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THE LAW AND PSYCHIATRY WARS, 1960 - 1980*

SHELDON GELMAN**

Neuroleptic or "antipsychotic" medications appeared during the early 1950s; they are now in their fifth decade of use, perhaps a longevity record for a prevailing psychiatric treatment. By the early 1960s, psychiatrists and policy makers were hailing the drugs and their potential for transforming the public mental health system. In short order, medications replaced psychiatric treatments such as insulin coma therapy and lobotomy, and they soon became the standard therapy for schizophrenia. Many hailed them as a "biological revolution" in psychiatry.

A parallel revolution occurred in law. By the late 1960s, courts were declaring civil commitment schemes and aspects of state mental hospital management unconstitutional. This represented a dramatic departure, for until then public mental health matters had been decided by state administrators and statutes, not by judges or the federal Constitution. Advocates and opponents alike likened the litigation over mental hospitals (in its ambitions, theories, and judicial demands) to lawsuits directed at racial segregation in public schools.

In the wake of the twin legal and psychiatric revolutions, the century-old network of state mental hospitals withered. If the hospitals exist at all today, they are only a fraction of their 1950 size, and their function has completely changed. Now state hospitals do little more than adjust or reinstitute medication regimens, and possibly care for some patients who respond to medications badly. "Community care" and community medication—"liberty" in legal terms—have taken the hospitals' place in the public mental health system.

On any view of developments, medications loom large. Yet their actual role receives relatively little scrutiny. Psychiatrists generally assume that the changes wrought by medications represent fruits of scientific and medical progress, and that little more than that need be said. Similarly, many lawyers assume that the state hospital litigation spurred moral and legal progress—though perhaps not as much as one would have liked. Obvious problems in the new public health system (homelessness, neglect, under-treatment, new burdens on family members, revolving door hospitalizations,

* This essay will appear in the author's forthcoming book and is reprinted with permission of Rutgers University Press. SHELDON GELMAN (untitled) (forthcoming 1998).

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and the occasional act of violence by a dangerous mentally ill person) usually get attributed to failures of implementation, planning, or funding; few regard them as inherent in the legal or psychiatric revolutions that produced the new system. These are standard views in psychiatry and law, but I believe they err in important ways. The essay that follows is excerpted from a book to be published by Rutgers University Press.^{***} The book examines the medication era in detail, and argues that the very conception of medications as a revolutionary treatment, and psychiatric ideas about their side effects and mechanism of action, all have a history—a history at odds with the idea that pure medical discovery drove developments.

Leading psychiatrists wanted an end to the old state hospital system in the 1950s. They also wanted to close the book on their profession's recent history (e.g., lobotomy) and its growing public and medical disrepute. In short, they wanted a revolution (in public health, in public perception and in their profession). But if medications worked as lobotomy had, by inducing pathology in patients (and many 1950s' psychiatrists thought medications did so) or if the medications caused permanent neurological disorders (as they do) these revolutions might well not occur. The public likely would have objected, as would have other physicians and courts, to a program of inducing pathology in patients on a massive scale and then discharging them from mental hospitals. After all, lobotomy induced pathology and as a result the public had turned against the therapy and, to no small extent, against psychiatry.

The desired public health and psychiatric revolutions occurred when leading researchers excluded pathology from their account of how medications worked, and ignored medications' persistent neurological side effects. Both of those things happened in the early 1960s, at just about the same time the federal government was endorsing deinstitutionalization. The book shows that these understandings of medications did not result from data (in the case of side effects, obvious data were suddenly ignored) but did conform to psychiatrists' vision of public health and their profession. Far from "science" or "progress" driving social and public health developments, it appears that at crucial junctures the "science" of medications reflected social and public health choices, not medical discovery or insight.

The chapter of the book excerpted below reaches similar conclusions about the law. It examines litigation developments from the late 1960s to the early 1980s. In law no less than in psychiatry, professional judgments produced anomalous results and professional processes worked in unexpected ways when it came to medications. These departures advanced a public mental health vision that was functionally the same as psychiatrists', even if couched in utterly different and more legalistic terms. Psychiatrists hailed medications as a medical revolution; lawyers by and large ignored the drugs. Yet, both professions reached the same general conclusions

^{***} The material will appear in a somewhat different form in the book.

about what should be done.

Commentators at the time saw an emerging "war" between law and psychiatry. However, the combat metaphor seems particularly ill chosen. Viewed in retrospect, the two disciplines' relationship seems like a ritualized dance—one marked by forceful gestures and occasional separation of the two partners, but always in response to the same music.

I. RIGHT TO TREATMENT

From the late 1960s through the mid-1970s, mental hospital reform litigation captured the imagination of lawyers and of the public. So-called "right to treatment" cases sought massive changes in state mental hospitals, and coincided with major changes in public mental health. By 1980, state mental hospitals had substantially given way to a new system of administering medications in the "community."¹

Without doubt, ample injustices warranted hospital reform litigation. Mental hospital life was often bleak, punctuated by violence, incompetent treatment, and abuse. In principle, the lawsuits challenging these conditions need not have comported with the emerging deinstitutionalization ideal.

Yet they did. The right to treatment cases typically produced a rapid reduction in the population of hospitals. Downsizing might not have been an explicit demand of the lawsuits, but it was widely recognized as a principal objective of the attorneys who brought the cases. Some lawyers hoped for the complete disappearance of state mental hospitals.² Often enough, the patients' lawyers and the defendant mental health department pursued the same deinstitutionalization objectives, with the only real opposition coming from mental hospital physicians and hospital unions, whose jobs were at risk. Even if the patients' lawyers began with other aims, acquiescing in deinstitutionalization assured them a "victory" that could justify their major litigation effort. This victory was always within reach because the principal

1. See generally George E. Crane, *Clinical Psychopharmacology in its 20th Year*, 181 *SCIENCE* 124 (1973) [hereinafter *Clinical Psychopharmacology*] (setting forth the classic account of deinstitutionalization and medications); Sheldon Gelman, *Mental Hospital Drugs: Professionalism and the Constitution*, 72 *GEO. L.J.* 1725, 1725-30, 1750-52 (1984) [hereinafter *Mental Hospital Drugs*] (describing deinstitutionalization); PHIL BROWN, *THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH* (1985) (describing and analyzing developments); ANN BRADEN JOHNSON, *OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION* (1990) (describing and analyzing developments).

2. See ALEXANDER D. BROOKS, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 870 (1974) (describing "what is perceived as the basic strategy of . . . [the prototype right treatment case]" as "requir[ing] . . . a standard of care that would be so difficult for most states to meet that it would be necessary to release large numbers of patients from state hospitals in order that the patients remaining would receive adequate treatment."). See also Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 *EMORY L.J.* 375, 403 (1982) (noting that "[t]he civil libertarian approach has been dominant" and it leads attorneys to prefer the "remedy of release for many patients" in right to treatment litigation).

defendants favored it. So lawyers claimed credit for what the states had wanted all along; and lawsuits provided political "cover" for states bent on releasing mental patients into sometimes reluctant communities.

Right to treatment lawsuits were almost always settled, and along just such lines. Still, some of the details sometimes provoked bitter controversy. Lawyers typically sought substantial improvements in the hospitals' physical plant, staffing levels, interior furnishings and programs, even as the hospital census fell. Those things required funding, but the states generally wished to spend less, not more. Real differences also arose over the timing of any improvements (lawyers generally wanted it faster) and about the closeness of any subsequent judicial supervision.³ Yet none of these disagreements altered the decrees' fundamental alignment with deinstitutionalization. If court decrees required improved staff-patient ratios, for example, discharging patients would help bring that about.

Though supposedly comprehensive in scope (even the temperature of shower water received attention in the decrees) right to treatment lawsuits effectively ignored medication issues. A typical consent decree might bar lobotomy (which the hospital hadn't performed in years), include a right to refuse electroconvulsive therapy (which state hospitals rarely used at this point), and then cite a vague right against "excessive" or "unnecessary" medication.⁴ These medication provisions did not produce results, and it is not even clear what hospitals were supposed to do differently. No physician had ever characterized his or her prescription as "excessive" or "unnecessary," and nothing in the decrees would change that. Later in the decade, decrees included hospital pharmacy reforms or standards that discouraged the prescription of more than one medication at a time. Whatever they accomplished, these measures did not prevent hospitals from administering medications to almost all patients and producing widespread side effects.

This lack of attention to medications was remarkable. Many mental patients intensely dislike medications, and notoriously complain about them. Two leading researchers documented the reasons for this in 1974.⁵ They conducted an experiment in which patients received a "test dose" of the drugs. Sixty percent experienced a "euphoric" or pleasant response; forty percent, a "dysphoric" or unpleasant one.⁶ Almost a quarter of this

3. See, e.g., Michael S. Lottman, *Paper Victories and Hard Realities*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (Valerie Bradley & Gary Clarke, eds. 1976) (reviewing decisions and recent settlements and expressing concern about the pace and "reality" of court mandated change).

4. The prototype for numerous decrees was *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

5. See Theodore Van Putten & Philip R.A. May, *Subjective Response as a Predictor of Outcome in Pharmacotherapy: The Consumer has a Point*, 35 ARCHIVES GEN. PSYCHIATRY 477 (1978).

6. *Id.* at 478.

forty percent “had such a severe dysphoric response that they [immediately] refused further treatment.”⁷ The researchers continued:

Can we assure a patient with an early dysphoric response that he will “get used to” the medication? Apparently not: 88% of the dysphoric responders eventually refused to continue taking [medications] because of a persisting dysphoria, against only 23% of the euphoric responders. . . . [M]ost [dysphoric responders] . . . complained throughout their treatment . . . of feeling “drugged,” of having “no drive or ambition,” of being “drowsy,” “tired,” and “slowed up.”⁸

For good or ill, medications dominate patients’ feelings and experiences of life in the mental hospital. Attorneys supposedly represented their clients’ views. Thus, patients’ dislike of the medications should have commanded lawyers’ attention. Yet in the early and mid-1970s, lawyers virtually never pressed complaints about medications; it was as if they were invisible.

In fact, attorneys had more reason to question medications than patients did themselves. In 1967, a research psychiatrist named George Crane demonstrated that tardive dyskinesia (a syndrome of repetitive, purposeless movements affecting various parts of the body, but especially the mouth, jaw, and tongue) affected about twenty five percent of medicated patients. Crane also showed that the disorder probably resulted from medications, and that it usually persisted after medications were withdrawn. That persistence, and an uncanny resemblance between tardive dyskinesia and the aftermath of a virulent type of brain encephalitis, suggested that medications caused long-lasting neurological damage.⁹

Upon hearing Crane’s findings, leading psychiatrists criticized him on a variety of mistaken and inconsistent grounds. Patients did not manifest the movements Crane had reported; or the patients did have the movements, but medications did not cause them; or medications caused the movements, but they were reversible and not serious; or the movements existed and were not reversible, but prior lobotomies and other brain damage were ultimately responsible. These psychiatrists criticized Crane as a threat to “progress in psychiatry,” and most of their brethren simply ignored the problem.¹⁰

Yet Crane was basically right. In fact, he had underestimated tardive dyskinesia’s prevalence. By the time right to treatment litigation blossomed in the early 1970s, tardive dyskinesia’s relationship to medications enjoyed

7. *Id.*

8. *Id.* at 479.

9. See George E. Crane, *Tardive Dyskinesia in Schizophrenic Patients Treated With Psychotropic Drugs*, in SECOND INTERNATIONAL SYMPOSIUM ON ACTION, MECHANISM AND METABOLISM OF PSYCHOACTIVE DRUGS DERIVED FROM PHENOTHIAZINE AND STRUCTURALLY RELATED COMPOUNDS 209 (1967) [hereinafter *Tardive Dyskinesia*]. For discussion, see Gelman, *Mental Hospital Drugs*, *supra* note 1, at 1753 & n.136.

10. Crane, *Tardive Dyskinesia*, *supra* note 9, at 218 (recording the “emergency discussion” that followed Crane’s paper).

wide recognition among researchers, even though leading psychiatrists still systematically underestimated the number of affected patients. These psychiatrists, like Crane's earliest critics, realized that tardive dyskinesia carried powerful implications for medication practice, and that its occurrence might undercut public support for the new public health system.¹¹

With widespread tardive dyskinesia, medications arguably took on the legally salient characteristics of lobotomy, a procedure that had raised grave legal and moral questions. Lobotomy produced permanent neurological damage; now medications did so as well. Lobotomy worked in largely unknown ways, and so did medications (the popularity of the theory that medications redressed a "chemical brain imbalance" notwithstanding). Moreover, the discoverer of the first antipsychotic drug, Thorazine, had theorized that it worked something like lobotomy by inducing a brain disease in patients (a disease whose symptoms closely resembled what psychiatrists later called "tardive dyskinesia").¹² In the 1950s, leading psychiatrists had even described medications as "chemical lobotomies."¹³

It is true that the late 1960s and early 1970s were the heyday of overly favorable research views of medications. Leading psychiatrists systematically downplayed side effects and exaggerated benefits in ways that had little support in data, and that later proved indefensible.¹⁴ Yet ample reason existed to challenge those categorizations when right to treatment litigation got underway, for example, in the work of 1950s psychiatrists, and of Crane and other tardive dyskinesia researchers. Indeed, as early as 1965, an editorial in the *Journal of the American Medical Association* had cautioned physicians about the danger of permanent neurological damage from medications.¹⁵ In 1973, a prestigious task force of government, academic and pharmaceutical industry psychiatrists had acknowledged tardive dyskinesia's existence, and drug companies added the disorder to their list of side effects.¹⁶ All of this had obvious legal and moral implications, which lead-

11. See Gelman, *Mental Hospital Drugs*, *supra* note 1, at 1753-54. More extensive arguments on these points will appear in my forthcoming book. See SHELDON GELMAN (untitled) (forthcoming 1998).

12. See Pierre Deniker, *Experimental Neurological Syndromes and the New Drug Therapies in Psychiatry*, 1 *COMPREHENSIVE PSYCHIATRY* 92 (1961) (arguing that drugs' clinical benefits probably result from a brain syndrome).

13. Sidney Malitz et al., *A Two-Year Evaluation of Chlorpromazine in Clinical Research and Practice*, 113 *AM. J. PSYCHIATRY* 540, 543 (1956) (noting that psychiatrists had called medications a "chemical lobotomy" and disagreeing with that usage—because medications did not work as well as lobotomy for many patients).

14. These claims receive considerable attention in the book. Research that played a pivotal role in constructing the new view of medications was published as The National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, *Phenothiazine Treatment in Acute Schizophrenia*, 10 *ARCHIVES GEN. PSYCHIATRY* 246 (1964).

15. See Editorial, *Irreversible Side Effects of Phenothiazines*, 191 *JAMA* 333 (1965).

16. See Am. College of Neuropsychopharmacology-FDA Task Force, *Neurological Syndromes Associated With Anti-psychotic Drug Use, A Special Report*, 28 *ARCHIVES GEN. PSYCHIATRY* 463 (1973).

ing psychiatrists presumably recognized as they devised an overly optimistic picture of medications. Yet if psychiatrists recognized the implications, lawyers and courts did not—not in right to treatment suits and, a half decade later, not even in the first wave of right to refuse medication suits.

Nor were medications' benefits as great, or as universal, as clinicians usually supposed. Hospital staff thought it self-evident that virtually every patient relapsed when medications were withdrawn, and that virtually no patient relapsed on a proper dose. Such beliefs were simply unfounded. Many patients do not relapse off drugs, at least over periods of up to two years, and many patients do relapse on medications. Almost all seriously mentally ill persons receive medications, George Crane noted in 1973, even though "fewer than 50 percent of patients hospitalized for several years improve in response" and even though drugs' capacity to forestall relapse, while significant, was not overwhelming.¹⁷ Crane observed that "60 to 70 percent of acute schizophrenics on no drugs are readmitted [to hospitals] within 1 year, while only 20 to 30 percent receiving some form of drug therapy require rehospitalization within 1 year."¹⁸ Thus, thirty to forty percent did not relapse within in a year despite their medication free status, while twenty to thirty percent did relapse in that same period, despite medications.¹⁹

It is difficult to see how lawyers could dismiss Crane's views, especially since he had formulated them while a researcher at NIMH. His views also accurately reflected existing literature. In 1976, Jonathan Cole (who was perhaps the country's leading medication researcher) and George Gardos examined relapse rates among medicated and placebo-treated outpatients. They concluded that "perhaps as many as 50% of such patients might not be worse off if their medications were withdrawn. In view of the long-term complications of antipsychotic drug therapy—primarily tardive dyskinesia—an attempt should be made to determine the feasibility of drug discontinuance in every patient."²⁰

Cole and Gardos also stated that "even in the most stable groups, a number of patients could be saved from the dangers of tardive dyskinesia as well as from the financial and social burdens of prolonged drug therapy"²¹ by adhering to the "major principle" that "*every chronic schizophrenic outpatient maintained on antipsychotic medication should have the benefit of an adequate trial without drugs.*"²²

The same principle applied with greater force outside of community settings, to chronic patients *within* mental hospitals. As a group, these pa-

17. Crane, *Clinical Psychopharmacology*, *supra* note 1, at 125.

18. Crane, *Clinical Psychopharmacology*, *supra* note 1, at 125.

19. See Crane, *Clinical Psychopharmacology*, *supra* note 1, at 125.

20. George Gardos & Jonathan Cole, *Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease?* 133 AM. J. PSYCHIATRY 32, 36 (1976).

21. *Id.* at 34.

22. *Id.* at 35 (emphasis in original).

tients did not respond well to medications. If they did, they would not have become chronic and remained hospitalized in the first place. Moreover, relapses posed less danger in hospitals where patients had constant supervision. For these reasons, psychiatrists had identified chronic inpatients as prime candidates for drug withdrawal ever since the discovery of tardive dyskinesia.²³ Yet right to treatment suits failed to address the practice of medicating nearly all chronic patients.

The litigation proceeded as though Crane's critics, and clinicians who prescribed medications indiscriminately, were right. Right to treatment decrees required adequate ventilation, clean kitchens, and functioning hospital pharmacies, but never seriously questioned every patient's need for medications. Medications constituted both the engine of deinstitutionalization, and the dominant force in the lives of patients and mental hospitals. Yet supposedly comprehensive "right to treatment" suits managed to pay almost no attention to them.

George Crane himself described the results. As an expert witness, Crane later examined patients in *Wyatt v. Stickney*,²⁴ the first class action right to treatment lawsuit. *Wyatt* had created the right to treatment reform case, and became the prototype for almost innumerable other lawsuits. A half decade after the *Wyatt* decision gave patients a right to be free of "excessive or unnecessary medication," Crane visited the affected hospitals and found a miserable situation regarding medications.²⁵

The trial record in *Rennie v. Klein* illustrated the problems that existed throughout the United States.²⁶ Thousands of patients, and five New Jersey state hospitals, were involved in this litigation. By the time of trial, in the late 1970s, tardive dyskinesia had supposedly become a matter of grave

23. See, e.g., Frank J. Ayd, *Persistent Dyskinesia—A Further Report*, INT'L. DRUG THERAPY NEWSLETTER, May 1967, at 19 ("the benefits of high doses, particularly in chronically ill patients over 40 years of age, in most instances, are so dubious that instead of prescribing high doses, treatment of another sort should be employed"); see also AMERICAN PSYCHIATRIC ASS'N, TARDIVE DYSKINESIA: REPORT OF THE AMERICAN PSYCHIATRIC TASK FORCE ON LATE NEUROLOGICAL EFFECTS OF ANTIPSYCHOTIC DRUGS 170 (1980) (describing "chronically hospitalized" patients as a "special case" that calls for "at least yearly, and preferably, twice yearly re-evaluations off neuroleptic medications"—to be achieved by reducing the dosage steadily until signs of relapse reappear or the dose reaches zero).

24. *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

25. Crane examined the patients as an expert witness for the United States Justice Department, which was litigating the *Wyatt* case at that point. To date, I have been unable to obtain Crane's deposition in that case, but he characterized his findings to me at the time in a personal communication. Earlier, the Department of Justice had asked me to recommend a potential expert witness on medication issues, and I gave them Crane's name.

26. *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978). I was the trial and appellate attorney during most of the *Rennie* case, and the trial record consists largely of evidence that I introduced. The account that follows comports with the trial judge's findings. It is also worth noting that neither the defendants nor the American Psychiatric Association (which participated as an *amicus* in the appeals) disputed this account of what New Jersey doctors actually did. Instead, the American Psychiatric Association suggested that New Jersey's state hospitals were uniquely bad ones.

psychiatric concern. Yet until that point, no state hospital physician in New Jersey had ever acknowledged a case of tardive dyskinesia. Two official reviews of the question (one by physicians at the state's medical school in 1974, which responded to public charges by social workers that tardive dyskinesia existed in the hospitals, and one by officials of the mental health department during the lawsuit) concluded that no New Jersey patient had tardive dyskinesia.²⁷

Testifying as an expert witness, Crane described the results of his own examination of hundreds of New Jersey patients and their charts. About one in four showed at least moderate symptoms of tardive dyskinesia, but no case was diagnosed. Beyond that, patient charts rarely even mentioned the symptoms (often bizarre movements) even when severe. In one case, for example, numerous parts of the patient's body were affected. Yet only a month before Crane's examination, a hospital neurologist had reported no symptoms or abnormalities. Nor had another examination found anything wrong, even though it was conducted in response to the lawsuit and was specifically designed to detect tardive dyskinesia.²⁸

Some hospital psychiatrists were undoubtedly incompetent and even unaware of tardive dyskinesia. But, the situation that Crane described required systematic efforts to avoid reporting the disorder. Physicians truly ignorant about tardive dyskinesia would have been struck by a patient's grotesque movements, and would have described them in patient charts. Yet, that rarely happened. Evidently, physicians knew precisely which symptoms not to notice or record.

On a few occasions, physicians did acknowledge the bizarre movements. For example, this would occur when relatives had complained about them, or, as happened in one case, when grotesque movements precluded a life for the patient outside of the hospital, and nothing else was wrong with him. In these instances, physicians attributed the bizarre symptoms to "nerves" or "faking." Both responses were indefensible; a patient could hardly "fake" such a disorder for every minute of his or her waking life (and would hardly bother, in any event, since the hospital never acknowledged tardive dyskinesia in the first place).

Physicians' responses varied when faced with other side effects such as tremor and stiffness, or nervousness and extreme restlessness. Physicians often administered a second medication to ameliorate the problem, assuming they had noticed it. If the symptoms did not respond to this second drug, doctors usually handled the matter as they did tardive dyskinesia; they denied the problem's existence, attributed it to nerves, or pronounced it "faking." There was no evidence that doctors recognized the possibility of a

27. See Sheldon Gelman, *Mental Hospital Drugging—Atomistic and Structural Remedies*, 32 CLEV. ST. L. REV. 221, 233 (1983) [hereinafter *Remedies*]. This article includes citations to the *Rennie* trial record.

28. See *id.* at 233.

patient responding to medications with distress.²⁹

These responses typified state hospital practice in the United States. Crane had inspected hospitals in various states, and testified that New Jersey's hospitals were representative.³⁰ The Joint Commission on Accreditation of Hospitals had accredited New Jersey's state institutions: it apparently found nothing remarkable about the institutions' medication practices, or about their claim (reported on accreditation forms) of a zero tardive dyskinesia rate.³¹ Moreover, New Jersey's practice followed the path laid down by leading psychiatric researchers, who had ignored tardive dyskinesia and other side effects starting in the early 1960s.³²

The language about "unnecessary medication" and "excessive medication" in right to treatment decrees was boilerplate that did not relate to actual problems. For example, no decree purported to judge "excess" by considering a patient's side effects. And every decree implicitly presumed that medications were necessary" (or at the least, not "unnecessary") no matter what a patient's actual response. Had courts and lawyers taken medications seriously (as they presumably would have if, for example, a form of brain surgery produced the identical profile of benefits and risks), the language of the decrees would have been obviously inadequate. (Imagine a decree that protected only against "unnecessary" and "excessive" brain surgery, or how hospitals would have understood such a decree during the heyday of lobotomy in 1949).

Under the classic model of attorney-client relationships, attorneys voice their clients' concerns. That did not happen in the right to treatment cases because one of the patients' principal complaints—medications—was effectively ignored. Beyond acting as their clients' voices, some attorneys also posit an obligation to safeguard a mentally ill client's real interests. Adding that element of paternalism to the mix still does not explain why right to treatment litigation ignored medications; many patients had good reason to complain, whether they actually did so or not. Nor does it explain why issues that were receiving attention among psychiatric researchers (tardive dyskinesia and patients who did not benefit from medications) played no role in the lawsuits. In fact, lawyers were ignoring the very things about medications that mental hospital clinicians ignored as they prescribed the drugs.

Lawyers and courts also ignored medications in the realm of legal the-

29. See Gelman, *Mental Hospital Drugs*, *supra* note 1, at 1757-60 (reviewing the litigation record and the available literature on management of other side effects).

30. See Gelman, *Remedies*, *supra* note 27, at 230-31.

31. See *id.* at 230, 233.

32. My forthcoming book documents these developments in detail. See GELMAN, *supra* note 11. For a classic account of psychiatry's response to tardive dyskinesia, see Crane, *Clinical Psychopharmacology*, *supra* note 1. See also Phil Brown & Steven C. Funk, *Tardive Dyskinesia: Barriers to the Professional Recognition of an Iatrogenic Disease*, 27 J. HEALTH & SOC. BEHAVIOR 116 (1986) (accepting much of Crane's account); and Gelman, *Mental Hospital Drugs*, *supra* note 1, at 1752-60 (describing developments).

ory. During this period, courts understood a “right to treatment” as requiring either “minimally adequate” mental hospital treatment or, in a more generous version of the right, “such individual treatment as will give . . . [patients] a reasonable opportunity to be cured or to improve . . . [their] mental condition.”³³ To sustain a right to treatment claim, then, attorneys had to prove that a particular hospital did not administer minimal or reasonable treatment. Yet nearly all patients received medications; and, according to leading researchers at this time, drugs constituted a revolutionary and truly “antischizophrenic” therapy. Such claims were seriously inflated, but presumably the attorneys did not know that. Even cautious psychiatrists regarded medications as very effective treatment for moderating psychotic symptoms. They believed medications to be, by far, the best available therapy.

Given such conclusions, medications alone should have qualified as a treatment that afforded patients “a reasonable opportunity to . . . improve.”³⁴ Thus, claims of a “right to treatment” violation should have failed because almost every patient received the drugs. At the same time, it does not appear that lawyers or courts considered medications ineffective; had they believed such a thing, attorneys surely would have objected vociferously. Medications would have been a useless treatment that many patients disliked, and that in fact caused considerable harm. So it was not that medications seemed ineffective. Rather, they became like the air that patients breathed—ever present in mental hospitals, indispensable, but worthy only of passing legal comment.

Had they recognized medications as a constitutionally adequate “treatment,” courts still would not have left mental hospitals entirely alone. An important component of right to treatment decrees dealt with patient safety (the physical environment in the hospital, the quality of ordinary medical services, violence) rather than with treatment as such. These safety concerns would have remained pressing even if medications constituted adequate “treatment.” What would have become virtually unsustainable, however, were the demands for additional therapeutic staff, new programs, more “therapeutic” environments, etc. Those very things had lent right to treatment litigation a revolutionary air, and, not incidentally, had added to the cost of complying with judicial decrees.³⁵

These “treatment” aspects of court decrees also had important ideologi-

33. *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974).

34. *Id.* at 520.

35. In 1982, the Supreme Court drew the distinction between safety and treatment. *See Youngberg v. Romeo*, 457 U.S. 307, 307 (1982). *Romeo* recognized a minimal right to safety in hospitals, but also cast doubt on the existence of a constitutional right to treatment apart from issues of safety and physical liberty. The *Romeo* Court powerfully discouraged any further mental hospital reform litigation. However, the Court left open the possibility that additional therapy might be constitutionally required in a particular case if it allowed the patient to enjoy a greater degree of liberty or safety.

cal implications. The lawsuits generally produced or coincided with rapid deinstitutionalization, as noted above. "Right to treatment" claims made that development appear legitimate. It was one thing to release patients as part of a process of upgrading treatment. It would have been another thing to discharge some patients simply in order to make mental hospitals safer for others. Yet, that would have been true if the lawsuits had sought only safety and not treatment. In the latter case, obvious questions arise about the rights and well-being of those discharged. With "treatment" such questions remain beneath the surface. "Treatment" related deinstitutionalization sounded like progress where "safety" related deinstitutionalization would have sounded like "dumping" or, at best, triage.

The right to treatment need not have developed as it did, and had appeared very differently at its birth, a decade earlier. The right was the brainchild of Morton Birnbaum, a lawyer-physician, who proposed it in a 1960 article for the *American Bar Association Journal*.³⁶ Birnbaum did so because he thought that state hospitals would remain the centerpieces of the public mental health system, and that medications would not significantly change matters. Thus, he believed that hospital staffing ratios, physician attention to patients, hospital programming and the like constituted the patients' only real medical hope.

Birnbaum presumed that medications did not represent a revolutionary treatment. He quoted at length from an article by another physician deploring the tendency to discharge patients more rapidly from hospitals because of medications. That happened, according to the quotation, despite the fact that many "patients continue to relapse and return to hospitals as before" and that many other patients "remain in their communities but are unable to adapt adequately even though their more disturbing symptoms are no longer present."³⁷ The quote concluded with a plea not to overvalue medications or undervalue hospitals:

Until we know a lot more about so-called mental disease and until we can treat the total person more successfully, let us continue to improve upon what we are able to do and not measure success by chemically induced tranquillity and the rate at which we discharge patients from our hospitals.³⁸

In case any doubt remained, Birnbaum added the following observations of his own:

Although it is hoped that new methods of treatment will be discovered that will allow a valid [ethical?] rapid increase in the discharge rate of the institutionalized mentally ill, at present, it appears that no such methods

36. Morton Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

37. *Id.* at 501 (quoting Sands, *Discharges from Mental Hospitals*, 115 AM. J. PSYCHIATRY 748 (1959)).

38. *Id.*

are on the horizon; therefore, it should be assumed that the need for more personnel and physical facilities will continue to exist.³⁹

Birnbaum's positions were completely transformed in right to treatment litigation, however. He had paid medications relatively little attention because he did not think they would (or, more precisely, that they should) produce dramatic changes. A decade later, attorneys paid medications virtually no attention even as the treatment was revolutionizing the mental health system, and after their serious side effects had become known. Unlike Birnbaum, reform attorneys generally hoped that more patients would be discharged into the community which they regarded as a state of "liberty." Again, unlike Birnbaum, the reform attorneys were unconcerned that deinstitutionalization resulted from the practice of medicating virtually every patient. Effectively turned upside down, Birnbaum's right became a means of advancing the very deinstitutionalization and medication objectives that he had deplored.

Birnbaum's idea got turned upside down in another way as well. Not foreseeing class actions and injunctions as the means of enforcing the right, he had proposed something more modest: allowing individual patients to obtain their release from a mental hospital on the ground that it had violated their "right to treatment." Birnbaum realized that this remedy conceivably could result in the release of the very patients he thought needed hospitalization. It was "[a]dmittedly . . . radical," he wrote, "[t]o release a mentally ill person who requires further institutionalization, solely because he is not being given proper care and treatment."⁴⁰ Doing so "may endanger the health and welfare of many members of the community as well as the health and welfare of the sick person."⁴¹ Birnbaum continued:

[H]owever, it should always be remembered that the entire danger to, and from, the mentally ill that may occur by releasing them while they still require further institutionalization can be removed simply by our society treating these sick people properly. This is an important reason why the right to treatment is being advocated. For if repeated court decisions constantly remind the public that medical care in public mental institutions is inadequate, not only will the mentally ill be released from their mental prisons, but, it is believed that public opinion will react to force the legislatures to increase appropriations sufficiently to make it possible to provide adequate care and treatment⁴²

In the end, however, the right to treatment upended this expectation of its creator too. Not only did a legal construct premised on the inadequacy of medications and the necessity of mental hospitals become a legal instrument for replacing hospitals with a system of "community" medication, but a

39. *Birnbaum*, *supra* note 36, at 501.

40. *Id.* at 503.

41. *Id.*

42. *Id.*

right designed to trigger public outrage over the release of patients did the opposite. As actually deployed, the right to treatment made wholesale deinstitutionalization seem progressive, a happy congruence of medical revolution and legal advance. By dampening public concern over deinstitutionalization, the lawsuits turned Birnbaum's dream into his nightmare, and then turned both into reality. With medications and deinstitutionalization thoroughly identified with progress, no one noticed the difference.

II. THE RIGHT TO REFUSE MEDICATIONS

In the mid-1970s, another type of mental hospital class action appeared—the “right to refuse medications” suit. This “right to refuse” rested on a conventional legal ground: the prerogative of each competent person to decide on his or her own medical treatment.⁴³ Since few institutionalized patients had been declared incompetent, they arguably retained that right. Moreover, if an incompetent patient needed a guardian, common principles pointed to the selection of someone other than a hospital physician in order to avoid a conflict of interest. And, even if a patient was incompetent, little precedent allowed states to assume control over a person's biological functioning.⁴⁴

Precedent did exist for forcing medications, but not the kind that would attract contemporary support for the practice. After World War II, state hospitals had forced therapies such as lobotomy and insulin coma therapy with little if any legal formality.⁴⁵ Yet those therapies seemed disreputable in the medication era. Thus, past practice suggested, if anything, that psychiatrists should *not* have power to force the prevailing treatment of the time.

The virtual absence of legal activity in the early 1970s seems remarkable with medications so widely used and so disliked by patients, and with arguments in favor of a right to refuse so substantial. At the time, courts and legislators were recognizing a right to refuse less common treatments such as lobotomy and electroconvulsive therapy. Many supposed that courts would do the same for medications. Among them was Alan Stone, a Professor of Law and Medicine at Harvard, who prophesied that courts

43. *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971) (holding that hospitalization per se did not render a person incompetent). See generally Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283 (1992), for a comprehensive survey of the right to refuse medications litigation.

44. See generally Sheldon Gelman, *The Biological Alteration Cases*, 36 WM. & MARY L. REV. 1203, 1294 (1995) [hereinafter *Biological Alteration*] (arguing that prior to 1990 the Supreme Court had never sustained a state biological intervention that caused the “serious, widespread side effects” that medications do).

45. Regarding this era in psychiatry, see ELLIOT S. VALENSTEIN, *GREAT AND DESPERATE CURES: THE RISE AND DECLINE OF PSYCHOSURGERY AND OTHER RADICAL TREATMENTS FOR MENTAL ILLNESS* (1986).

would recognize the right to refuse.⁴⁶ Moreover, some state Attorneys General supposed that the right already existed, though the state hospitals typically acted as though it did not.⁴⁷ And when a federal appellate court first addressed the issue squarely in 1975, it strongly suggested that mental patients possessed the right. That case was a *pro se* action by a mentally ill man who had killed his grandmother. In a nation with a sizable mental health bar and a burgeoning docket of lawsuits over mental hospitals, he was arguably the leading litigator of medication issues.

Despite the right's evident doctrinal support, it received almost no attention. The leading law and psychiatry text in 1974 could cite only four right to refuse medication cases.⁴⁸ Two were petitions by individual prisoners objecting to a federal penitentiary's practice of forcing medications; one prisoner represented himself, and both lost in 1968.⁴⁹ At about the same time, a Michigan woman successfully sued for monetary damages after a physician forcibly medicated her during her "temporary" commitment in a private psychiatric hospital. The plaintiff's estranged husband had her confined under questionable circumstances, and the Michigan Supreme Court held both that a "husband can[not] force medical care upon his wife"⁵⁰ and that "private psychiatric hospitals lacked the power that public institutions had to force treatment on temporarily committed patients."⁵¹ None of these three lawsuits evidenced the kind of reformist impulse that animated right to treatment cases. None was a class action, or involved a state mental hospital, or came from the kind of non-profit, legal reform organization that brought right to treatment suits.

The fourth medication case, *Winters v. Miller*,⁵² was different. Filed in the late 1960s, it involved a state mental hospital defendant and the New York Civil Liberties Union (a reformist legal organization).⁵³ Bruce Ennis, the Civil Liberties Union attorney who represented Ms. Winters, went on to play a leading role in the first class action right to treatment case, *Wyatt v. Stickney*, and later became the country's best known litigator in mental hos-

46. See Alan A. Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 AM. J. PSYCHIATRY 273 (1977); see also Alan A. Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make it Work*, 38 ARCHIVES GEN. PSYCHIATRY 358, 358 (1981) (observing that "once the issue was presented to the courts the result was almost inevitable").

47. For example, the Massachusetts Attorney General did not object to a federal court restraining order in 1975 that barred forcible medication in state hospitals; presumably, the Attorney General believed forced medication was *prima facie* illegal. See *Rogers v. Okin*, 478 F. Supp. 1342, 1353 (D. Mass. 1979) (describing the case's procedural history).

48. BROOKS, *supra* note 2, at 897.

49. See *Peek v. Ciccone*, 288 F. Supp. 329 (W.D. Mo. 1968); *Veals v. Ciccone*, 281 F. Supp. 1017 (W.D. Mo. 1968) (prisoner represented himself).

50. *Stowers v. Wolodzko*, 191 N.W.2d 355, 360 (Mich. 1971).

51. *Id.* at 362 (distinguishing instances in which treatment is "necessary to keep a person on the premises or to prevent harm to the patient or to others").

52. *Winters v. Miller*, 306 F. Supp. 1158 (E.D.N.Y. 1969).

53. See *id.*

pital reform cases.⁵⁴ Based on *Winters*, one might have foreseen medication refusal, not the right to treatment, as the most important issue in future reform litigation.

In *Winters*, a New York mental hospital had forcibly treated a temporarily committed woman, who had not yet had any type of court hearing, and who had asserted religious reasons for refusing treatment.⁵⁵ The woman sued for damages, but in 1969 the trial court dismissed her complaint on the ground that the hospital had the right to force treatment. In 1971, the Second Circuit overturned that conclusion and remanded the case for trial.⁵⁶ The appellate court's reasons were not entirely clear; at a minimum, it appeared that a non dangerous, temporarily committed person should have a judicial commitment hearing before the hospital forced medications, at least when the patient's objection rested on religious grounds.⁵⁷

Despite this success, *Winters* did not spawn other challenges to forcible medication. Indeed, Bruce Ennis soon described the case as primarily about the rights due to religious believers in mental hospitals, and not as a challenge to the prevailing biological therapy in psychiatry.⁵⁸ Beyond that, *Winters* relied almost entirely on legal abstractions in reaching its result, rather than on the nature of medications. Thus, neither the appellate court opinion nor Ennis' later account of the litigation said anything about the medications' benefits or risks, or about the medical reasons why someone might refuse them. The court's opinion treated "medications" as an indiscriminate category with a fungible membership, noting only that "for the most part" the drugs Ms. Winters had received consisted of "rather heavy doses of tranquilizers."⁵⁹ Had the hospital forced Ms. Winters to take an aspirin or an allergy pill, it appeared that the analysis would have remained the same: the issue was "medications" in general, not the particular drugs that the states and psychiatrists now favored. Whether the medications caused permanent neurological changes or distress seemed irrelevant.

In retrospect, this aspect of *Winters*, and of the other medication cases before 1975, seems as surprising as any development during this period. As noted above, psychiatry was already in ferment over Crane's findings of widespread tardive dyskinesia, and the Journal of the American Medical Association had already editorialized about the dangers of permanent side ef-

54. Ennis described his work for the New York Civil Liberties Union on behalf of mental patients in BRUCE ENNIS, PRISONERS OF PSYCHIATRY; MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW (1972) (his account of the *Winters* case appears in pages 128-44; the plaintiff, Miriam Winters, is given the pseudonym "Mary Summers").

55. See *Winters*, 306 F. Supp. at 1160.

56. *Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971).

57. For discussion of the uncertainties in the *Winters* opinion, see Gelman, *Mental Hospital Drugs*, *supra* note 1, at 1728 n.27.

58. See ENNIS, *supra* note 54, at 128-44 (describing the case).

59. *Winters*, 446 F. 2d at 68.

facts.⁶⁰ Yet, none of that ferment or that concern managed to penetrate the world of lawyers, courts and rights.

Nor did that change as the right to refuse medications came of age during the mid and late 1970s. Two class actions, *Rogers v. Okin*⁶¹ and *Rennie v. Klein*,⁶² became the prototypes for “right to refuse” litigation. Both represented the work of law reform agencies and both named state mental hospitals as defendants. These cases attracted enormous attention from lawyers and psychiatrists, and even produced front page stories in leading newspapers.

The earlier case, *Rogers*, began in 1975 as a challenge to seclusion practices and forced medication at Boston State Hospital. *Rennie* began as an action by a single patient in 1977, and turned into a class action the next year. In neither case did the medical ferment over tardive dyskinesia play much of a role during the early stages of litigation. No named plaintiff in *Rogers* had the disorder, or for that matter ever developed it.⁶³ Mr. Rennie became a victim of tardive dyskinesia only after his litigation had begun; and the possibility it might develop played no role in the decision to file his lawsuit.⁶⁴

A decision on the merits of each case appeared in 1979. The *Rogers* opinion, like that in *Winters*, focused on legal abstractions and general legal rights.⁶⁵ Now, however, the existence of tardive dyskinesia received considerable attention as a factor relevant to the assessment of patients’ rights. The district court noted that “recent studies” had “suggest[ed] that tardive dyskinesia is more widespread in mental patients than previously [thought]” and cited psychiatric research estimating that fifty percent or more of chronic patients, and over forty percent of outpatients treated with medications developed tardive dyskinesia.⁶⁶ Moreover, although none of the named plaintiffs had the disorder, “several” defendants conceded that “other patients” at the hospital did.⁶⁷

Rennie dealt in legal abstractions as well, but (to a greater extent than *Rogers*) the court record documented the hospitals’ actual response to tardive dyskinesia and other side effects. The results, including George Crane’s testimony, are described above. Although New Jersey hospitals had never before acknowledged so much as a single case of tardive dyskinesia, mid-way through the trial they conceded that twenty five to fifty percent in fact developed it.⁶⁸ The decade-old posture of denying tardive dyskinesia

60. See Editorial, *supra* note 15.

61. *Rogers v. Okin*, 457 U.S. 291 (1982).

62. *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978).

63. See *Rogers*, 478 F. Supp. at 1342.

64. See *Rennie v. Klein*, 476 F. Supp. 1294, 1302-13 (D.N.J. 1979).

65. See *Rogers*, 478 F. Supp. at 1360.

66. *Id.* at 1360.

67. *Id.*

68. See *id.* at 1300 (describing the testimony of the hospital’s medical directors).

had proved impossible to sustain in litigation. What had thrived in the culture of mental hospital psychiatry simply collapsed when exposed to courts and outside scrutiny.

Largely in connection with these lawsuits, the national press carried some of the most critical articles about a prevailing psychiatric therapy to appear since the era of lobotomy.⁶⁹ The *Rennie* judge castigated the hospitals for ignoring tardive dyskinesia and for badly mishandling other side effects. And new cases began to appear, in much the same way that the first right to treatment case had spawned copies.⁷⁰

In part because of the litigation, in part because of the media accounts of it, and in part because of new research reports finding high tardive dyskinesia rates, the psychiatric ground shifted. Leaders of the profession now acknowledged double digit rates of tardive dyskinesia (although the "consensus" now estimated its prevalence at only about fifteen or twenty percent) and the old claims that medications did not cause the disorder fell into disfavor.⁷¹ At the same time, many psychiatrists attached less importance to tardive dyskinesia as a factor in prescribing. Urging clinicians to carefully weigh the risks against the benefits of medications, leaders of the profession nonetheless supposed that a decision to continue medication would be the result of that weighing. Within clinical practice, the profession's acknowledgment of tardive dyskinesia had virtually no discernible effect; medications continued to be prescribed at the same or higher doses, and to as many patients, as before.⁷²

Nor did legal holdings significantly affect prescribing practice. Different varieties of the "right to refuse medications" received recognition in the cases. Some recognized a nominal right to refuse, but allowed a mental hospital director or other hospital officials to override the patient's refusal and force medications. That was the outcome of *Rennie*. Others recognized a seemingly more substantial right, requiring that hospitals respect a patient refusal absent a judicial adjudication of the refuser's incompetence and/or a judicial assessment of the reasons for and against compelling medications. After a tortuous course of litigation in federal and state courts, that was the outcome in Massachusetts, where *Rogers* had been litigated.⁷³ Yet neither version of the right, nor any in between, significantly affected medication

69. See, e.g., Peter Sterling, *Psychiatry's Drug Addiction*, NEW REPUBLIC, Dec. 8, 1979, at 14.

70. See generally Cichon, *supra* note 43 (surveying the cases).

71. See AMERICAN PSYCHIATRIC ASS'N, *supra* note 23.

72. See Gerard T. Reardon et al., *Changing Patterns of Neuroleptic Dosage Over a Decade*, 146 AM J. PSYCHIATRY 726, 727-29 (1989) (surveying a hospital psychiatric ward, a community mental health center, and a state mental hospital, Reardon reported that "the overall mean dose [of medications] doubled at each center between 1973 and 1982." The study ended in 1982, but Reardon observed that its results "confirm[ed] . . . the impression of many clinicians and investigators that higher doses of antipsychotics are being routinely used.").

73. *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E. 2d 308 (Mass. 1983) (answering questions certified by the First Circuit Court of Appeals).

prescribing or (so far as anyone can tell) the incidence of tardive dyskinesia and other side effects.

Rennie-type decrees, which allowed hospital officials to override patients' refusals, could at most guarantee that individual physicians would conform to prevailing prescribing standards in the hospital. But the prevailing practice entailed medicating virtually all patients, whatever the actual benefits or side effects in a particular case. That circumstance, rather than an occasional deviation by an individual physician, produced the high incidence of tardive dyskinesia.⁷⁴ And, as the *Rennie* trial record demonstrated, hospitals often found a way to consider medication "voluntary," even if that meant threatening to hold the patient down for an injection.⁷⁵

Despite their substantial court procedures, *Rogers*-type rights seemingly have had little more effect. In an overwhelming number of cases, courts uphold the hospitals' power to force the medications. A review in Massachusetts, for example, found that courts allowed forced medication in 98.6 percent of the cases.⁷⁶ Moreover, as the psychiatrist Paul Appelbaum observes, few patients are reported to refuse medications for any substantial time in the first place.⁷⁷

Appelbaum himself sees evidence of benefit from both types of court decree, however. The existence of the right to refuse, he believes, has led to negotiation between refusing patients and their psychiatrists. Noting that thirty percent of patients cite side effects as a reason for refusing, Appelbaum comments that "it should be possible to end many refusals by negotiating . . . about the dose and type of medication."⁷⁸ For example, Appelbaum cites a study finding that about a quarter of patients reacted to medications with distress, and he implies that negotiation could alleviate the problem.⁷⁹

Although negotiation undoubtedly occurs, Appelbaum's conclusions are unduly optimistic. For instance, the study of patients who responded to medications with distress did not claim that changing the dose or the drug would necessarily eliminate the problem.⁸⁰ In many cases, no "negotiation" will do so; Appelbaum's assumption that a comfortable dose exists for everyone arises from his views about the law and about what should be done, not from medical research. Studies other than those cited by Appelbaum find very high rates of patient dissatisfaction with medication.⁸¹ And while

74. See Gelman, *Remedies*, *supra* note 27, at 235-40.

75. *Rennie v. Klein*, 476 F. Supp. 1294, 1304 (D.N.J. 1979) (noting that patients were "too intimidated to attempt to refuse medication and would still be ignored [if they tried]").

76. See PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 143 (1994) (describing the results of a study undertaken by the state).

77. See *id.* at 140.

78. *Id.* at 142.

79. See *id.*

80. See Van Putten & May, *supra* note 5.

81. See M. Wallace, *Schizophrenia—A National Emergency: Preliminary Observations on SANELINE*, 89 *ACTA PSYCHIATRICA SCANDINAVICA SUPPLEMENTUM* 33 (1994) (reporting that

thirty percent of patients may cite side effects as a reason for refusing, as Appelbaum says, many more patients than that in fact suffer side effects. The Yale Tardive Dyskinesia Study estimates that a majority of patients maintained on medications long-term will develop tardive dyskinesia, alone; thus, a probable majority of Appelbaum's non-refusing and "negotiating" patients will probably do so.⁸²

Perhaps most importantly, Appelbaum does not suggest that significantly more patients will manage to remain medication-free for any length of time because of a legal right to refuse medications. The fact that patients generally will end up on medications gives Appelbaum satisfaction, since he believes that "it makes no sense to create a system that allows us to hospitalize people against their will and then decline to treat them with medication."⁸³ Again, that reflects his undefended assumption that the patients should receive medications, whether they want to or not. Taking the risks of medication more seriously, one might regret that legal interventions have, by and large, failed to influence events.

Appelbaum simply assumes that medications benefit almost every seriously mentally ill person, in a medical sense. From that, it follows that objections to medications must fall into three, somewhat overlapping categories: (1) those groundless, mad or delusional; (2) those based on legal or moral concepts of individual autonomy, rather than on medical considerations; and (3) those that result from a particular clinician's failure to find the optimum drug or dose. Appelbaum himself once vociferously objected to the right to refuse, in effect treating the legal right itself as something akin

most people taking the medications dislike how the drugs make them feel); Samuel Gershon, *Concluding Summary to the Neuroleptic-induced Deficit Syndrome: Proceedings of the First International Meeting on the Neuroleptic-Induced Deficit Syndrome*, 89 ACTA PSYCHIATRICA SCANDINAVICA SUPPLEMENTUM 83, 84 (1994) (a psychiatrist observing that "anyone who takes . . . [these medications] gets a neuroleptic-induced deficit syndrome: that is, one's head is fuzzy, it feels as if it is packed with cotton, one cannot think straight, and one cannot do one's work. I have tried taking these drugs, and it is extremely difficult to get your thoughts straight").

82. See William M. Glazer et al., *Predicting the Long-Term Risk of Tardive Dyskinesia in Outpatients Maintained on Neuroleptic Medications*, 54 J. CLINICAL PSYCHIATRY 133, 137-38 (1993); Hal Morgenstern & William M. Glazer, *Identifying Risk Factors for Tardive Dyskinesia Among Long-term Outpatients Maintained With Neuroleptic Medications: Results of the Yale Tardive Dyskinesia Study*, 50 ARCHIVES GEN. PSYCHIATRY 723 (1993).

83. APPELBAUM, *supra* note 76, at 150. At other points, Appelbaum's analysis reflects wishful thinking on his part. He is obviously aware that researchers have suggested withdrawing chronic, hospitalized patients from medications because of the high risk of tardive dyskinesia and the evidently minimal benefits chronic patients derive from the treatment, at least in terms of preparing them for release from the hospital. Appelbaum does not describe this research, but he says it is "possible" that "chronic patients with intractable symptoms" may "be able to persuade their psychiatrists to respect their desires to decline medication." *Id.* at 142-43. No evidence is cited for these "possibilities." Nor does Appelbaum note that clinicians have ignored the advice about withdrawing medications from chronic patients for a quarter of a century. How deteriorated, chronic patients would acquire the wherewithal to persuade clinicians—on a point where leading researchers have utterly failed to affect clinical practice—remains a mystery.

to a mad or groundless objection.⁸⁴ He has now moderated his views because he recognizes more objections of the third kind, which he supposes will lead to “negotiation” and an optimum dose. And he continues to reject objections of the second kind (based on moral autonomy) because “it makes no sense” to commit people and not medicate them.⁸⁵ Yet all of this assumes that the case for almost universal medical benefits from medication is clear, and that no moral considerations are intertwined with the medical judgments.

Both positions are mistaken. Researchers estimate that ten to forty percent of patients do not measurably benefit from medications, yet it is clear that most of those people receive them anyway.⁸⁶ “Right to refuse treatment” litigation did virtually nothing for this group. Even more importantly, during the 1960s and early 1970s it seemed far from clear that patients who developed permanent side effects, or were at high risk for them, should routinely receive medications. The objection to medications in this case was both medical and moral, and it had vast implications. Among psychiatrists, a widespread assumption existed that if drugs caused such effects, their use would be (and perhaps should be) curtailed.

Viewed in this light, “right to refuse” litigation legitimated questionable practices more than it did anything else. The lawsuits greatly contributed to public and professional awareness of tardive dyskinesia, it is true, but they also produced broad public acceptance of the idea that permanent neurological damage from medications did not necessarily rule out treatment, even forced treatment. Before *Rennie* and *Rogers*, it appeared far from obvious that the public would accept even a ten percent tardive dyskinesia rate. The prospect of public resistance, I believe, explains the refusal of many researchers and virtually all clinicians to acknowledge the disorder in the first place. After *Rennie* and *Rogers*, however, a fifty percent tardive dyskinesia rate seemed well within reason—regrettable certainly, but hardly cause for radical changes in psychiatric practice.⁸⁷

Without “right to refuse” litigation, the public would have faced a choice: tolerate widespread permanent side effects of medication or signifi-

84. See Thomas Gutheil & Paul Appelbaum, “Rotting With Their Rights On”: *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & LAW 306 (1979).

85. APPELBAUM, *supra* note 76, at 150.

86. See David Pickar, *Prospects for Pharmacotherapy of Schizophrenia*, 345 LANCET 557, 557 (noting that “30% to 40% of patients with schizophrenia may have an inadequate or poor response to traditional antipsychotic neuroleptics”); William T. Carpenter, Jr. & Robert W. Buchanan, *Medical Progress: Schizophrenia*, 330 N.E. J. MED. 681, 686 (1994) (“about 10% to 20% of patients have a poor response to antipsychotic drugs, and most patients have an incomplete response”).

87. Indeed, early in the *Rennie* litigation the trial held that medications could not be forced if a permanent side effect would result; by the end of the case, however, that restriction disappeared, and Rennie himself received medications involuntarily though the court acknowledged that he was developing tardive dyskinesia. See *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978).

cantly alter psychiatric practice. With courts ostensibly taking care of the problem, the necessity for that choice was avoided. What once had seemed intolerable became, in connection with the lawsuits, a regretted but apparently unavoidable fact of life. Today, psychiatrists remain reluctant to baldly state that obvious truth. But, no one worries any longer that the widespread use of medication will change because of tardive dyskinesia.

If "right to refuse" litigation speeded public acceptance of questionable public health policy, and quieted moral doubts, it was only following in the footsteps of right to treatment lawsuits. The right to treatment, as noted above, contributed to social acceptance of deinstitutionalization, thereby confounding the hopes of its creator. Litigation over treatment refusal simply enabled society and public decision-makers to accept the means (near-universal medication) and the incidents (tardive dyskinesia) of that great transformation in public mental health policy.

To appreciate what actually happened, it is helpful to consider what did not. No legal case portrayed the high level of side effects or permanent neurological damage associated with medications as wrongs in themselves. *Rennie* paid the most attention, but it still cited side effects as a reason for recognizing a right to refuse—not as a problem or wrong standing alone. Yet even if a right to refuse had represented as mad an idea as Appelbaum once thought it did, the extent of medication induced harm still should have constituted cause for alarm.

No lawsuit contemplated the kind of legal remedy that might have made a significant difference. No injunction protected against any particular side effect or required maintaining any number of patients medication-free. Nor did any court require hospitals to regain the capacity of managing mentally ill patients without medications—a capacity all but lost with the pervasive use of medications.

Without such measures, the most robust right to refuse medications left judges (and patients) facing a stark reality. Since virtually no institution (community or otherwise) is any longer willing or equipped to deal with psychotic episodes and not use drugs, the judges who hear individual cases must consign patients to a hopeless limbo if they uphold the right of refusal. Not surprisingly, they prefer not to do so. The fact that courts uphold virtually all applications to force medications reflects this failure of the law, not any success of medications.

A common view of the preceding era in psychiatry (the era of lobotomy) holds that psychiatric interventions then produced too severe consequences. That moral and legal problem survived the shift from lobotomy to medications. Indeed, medications cause harm on a far wider scale because of their much more common use. By 1980, however, the law and lawyers simply refused to recognize that fact. Partly because of this, much of the public did too.

And so it happened that the main developments in twentieth century public mental health (deinstitutionalization, near universal medication for

the seriously mentally ill, side effects and permanent neurological changes on a scale previously unknown in public psychiatry or, for that matter, in almost any sphere of public activity⁸⁸) remained largely outside of the law's attention and concern. The fact that this happened is remarkable. At the time, a widespread feeling existed that lawyers and courts had psychiatry under siege, and that law had penetrated to the very core of psychiatric institutions and practice.

Nor was that the only profound misunderstanding of what was underway. Psychiatrists such as Appelbaum complained that litigators and courts insufficiently appreciated their profession and their science. But that got things backwards. In fact, organized psychiatry would have faced far more scrutiny had lawyers taken research findings and conclusions about medications more seriously. Contrary to the usual claims, it was precisely lawyers' insufficient appreciation of psychiatry that allowed the profession to stay the course.

At the heart of psychiatric and legal developments in the 1960s and 1970s lies the modern public health system of small mental hospitals and short hospital stays, "community" living and near universal prescription of medications. One can speculate about how legal and medical developments contributed to this system's realization. Yet it makes more sense, I think, to ask how the emerging public health system shaped developments in psychiatry and law. In the area of medications, the answer is that the system's imperatives often underlay the actions of lawyers, psychiatrists, and judges. The course of the legal right to treatment, the psychiatric ignoring of medications' side effects, the later legal failure to notice medications, the turn in the courts that allowed states to forcibly medicate past the point of neurologically damaging the patient—all seem anomalous, or at least surprising, if one thinks of ordinary professional processes in psychiatry and law. And yet each development advanced the new system of medicating and deinstitutionalizing patients. Without widespread medication, deinstitutionalization could not have occurred as it did; and nothing seriously interfered with it. Neither side recognizes the fact, but lawyers and psychiatrists became soldiers in the same questionable cause.

88. See generally Gelman, *Biological Alteration*, *supra* note 44 (observing that, historically, courts have hesitated to allow states to intervene biologically and cause harm).

