The Supreme Court's 1984 *Strickland v. Washington*<sup>254</sup> decision, which established a vague and watered-down reasonableness standard in cases assessing the adequacy of counsel under the sixth amendment,<sup>255</sup> further highlights the problem. Post-*Strickland* cases involving mentally disabled criminal defendants have starkly revealed the minimal level of competency that the courts expect of counsel representing this most fragile of populations.<sup>256</sup> The *Charters II* court's refusal to even touch on this issue will simply exaggerate this competency problem in the future.<sup>257</sup>

### C. The Competency of Courts

This issue involves two separate but somewhat overlapping issues: The federal courts' *jurisdictional* competency to weigh claims

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254. 466 U.S. 668 (1984). In *Strickland*, the Court established a two-part test to determine "whether counsel's conduct so undermined the proper functioning of the adversarial process that the trial cannot be relied on as having produced a just result." *Id.* at 686.

First, the defendant must show that counsel's performance was deficient. This requires showing that counsel made errors so serious that counsel was not functioning as the "counsel" guaranteed the defendant by the Sixth Amendment. Second, the defendant must show that the deficient performance prejudiced the defense. This requires showing that counsel's errors were so serious as to deprive the defendant of a fair trial, a trial whose result is reliable.

*Id.* at 687.

The standard to be employed was "reasonably effective assistance," an objective test measured by simple "reasonableness under prevailing professional norms" to which judicial scrutiny must be "highly deferential." *Id.* at 687-89. The Court established a "strong presumption" that counsel's conduct falls within the wide range of "reasonable professional assistance." *Id.* at 689.

255. In dissent, Justice Marshall charged that the *Strickland* standard was "so malleable that, in practice, it will either have no grip at all or will yield excessive variation in the manner in which the Sixth Amendment is interpreted" and that the Court "abdicated its responsibility to interpret the constitution." *Id.* at 707-08 (Marshall, J., dissenting). The chair of the Competency Committee of the American Bar Association Section on Criminal Justice called the majority opinion "unfortunate and misguided," charging that the Court "failed to meet its obligation to help ensure that criminal defendants receive competent representation" and viewing the decision as a "clear signal that th[e] court is not at all disturbed with inadequate performance by criminal defense lawyers." Genego, *The Future of Effective Assistance of Counsel: Performance Standards and Competent Representation*, 22 AM. CRIM. L. REV. 181, 182, 202 (1984).

256. See generally 2 M. PERLIN, *supra* note 1, § 8.30; Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91 (1985).

257. See, e.g., *Alvord v. Wainwright*, 469 U.S. 956, 959 (1984) (Marshall, J., dissenting from denial of certiorari) (discussing counsel's total failure to pursue possible insanity defense: "[The decision below] renders meaningless defense counsel's vital function as an adviser"). For a recent, careful, judicial criticism of the *Strickland* standard, see *State v. Davis*, 116 N.J. 341, 377, 561 A.2d 1082, 1113-15 (1989) (Handler, J., concurring in part and dissenting in part).

such as those raised by *Charters* and judges' competency to *substantively* decide such claims.

### 1. Jurisdictional Competency

*Charters II* raises the fundamental policy question of the degree to which the federal courts remain willing to involve themselves in institutional issues.<sup>258</sup> During the past decade, the Supreme Court, with increasing frequency, has expressed its irritation with civil rights-public interest plaintiffs and their counsel<sup>259</sup> and has consciously narrowed federal court jurisdiction over civil rights claims through a series of prudential limiting devices.<sup>260</sup> As the Court becomes a *majoritarian* court,<sup>261</sup> its hostility toward virtually all civil rights claims grows.<sup>262</sup> The lower federal courts are quick to pick up on the Court's cues, and as a result, they decide such cases more narrowly.<sup>263</sup>

In the context of issues involving patients' substantive rights, *Youngberg* became the perfect paradigm of the "new" Supreme Court's unwillingness to seriously deal with the merits of such

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258. See generally 1 M. PERLIN, *supra* note 1, § 1.03.

259. See generally *id.* § 1.04; see also *Valley Forge Christian College v. Americans United for Separation of Church & State*, 454 U.S. 464, 487 (1982) (footnote omitted): "[Respondents'] claim that the Government has violated the Establishment Clause does not provide a special license to roam the country in search of governmental wrongdoing and so reveal their discoveries in federal court. The federal courts were simply not constituted as ombudsmen of the general welfare."

260. See C. WRIGHT, *THE LAW OF FEDERAL COURTS* § 52A (4th ed. 1983) (discussing "Our Federalism"). This has occurred most notably through the Court's expansion of the eleventh amendment in *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984) (eleventh amendment bars federal courts from ordering state officials to conform their conduct to state law, even when only prospective injunctive relief is being sought). See, e.g., Chemerinsky, *State Sovereignty and Federal Court Power: The Eleventh Amendment After Pennhurst v. Halderman*, 12 HASTINGS CONST. L.Q. 643 (1985); Rudenstine, *Pennhurst and the Scope of Federal Judicial Power to Reform Social Institutions*, 6 CARDOZO L. REV. 71 (1984).

261. See, e.g., Rudenstine, *Judicially Ordered Social Reform: Neofederalism and Neoliberalism and the Debate Over Political Structure*, 59 SO. CAL. L. REV. 451 (1986); Sherry, *Issue Manipulation by the Burger Court: Saving the Community From Itself*, 70 MINN. L. REV. 611 (1986).

262. See, e.g., Perlin, *supra* note 9, at 1258-59 (footnotes omitted):

[T]he significance of the *Pennhurst II* line of cases lies in the undeniable fact that, at least until there is a significant restructuring of the Supreme Court, the terrain of federal courts will prove to be far more hostile to suits brought on behalf of the mentally disabled than it was a decade ago.

263. See Rudenstine, *supra* note 260, at 109 (after *Pennhurst*, court reform of mental institutions will be countenanced only in "extreme circumstances").

cases. The long-term effect of *Youngberg* is felt clearly in *Charters II*.<sup>264</sup>

## 2. Competency of Judges

Aside from these jurisdictional and procedural limitations, *Charters II* raises other important questions about the self-assessed competency of judges to confront cases involving mentally disabled criminal defendants or social science data.<sup>265</sup> In *Charters II*, the court abdicated its responsibilities to read, harmonize, distinguish, and analyze social science data on the issues before it. It not only inadequately addressed the issue of side effects, but it also failed to adequately address issues concerning competency determinations, the therapeutic value of decision making, the empirical results of an announcement of a right to refuse treatment, and the courts' role in such processes.<sup>266</sup>

It is not coincidental that the court chose to do this in a case involving a litigant like *Charters*. The court's discomfort with the case is apparent upon reading the opinion.<sup>267</sup> The court's use of

264. The silent effect of *Pennhurst*, 465 U.S. 89 is similarly present. Although *Pennhurst* is facially inapplicable to *Charters*, which involved the application of federal constitutional law to the actions of federal officials at a federal institution, the *Pennhurst* Court's hostility toward institutional reform (and toward the litigants' underlying substantive claims, see Rudenstine, *supra* note 261, at 482) resounds in *Charters*. See Cohen, *Corrections Law: Forced Medication of Inmates—United States v. Charters*, 25 CRM. L. BULL. 279, 286 (1989) (*Charters* "hastens the erosion" of the "claims of right and of human dignity and autonomy" raised by pretrial detainees).

265. See Appelbaum, *supra* note 115, at 348 ("If it is not beyond the dignity of scholars in a medical or scientific field to admit their inability to understand fully the statistical data before them, surely no one would begrudge a jurist a similar confession"); *id.* at 347 ("When the import of a body of data runs counter to the views that a Justice would otherwise hold on an issue, the tendency to discount the data must at times be difficult to resist" (discussing Justice Powell's concurring opinion in *Ballew v. Georgia*, 435 U.S. 223, 246 (1976) (Powell, J., concurring) (decrying majority's reliance on "numerology" in deciding jury composition cases))).

266. See, e.g., Suarez, *A Critique of the Psychiatrist's Role as Expert Witness*, 12 J. FORENSIC SCI. 172, 173 (1967) (the judicial system lumps "the conflicts, needs and fears" of its terrible responsibility on psychiatry).

267. See Perlin, *supra* note 212, at 4 (quoting in part Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91, 168 (1985) ("Members of the [Supreme] Court—like the rest of us—are beset by ambiguous and ambivalent feelings in need of self-rationalization: unconscious feelings of awe, of fear, of revulsion, of wonder' towards the mentally ill individual charged with crime")). The classic expression of this argument is found in Goldstein & Katz, *Abolish the 'Insanity Defense'—Why Not?* 72 YALE L.J. 853, 868-69 (1963). For a recent judicial expression, see *O'Connor v. Ortega*, 480 U.S. 709, 734 n.3 (1987) (Blackmun, J.,

heuristic reasoning, its refuge-taking in "ordinary common sense," and its cramped reasoning reflect its apprehension about dealing with the type of "crazy"<sup>268</sup> impulses upon which defendants like Charters appear to freely act.<sup>269</sup> Because of this fear, the courts decide cases such as *Charters II* in the same way that the Supreme Court regularly decides cases involving mentally disabled criminal defendants: "out of consciousness."<sup>270</sup>

## VI. CONCLUSION

The specific reach of the *Charters II* holding is limited because, on its face, it applies only to pretrial federal detainees, a numerically small percentage of all institutionalized individuals who might wish to assert their right to refuse antipsychotic medication.<sup>271</sup> The Fourth Circuit decision remains important on two separate levels. Jurisprudentially, it is hard to conceive of a more narrowly crafted opinion that could still pay lip service to the existence of the constitutional right.<sup>272</sup> Symbolically, the court's erection of a facade of "arbitrariness" speaks directly and eloquently to the judiciary's discomfort in deciding certain types of cases involving specific types of litigants.<sup>273</sup>

dissenting) (quoting B. CARDOZO, *THE NATURE OF THE JUDICIAL PROCESS* 167 (1921)):

[J]udges are never free from the feelings of the times or those emerging from their own personal lives . . . "Deep below consciousness are . . . the likes and dislikes, the predilections and the prejudices, the complex of instincts and emotions and habits and convictions, which make the man, whether he be litigant or judge."

See also Benner, *Diminishing Expectations of Privacy in the Rehnquist Court* (1989) (manuscript to be published in *JOHN MARSHALL L. REV.*).

268. The word "crazy" is used extensively in this context in the work of Professor Stephen Morse. See, e.g., Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 *SO. CAL. L. REV.* 777 (1985). On the use of such vernacular, compare Fletcher, *The Universal and the Particular in Legal Discourse*, 1987 *B.Y.U. L. REV.* 335, 341 ("[l]anguage shapes cultural identity") with Tournlin, *Introductory Note: The Multiple Aspects of Mental Health and Mental Disorder*, 2 *J. MED. & PHIL.* 191 (1977) (colloquial language used to describe the mentally disabled is "confused and confusing").

269. For a discussion of the role of judges' personal value judgments in the shaping of constitutional law, see Benner, *supra* note 239, at 149.

270. Perlin, *supra* note 212, at 98.

271. Cf. *Washington v. Harper*, 110 S. Ct. 1028 (1990).

272. But see *Sanders v. New Mexico Health & Env't Dep't*, 108 N.M. 434, 773 P.2d 1241, 1244 (1989) (citing *Charters II* for the proposition that "safeguards are required where 'mind-altering' medication or techniques are sought to be imposed against an individual's consent").

273. See, e.g., Perlin, *supra* note 48; Suzarez, *supra* note 266; Wasyliw, Cavanagh & Rogers, *Beyond the Scientific Limits of Expert Testimony*, 13 *BULL. AM. ACAD. PSYCHIATRY & L.* 147, 152 ("Public decisions are often so close to impossible that those charged with making them are more than anxious to pass their burdens to unwilling experts").

The *Charters* decision has dealt a crippling, near-fatal blow to the development of a coherent conceptualization of "competency" in the federal courts in cases involving pretrial detainees who wish to refuse psychotropic drug treatment. The court's slavish incantation of the *Youngberg* "professional judgment standard," its refusal to "unpack" the multiple and complex meanings of "competency," and its failure to consider the differences between competence for purposes of refusal of medication and competence for purposes of standing trial on criminal charges augurs the final exodus of right-to-refuse-treatment litigation from the federal courts. Thus, the substance of the right in that forum is little more than a "pious fraud."<sup>274</sup>

More importantly, the court's vision of *other* competencies is myopic. It blinds itself to questions of the competency of public mental institutions to adequately self-monitor involuntary medication policies and of the competency of counsel to provide adequate representation to the mentally disabled defendant in such cases. Most significantly, the opinion paints a portrait of a court that does not—by its own terms—see itself as competent to confront, weigh, and assess competing claims involving social science data, empirical evidence, and scientific thought. The court takes an allegedly common-sense refuge in heuristic reasoning devices and uses rhetoric to blur policy choices. When the facade is stripped from *Charters II*, it is left like the emperor in his new clothes: naked to the public eye.

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274. See Benner, *supra* note 239, at 158 (discussing *Miranda*).

