When cases involving a civilly committed individual's right to refuse medication began to navigate their way through the appellate process in the 1980s, medical considerations about antipsychotic medications played a limited role in court opinions. Initially, the focus of judicial decision-making was on determining whether a patient had a constitutional right to refuse treatment with antipsychotic medication and if so, what the legal basis was for such right. However, once courts universally recognized a civilly committed individual's constitutional right to refuse medication, the courts began to turn their focus to the procedural aspect of the right. In other words, the courts began to develop standards or tests in order to determine when physicians are permitted to override an individual's right to refuse treatment with antipsychotic medication.

One approach, taken by federal courts, is to defer to the opinions of treating physicians. This approach is known as the "professional judgment" standard, which places the burden of weighing the risks and benefits of antipsychotic medication on medical professionals. Under the "professional judgment" standard, the court asks whether a decision such as forcible use of antipsychotic medication is 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." Judge Adams writing the concurrence in Rennie v. Klein, 720 F.2d 266, explained that a physician treating patients in a state mental hospital "must, at the very least, consider the side effects of the drugs, consult with other professionals and investigate other options available before that physician can be said to have discharged full professional judgment." Judge Seitz added in a separate concurrence that determining whether to administer antipsychotic medication against a patient's will is "by its nature fact-specific." In jurisdictions that have retained a "professional judgment" standard, federal courts themselves do not have to consider in detail the risks and benefits of antipsychotic medications. Rather, they defer to the judgments of medical professionals.

In contrast, some state courts apply a "least restrictive means" test or a "best interest of the patient" standard, where the burden is on the court to assess the medical risks and benefits of treatment by antipsychotic medication before deciding whether to override a patient's refusal of the treatment. In 2000, the Ohio Supreme Court heard Steele v. Hamilton County Community Health Board, where it articulated the procedural aspect of the right to refuse as allowing a court to issue an order permitting forcible medication, without finding that a patient is dangerous, when the court finds by clear and convincing evidence that: (1) a patient lacks the capacity to give informed consent to the treatment; (2) the medication is in the best interest of the patient; and (3) no less intrusive treatment will be as effective in treating the mental illness. The second and third prongs of the test are the most significant, since they require the court to make medical considerations about antipsychotic medication.

As one might expect, under the state standard, the judges in Steele v. Hamilton dedicate a significant part of the opinion to the medical implications of treating a patient with antipsychotic medication. The Ohio Supreme Court has explained that administering antipsychotic medications to patients against their wishes is "particularly severe" since the drugs alter the chemical balance in a patient's brain, which changes his or her cognitive processes. The court further stated that the alterations and other negative side effects associated with the drugs could be "severe and/or permanent."

Over the years, state courts have repeatedly applied the legal standards in the context of patients who have been prescribed first- or second-generation antipsychotics. However, as the field of medicine evolves, a third generation of antipsychotic medication has been introduced into the clinical setting. It is quite possible that this third generation of antipsychotic medicines will no longer target dopamine, but rather serotonin, which is a chemical known to affect an individual's mood. This means that as medicine changes, state courts responsible for weighing the risks and benefits of antipsychotic medications should rebalance the factors that determine the "best interest of the patient" or the "less intrusive treatment."

In order to facilitate this transition, the state courts should consult only the most current and credible resources to guide their analysis. For example, it is important to include psychiatrists in the court's decision-making process. In some state cases the testimony of psychiatrists have educated the judges on the types of drugs currently

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2 Id. at 272 (Adams, J., concurring).
3 Id. at 271 (Seitz, J., concurring).
5 Id. at 15.
6 Id. at 16 (citations omitted).
7 Id. at 16-17 (citations omitted).
8 Third Generation Antipsychotic Drugs: Partial Agonism or Receptor Functional Selectivity, 16 CURRENT PHARMACEUTICAL DESIGN 488, 500 (2010).
Antipsychotic Treatment continued...

prescribed to mental health patients, which is essential to a court’s analysis, when newer drugs were not even in existence at the time cases such as Rennie v. Klein were decided in the federal courts. However, the drawback of having psychiatrists testify is that they have a bias towards using antipsychotic medication to treat mental health patients. In order for the court to have testimony representative of the entire mental health profession, the court should have encouraged input from psychologists, too, because they tend to be less willing to advocate for treatment by medication.

Courts should also consider requesting amicus briefs on an antipsychotic medication at issue in a right to refuse case. Ideally, the briefs would be submitted by professional organizations with members involved in the practice of medicine, specifically the treatment of mentally ill patients. As mentioned with regards to testimony, courts have to be aware of the potential for bias. For example, in the amicus briefs submitted to the Court in Washington v. Harper, the American Psychiatric Association submitted a brief bolstering the therapeutic benefits of antipsychotic medications, while the American Psychological Association submitted a brief emphasizing the negative side effects of antipsychotic medications. The risk of bias should not stand in the way of a court reviewing the briefs and using them to support its analysis, as long as the judges believe that the briefs were prepared in close proximity to the case and are supported by reliable scientific studies.

In conclusion, while both federal and state courts recognize a civilly committed individual’s right to refuse treatment by antipsychotic medication, the courts have adopted different tests or standards to determine when it is appropriate to override the patient’s right. In federal courts, judges employ the “professional judgment” standard, which allows the court to defer to medical professionals as long as they adequately weigh the risks and benefits to the patient. In state courts, judges consider whether treatment with antipsychotic medication is the “least restrictive means” and within the “best interest of the patient,” despite the patient’s refusal. This second approach requires that the court consider the risks and benefits associated with the treatment. In order to ensure that state court analyses continue to develop concurrently with medicine, judges must consider testimony by medical professionals and amicus briefs submitted by professional organizations.

Commentary: Presymptomatic Genetic Testing in Children

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As a genetic counselor, I am often tasked with the interpretation of genetic screening or test results for my patients, and attempt to provide answers to questions such as “What does having this mutation mean to me?” Or, “My amniocentesis results show that my baby will have Down syndrome? What can I expect for her?” And while answering these questions is vital, I believe the most important and difficult part of my interaction with patients occurs prior to them undergoing genetic testing.

I often talk with them about their “risk” or potential of having a genetic condition themselves, or, in a prenatal context, the “risk” for their unborn child to have a genetic condition. This may be a chromosome condition, such as Down syndrome, or a single gene condition, such as cystic fibrosis. I ask them to imagine how they might feel if their baby, indeed, has the condition, and they learned of the diagnosis early in the pregnancy. I ask them to consider how the same situation may feel different if they learned of the diagnosis after the baby was born. They have the opportunity to imagine, and on some level, experience these feelings prior to having to accept the information from the genetic testing. I then ask them to decide if this information they will benefit from, or if it is something that the baby may benefit from directly. I ask them to consider if this information has the potential to cause them more distress than do any good.

In order to answer these questions, one must consider the idea of a derived benefit more closely. A benefit is something that is advantageous or good, that can result from a specific action or choice. If medical care for the patient or the pregnancy will change as a result of the information learned, there may be a direct benefit. If nothing will change for the better, either from a medical management standpoint, or with regard to a patient’s emotional well-being, there may not be a benefit. Similarly, if one is likely to undergo significant psychological stress from learning about a diagnosis, this may cause harm rather than provide direct benefit. By asking my patients to imagine both scenarios, I have them weigh perceived benefits against potential harms in a way that they aren’t typically asked to do. This is a fairly sophisticated intellectual endeavor, and something that many of my patients are not used to doing.

Typically, if the health care provider “recommends” a test, most often it is accepted by the patient with no further questions or thoughts about the future that those results might bring. My role and ethical responsibility as

11 See id. at *10; see also Brief of the American Psychological Association, at *5.