CONSTITUTIONAL LAW – RIGHT OF PRIVACY – ALASKA CONSTITUTION REQUIRES JUDICIAL REVIEW BEFORE MENTAL HEALTH TREATMENT FACILITIES MAY MEDICATE INVOLUNTARILY-COMMITTED, MENTALLY-ILL PATIENTS AGAINST THEIR WILL IN NON-EMERGENCY SITUATIONS. *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006).

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I. INTRODUCTION

In *Myers v. Alaska Psychiatric Institute*, the Supreme Court of Alaska vacated an involuntary treatment order issued by the superior court on the grounds that sections 7 and 22 of article one of the Alaska Constitution, guaranteeing liberty and privacy,[1] respectively, afford involuntarily-committed, mentally-ill patients the fundamental right to refuse antipsychotic medication in non-emergency situations.[2] This comment will suggest that the court reached a sound decision, employing judicial intervention to strike a balance between the medical and legal interests of both mentally-ill patients and treatment facilities.

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1. The Alaska Constitution provides that: "No person shall be deprived of life, liberty, or property, without due process of law." ALASKA CONST. art. I, § 7. It further states that: "The right of the people to privacy is recognized and shall not be infringed." *Id.* art. I, § 22. While the former provision has a federal counterpart, the latter right to privacy is not expressly mentioned in the United States Constitution. *See* Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 245 (Alaska 2006). Because privacy is expressly found in the Alaska Constitution, the courts of Alaska construe the protected right to privacy more broadly than do courts construing the federal right of privacy. *See id.*

2. *Id.* at 254.

II. STATEMENT OF THE CASE

Faith Myers had been suffering with mental illness for approximately twenty years when she was involuntarily committed to the Alaska Psychiatric Institute ("API") in February 2003.[3] Once committed, Myers refused to discuss treatment options with doctors. API subsequently filed a petition for authorization to medicate Myers without her consent.[4]

Myers challenged the constitutionality of the statute that authorized the administration of psychotropic medication, of which antipsychotic drugs are a subclass, without a patient's consent.[5] Myers contended that the Alaska Constitution's protections of liberty and privacy expressly afforded her the right to "be free from unwanted mind-altering chemicals."[6] The superior court found that Myers was unable to appreciate that she had a mental disorder, and she therefore lacked the capacity to make informed decisions about her treatment.[7] Because the court interpreted the statute as limiting its role to determining whether a patient is competent to make informed

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3. *Id.* at 239. Myers' civil commitment was based on concerns voiced by both her daughter and her neighbors. *Id.*

4. *Id.* The statute authorizing court-ordered administration of psychotropic medication requires that a court find a patient to lack the competence to give informed consent. ALASKA STAT. § 47.30.839(g) (2004). Once a court finds a patient incompetent, the court "shall approve the . . . proposed use of psychotropic[s]." *Myers*, 138 P.3d at 240.

5. *Id.* at 239; *see also* ALASKA STAT. § 47.30.839(g).

6. *Myers*, 138 P.3d at 239. Myers argued that the aforementioned sections 7 and 22 of the Alaska Constitution guaranteed her the right to refuse psychotropic, or the subclass of antipsychotic, medication, unless the state could prove that it had a compelling interest warranting encroachment upon her rights and that the proposed encroachment was the least restrictive means of furthering the compelling interest. *Id.* Myers further contended that the statute authorizing unconsented administration of such medication was unconstitutional because it required mandatory approval of treatment plans upon only a showing of incompetence. *Id.* The statute, Myers argued, did not allow for a determination of the patient's best interests by an independent decision maker. *Id.* at 240.

7. *Id.* At Myers' hearing on API's petition, API presented the testimony of two psychiatrists who felt that psychotropic medication was an appropriate treatment under the circumstances. *Id.* Myers offered two expert psychiatrists who advanced the views that such treatment is neither the only viable option for patients like Myers, nor was it the best treatment option due to the dangerousness of the drugs and the evolving doubts concerning their effectiveness. *Id.* Myers' experts also highlighted the range of dangerous side effects associated with drugs like Zyprexa, the drug API prescribed for Myers. *Id.* The court largely disregarded Myers' arguments, as it found that she lacked the capacity required to make informed decisions concerning her medical treatment. *Id.* The statute, the court held, provided no judicial discretion once a patient had been found incompetent; approval of the proposed treatment was mandatory under the statute. *Id.*

treatment decisions, and because the court in fact found Myers lacked such capacity, the court granted API's treatment order.[8]

Myers appealed and was granted review by the Supreme Court of Alaska.[9] The supreme court agreed with Myers' contention that the statute violated her constitutional protections of liberty and privacy because it did not allow for a judicial determination of her best interests and because it did not require a judicial finding that the proposed treatment was the least intrusive means of advancing the state's countervailing interests.[10] The supreme court therefore vacated the superior court's treatment order.[11]

III. THE COURT'S REASONING

The court began its analysis by noting that the Alaska Constitution, like several other state constitutions,[12] contains an express right of privacy that protects its citizens to a greater extent than does the United States Constitution.[13] Section 22 of the Alaska Constitution reads: "The right of the

8. *Id.*

9. *Id.*

10. *Id.* at 254.

11. *Id.* The state attempted to have Myers' appeal dismissed because, prior to this action, Myers had been released from API without having received the medications at issue. *Id.* at 241. These facts, the state contended, rendered the issue moot and warranted dismissal. *Id.* Invoking the public interest exception, the court held that the issues implicated in the Myers case were "of grave public concern." *Id.* at 244. Further, the subject of the case was "recurrent" but "capable of evading review." *Id.* Therefore, the court held, the doctrine of mootness did not apply. *Id.*

12. *See* JENNIFER FRIESEN, STATE CONSTITUTIONAL LAW: LITIGATING INDIVIDUAL RIGHTS, CLAIMS AND DEFENSES § 2-2 (2d ed. 1996). Alaska, California, Florida, Hawaii, and Montana protect a broad right of privacy via an independent "free standing clause" in their state constitutions. *Id.* Illinois, South Carolina, and Louisiana contain narrower privacy provisions included in search and seizure provisions, and Washington and Arizona expressly protect "private affairs." *Id.* Other states, like New Jersey, protect the right of privacy in the state Declaration of Rights via an implied or penumbral interpretation similar to that employed in interpreting the federal right of privacy. *Id.* Finally, other states, like Mississippi, have found the right of privacy in the common law. *Id.* The source of the right of privacy may affect the scope of the right as construed by state courts. *Id.*

13. *Myers*, 138 P.3d at 245. Indeed, state constitutions have become the "preeminent source of rights" for involuntarily-committed, mentally-ill patients. Michael L. Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled*: *The Last Frontier?*, 20 LOY. L.A. L. REV. 1249, 1264 (1986). This is likely the result of the Supreme Court's "extraordinary deference" to physicians' judgments in cases concerning involuntarily-committed, mentally-ill citizens. *Id.* at 1260; *see* FRIESEN, *supra* note 12, at § 2-6 (noting that the Supreme Court has not found a need for judicial hearings prior to the forcible administration of psychotropic medication); Alan Meisel, *The Rights of the Mentally Ill Under*

people to privacy is recognized and shall not be infringed."[14] The court explained that:

> Since the citizens of Alaska, with their strong emphasis on individual liberty, enacted an amendment to the Alaska Constitution expressly providing for a right to privacy not found in the United States Constitution, it can only be concluded that the right is broader in scope that that of the Federal Constitution.[15]

State Constitutions, 45 LAW & CONTEMP. PROBS. 7, 16 (1982) (noting that because the Supreme Court has failed to adequately protect psychiatric patients' rights, the "reliable sanctuary from Supreme Court review lies in the state courts' ability to decide cases exclusively on the basis of state law"). *But see* Sell v. United States, 539 U.S. 166, 179-80 (2003) (holding criminal defendants may be forcibly medicated with antipsychotic medication only upon showings of an important state interest, a substantial likelihood that the medication will render the defendant able to stand trial, medical necessity or appropriateness, and the unavailability of less intrusive alternatives).

However, greater state constitutional protection of privacy is not always dispositive. Perlin describes three methods of analyzing state constitutional law issues. Perlin, *supra*, at 1274. First, some courts employ a "dual reliance" analysis, which requires consideration of both the federal and state constitutions. *Id.*; *see, e.g.*, State v. Gerhardstein, 416 N.W.2d 883, 892 (Wis. 1987). Second, some courts employ the "primacy approach," which requires a court to first consider its state constitution and only considers the Federal Constitution if the "infringement" is allowed under the state constitution. Perlin, *supra*, at 1275; *see, e.g.*, *Myers*, 138 P.3d at 245. Finally, other courts use the "supplemental approach," a method that first examines the Federal Constitution and then proceeds to the state constitution only if the infringement is allowed under the Federal Constitution. Perlin, *supra*, at 1275; *see, e.g.*, Jarvis v. Levine, 418 N.W.2d 139, 147 (Minn. 1988).

Despite these varied approaches, the predictions of Perlin and Miesel have become realities. "[I]n many areas of personal decision making, including medical treatment, reproductive autonomy, and individual lifestyle, state courts have proven the theorem that they need not depend upon federal analyses of similar federal rights." Ken Gormley & Rhonda Hartmann, *Privacy and the States*, 65 TEMP. L. REV. 1279, 1297 (1992).

14. ALASKA CONST. art 1, § 22. Voters approved this provision in 1972, largely in response to concerns about "abuse of computerized information systems as well as police surveillance." GERALD A. MCBEATH, THE ALASKA STATE CONSTITUTION: A REFERENCE GUIDE 64 (1997).

15. *Myers*, 138 P.3d at 245. Further, the court noted that it had "similarly declared Alaska's constitutional guarantee of individual liberty to be more protective." *Id.*; *see also* Anchorage Police Dep't Employees Ass'n v. Municipality of Anchorage, 24 P.3d 547, 549 (Alaska 2001). The court's reliance on the Alaska Constitution's privacy provision to protect the right of its citizens to make medical treatment decisions in a variety of contexts reflects a trend in state constitutional law. Gormley & Hartmann*,* *supra* note 13, at 1284-90. However, such protection is not unlimited, especially not in the context of involuntarily-committed,

Relying on this explicit constitutional protection, the court held that the right to refuse psychotropic medications implicates fundamental liberty and privacy interests.[16] Further, the court engaged in horizontal federalism,[17] acknowledging that its categorization of the right to refuse antipsychotic medication as fundamental was in following with nationwide state constitutional law trends.[18] The court cautioned, however, that even a fundamental right is not absolute.[19] Rather, the state could justify placing a "substantial burden" on a fundamental right by showing a "compelling state

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mentally-ill patients. Rather, "so long as procedural safeguards are in place, the privacy right is not violated." *Id.* at 1290.

16. *Myers*, 138 P.3d at 246. The court also noted its history of construing its constitutional liberty and privacy protections to "encompass the prerogative to control aspects of one's personal appearance, privacy in the home, and reproductive rights." *Id.*; *see also* Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice, 948 P.2d 963, 968 (Alaska 1997) (holding the Alaska Constitution's privacy provision encompassed a woman's fundamental right to obtain an abortion); Ravin v. State, 537 P.2d 494, 504 (Alaska 1975) (holding the explicit protection of privacy in the Alaska constitution guaranteed its citizens the right to possess and ingest marijuana, in a non-commercial context, in their own homes absent a countervailing legitimate state interest); Gray v. State, 525 P.2d 524, 528 (Alaska 1974) (holding the privacy provision in the Alaska Constitution "clearly . . . shields the ingestion of food, beverages or other substances"); Breese v. Smith, 501 P.2d 159, 169 (Alaska 1972) (holding the right to liberty protected a public school student's fundamental right to choose his own hairstyle despite objections by his school).

The privacy provision of the state constitution has also been used to protect the sexual privacy rights of juveniles and the right to be free from unwarranted electronic surveillance. MCBEATH, *supra* note 14, at 67.

17. G. ALAN TARR, UNDERSTANDING STATE CONSTITUTIONS 98-99 (1998).

18. *Myers*, 138 P.3d at 246; *see also* People v. Medina, 705 P.2d 961, 963-64 (Colo. 1985); Rogers v. Comm'r of the Dep't of Mental Health, 458 N.E.2d 308, 314 (Mass. 1983) ("Every competent adult has a right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks . . . ."); *Jarvis*, 418 N.W.2d at 148 (holding the right to privacy under the Minnesota Constitution "begins with protecting the integrity of one's own body and includes the right not to have it altered or invaded without consent"); Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (holding the common law right of an individual "to determine what shall be done with his own body" so as to "insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference" was coextensive with that individual's liberty); Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 15 (Ohio 2000) ("The right to refuse medical treatment is a fundamental right in our country . . . ."); *In re* Mental Health of K.K.B., 609 P.2d 747, 750 (Okla. 1980); *Gerhardstein*, 416 N.W.2d 710.

19. *Myers*, 138 P.3d at 251-52.

interest" and the "absence of a less restrictive means" of furthering that interest.[20]

In examining the state's proffered countervailing interests, the court quickly dismissed the state's police power as warranting infringement upon an incompetent patient's right to refuse medication in non-emergency situations.[21] The court noted that API did not prove that Myers presented an "imminent threat of harm to herself or anyone else after she was committed for treatment at API."[22] In the absence of an imminent threat of danger, the court reasoned, the state could not use its police power to justify such extreme intrusions into a patient's bodily integrity.[23]

The court did accept the state's parens patriae obligation, or its obligation to protect citizens from themselves, as a compelling government interest that might warrant the forcible administration of psychotropic medication in some situations.[24] However, the parens patriae power can only

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20. *Id.* at 245; *see also* Ranney v. Whitewater Eng'g, 122 P.3d 214, 221 (Alaska 2005); Sampson v. State, 31 P.3d 88, 91 (Alaska 2001); *Valley Hosp. Ass'n*, 948 P.2d at 969; *Ravin*, 537 P.2d at 511; *Gray*, 525 P.2d at 527; *Breese*, 501 P.2d at 170.

21. *Myers*, 138 P.3d at 248; *see also* Jessica Litman, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1739-40 (1982) (discussing the legitimate invocation of states' police powers to administer antipsychotic medication only when there is an imminent threat of harm). Litman also discusses the tendency of treatment facilities to argue that many mentally-ill patients exhibit a potential for violent behavior, but she notes that many courts have nonetheless found the state's police power inadequate to justify using antipsychotic medication as a means of preventing future violence in the absence of an imminent threat. *Id.* at 1740-42; *see, e.g.*, *Rogers*, 458 N.E.2d at 320-22; *Rivers*, 495 N.E.2d at 343; *Steele*, 736 N.E.2d at 18.

22. *Myers*, 138 P.3d at 248. The court acknowledged that in emergent circumstances, such as when a patient who has been committed poses an imminent threat of harm to themselves, to other patients, or to the staff, API "might be correct" in using the state's police power to justify forced administration of psychotropic medication. *Id.* The *Myers* court's holding on this issue was in following with current trends in state constitutional law across the country. *See Rogers*, 458 N.E.2d at 320; *Rivers*, 495 N.E.2d at 343; *Steele*, 736 N.E.2d at 18.

The Alaska statute, however, provided that "a court can grant authorization to medicate without ever considering whether or not the patient poses a threat of harm to anyone." *Myers*, 138 P.3d at 249 n.77 (citing ALASKA STAT. § 47.30.839(g) (2004)).

23. *Id.* at 248.

24. *Id.* at 249. "The doctrine of parens patriae refers to the inherent power and authority of the state to protect the 'person and property' of an individual who 'lacks legal age or capacity.'" *Id.* (emphasis omitted). As the lower court found Myers incompetent to make treatment decisions, the state was justified in making such decisions for her protection. *Id.* Again, the court's holding was in keeping with national trends. *See Rogers*, 458 N.E.2d at 322; *Rivers*, 495 N.E.2d at 343-44; *Steele*, 736 N.E.2d at 19; *see also* Litman, *supra* note 21, at 1742-50. Litman notes that commitment alone does not warrant a presumption of a patient's incompetence to make treatment decisions. *Id.* at 1747. Quite the contrary, many involuntarily

be invoked when citizens are incompetent to protect themselves; civil commitment alone does not trigger even a presumption of a patient's incompetence to make treatment decisions.[25] Rather, a judicial determination of incompetence must precede the forced medication under the parens patriae theory. Because the superior court found Myers incompetent to make treatment decisions, the supreme court proceeded to a second level of analysis.

In determining whether the state is justified in forcibly administering psychotropic medication under the parens patriae theory, the court held that the judiciary must first determine the incompetent patient's best interests, a determination that relies wholly on the specific facts of each case.[26] The court required that "[a]t a minimum . . . courts should consider the information that our statutes direct the treatment facility to give its patients in order to ensure the patient's ability to make an informed treatment choice"[27]

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committed patients make rational decisions regarding treatment that reflect the serious side effects associated with antipsychotic medication. *Id.* at 1748.

The range and seriousness of such side effects is considerable. Common side effects include Parkinsonian Syndrome, akathisia, dystonia, and dykinesia. BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 72-75 (1997). Parkinsonian Syndrome involves muscle problems, tremors, salivation, motor problems, difficulty walking, paralysis of the face muscles, and a variety of other issues. *Id.* at 72. Akathisia involves a feeling of perpetual restlessness. *Id.* Dykstonia involves random muscle spasms, often in the head, neck, face, tongue and arms, as well as "oculogyric crisis marked by eyes flipping to the top of the head in a painful upward gaze persisting for minutes or hours." *Id.* at 73. Dykinesia involves similar spasms throughout the body, particularly in the fingers and mouth or tongue. *Id.* Most of these side effects are treatable; however, some others are often permanent and have no known treatment. *Id.* at 73-74. Indeed, "[c]urrent practices of administering psychoactive drugs present unacceptably high risks," yet "the practice is used 'far more often that experimental evidence or common sense dictates.'" *Id.* at 83.

25. *See Rogers*, 458 N.E.2d at 314; *Rivers*, 495 N.E.2d at 342; *Steele*, 736 N.E.2d at 20; State v. Gerhardstein, 416 N.W.2d 883, 890-94 (Wis. 1987) ("An individual may be psychotic, yet nevertheless capable of evaluating the advantages and disadvantages of taking psychotropic drugs and making an informed decision. . . . This presumption of incompetency has been reversed."); Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 191 (1980); Litman, *supra* note 18, at 1742-50. *But see* Davis v. Hubbard, 239 N.W.2d 905, 911 (Minn. 1976) ("Inherent in an adjudication that an individual should be committed . . . is the decisions that he can be forced to accept . . . treatment . . . ."). The *Myers* court did not address this issue, as the superior court had already found Myers incompetent to make treatment decisions. *Myers*, 138 P.3d at 249.

26. *Id.* at 252.

27. *Id.* ALASKA STAT. § 47.30.837(d) (2) requires:

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without medication;

when attempting to discern a patient's best interests. By considering each of the factors that doctors discuss with competent patients in order to allow them to make informed decisions, the court hoped to arrive at the answer the patient would make were he or she competent to do so. The court did not need to apply this reasoning to Myers' case, however, as Myers had already been released from API without ever having received the medication in question.[28]

Once the court determines a patient's best interests, it must ensure that the state's proposed treatment is the least intrusive means of furthering both the state's and the patient's interests.[29] The court expressly disagreed with API's contention that this was a medical question more appropriately resolved by its medical staff.[30] Rather, the court held that the right to refuse medication has its foundation in the state constitution, because "[t]he constitution itself requires courts, not physicians, to protect and enforce these guarantees."[31]

In sum, the court ruled that the Alaska Constitution requires a judicial determination of incompetence as well as a determination of the incompetent mental patient's best interests and a finding that no less intrusive means of

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> (B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
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> (C) a review of the patient's history, including medication history and previous side effects from medication;
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> (D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and
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> (E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.]

Id. (quoting ALASKA STAT. § 47.30.837(d) (2) (2004)).

28. *Id.* at 244.

29. *Id.* at 250; *see also Rogers*, 458 N.E.2d at 308; *Steele*, 736 N.E.2d at 21.

30. *Myers*, 138 P.3d at 250.

31. *Id.* The court noted that "though the answer certainly must be fully informed by medical advice received with appropriate deference, in the final analysis the answer must take the form of a legal judgment that hinges not on medical expertise but on constitutional principles aimed at protecting individual choice." *Id.* Many other state supreme courts have acknowledged the court's role in determining the extent of constitutional protection when medical judgments become implicated in the protection of constitutional rights. *Id.* (citations omitted).

treatment is available before a court may authorize forcible administration of psychotropic medication.[32]

IV. DISCUSSION

The right of involuntarily-committed, mentally-ill patients to refuse antipsychotic medication in non-emergencies was well established in state constitutional law prior to *Myers v. API*.[33] The supreme courts of other states followed a similar rationale in reaching this conclusion: they first found that a patient's right to refuse antipsychotic medication is fundamental.[34] Next, they attempted to balance the states' parens patriae interest against the patients' best interests by formulating a rule respecting the legitimacy of both interests.[35]

Perhaps the most interesting common thread in these cases, however, is the consistent insistence that the aforementioned balancing test be conducted by the judiciary and not medical professionals.[36] This shift towards greater judicial protection of mentally-ill patients' rights represents a marked shift from the "hands off" attitude of most courts through the 1960s.[37] Recent trends, however, suggest that the courts now have few reservations about clinging to their role as sole interpreters of state constitutions, even when

32. *Id.* at 254. The court maintained that such judicial hearings would be governed by a clear and convincing evidentiary standard with the burden on the state to prove that the proposed course of treatment is in the patient's best interests and that no less intrusive alternative is available. *Id.* at 253.

33. *See supra* note 15. For a concise discussion of the history of the right to refuse and the related rationale, see Marshall B. Kapp, *Treatment and Refusal Rights in Mental Health*: *Therapeutic Justice and Clinical Accommodation*, *in* LAW, MENTAL HEALTH, AND MENTAL DISORDER 279, 281-83 (Bruce D. Sales & Daniel W. Shuman eds., 1996).

34. *See supra* note 15.

35. *See, e.g.*, Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 20 (Ohio 2000).

36. *See, e.g.*, Jarvis v. Levine, 418 N.W.2d 139, 147-48 (Minn. 1988) ("When medical judgments collide with a patient's fundamental rights . . . it is the courts, not the doctors, who possess the necessary expertise."); Rivers v. Katz, 495 N.E.2d 337, 343-44 (N.Y 1986).

37. *See* Jan C. Costello, *"Why Would I Need a Lawyer?"*: *Legal Counsel and Advocacy for People with Mental Disabilities*, *in* LAW, MENTAL HEALTH, AND MENTAL DISORDER, *supra* note 33, at 18 ("Some [mental health professionals] who practiced before the recognition of mental patients' constitutional rights . . . may be nostalgic for the good old days when 'we could just practice medicine without interference from the law.'" (citation omitted)). Costello further discusses the great power wielded by mental health practitioners during this time: "[I]n many states a psychiatrist's signature on a paper was sufficient to authorize prolonged involuntary confinement . . . as well as to restrict all aspects of a patient's life within an institution." *Id.*

those interpretations implicate complicated medical analysis.[38] Indeed, the *Myers* court noted that "the issue is not one of medical competence or expertise."[39] Rather, the court held that the issue was the extent to which the Alaska Constitution protected its involuntarily-committed, mentally-ill citizens' privacy and liberty.[40]

As discussed above, the court found that the statutory scheme failed to provide a constitutionally acceptable level of protection. The court summarized the statutory requirements: "once the court finds that the patient is presently incapable of consenting and has never before expressed medication-related wishes while competent, these provisions leave the court no discretion to determine a patient's best interests: the provisions require it to approve the treatment."[41] In essence then, the statute provided no protection of a patient's liberty or privacy interests once the patient was found incompetent, a proposition already rejected by several state supreme courts.[42]

The healthcare profession voiced three main objections to judicial interference with medical care. First, clinicians argued that patient care would be adversely affected as a result of the judicial presumption that patients do not want to be treated.[43] Second, clinicians argued that failure to medicate would result in prolonged hospitalization, thereby necessitating greater restrictions in patients' freedom and autonomy.[44] Finally, clinicians

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38. *See, e.g.*, *Jarvis*, 418 N.W.2d at 148; *Rivers*, 495 N.E.2d, at 344; State v. Gerhardstein, 416 N.W.2d 883, 895 (Wis. 1987) ("The court has been presented with horror stories of delay in administering drugs . . . and interference with professional judgment; however . . . the constitutional rights of the recipients . . . must supersede these other considerations."), *superseded by statute*, 1987 Wis. Act 366, § 18, *as recognized in* State v. Anthony D.B., 614 N.W.2d 435 (Wis. 2000).

39. Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 250 (Alaska 2006).

40. *Id.*

41. *Id.* at 244.

42. *See, e.g.*, *Rivers*, 495 N.E.2d at 342 ("Nor does the fact of mental illness result in the forfeiture of a person's civil rights . . . including the fundamental right to make decisions concerning one's own body.").

43. Kapp, *supra* note 33, at 284. Further, clinicians maintained that many patients would even thank them after the fact for administering medication against the patient's wishes, as the objections are generally a result of mental illness and not rational analysis. *Id.*

44. *Id.* "Untreated patients would thus be forced to 'rot with their rights on.'" *Id.* (citation omitted). In presenting this argument, clinicians attempted to disprove the notion that the aforementioned conflicts of interest adversely affected their motives in determining patient treatment. *Id.* "Clinicians complained that their ethical integrity and sense of professional self-esteem were potentially compromised by legal rules that changed their role from healer to jailor." *Id.*

maintained that a judicial approval process would be time consuming and costly.[45] In essence, clinicians felt that such a complicated approval process diverted valuable resources away from patient care, once again hurting the very group the judiciary sought to protect.

The court responded to these arguments by noting several factors that complicate medical judgment in the context of involuntary civil commitment. The *Myers* court observed that the conflicting interests of hospital staff warrant independent judicial review of decisions that implicate a patient's fundamental rights.[46] While the court acknowledged that hospital staff does have an interest in providing appropriate treatment to its patients, it also has an interest in maintaining a safe and orderly environment for other patients and staff.[47] To be sure, "[p]sychotropic drugs are much abused, particularly in institutions for the mentally disabled"[48] are used to subdue

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This argument seems to be a corollary to the rationale employed by most courts in explaining the need for judicial intervention. Seemingly, courts distrust the notion that the ethical obligations of medical professionals adequately protect patients' best interests. However, clinicians argued that courts, in attempting to protect those interests, actually curtailed treatment that would have therapeutic value, thereby actively restraining medical professionals from acting as "healers," thereby forcing medical action inconsistent with the ethical integrity found to be so suspect by the judiciary.

Further, it is important to note the therapeutic value of psychotropic medication. Though such medication does not cure most mental disorders, it has allowed many patients to live with mental disorders free from the rampant institutionalization that categorized the era before the advent of such medication. *See* WINICK, *supra* note 24, at 68-69.

45. *Id.*

46. *Myers*, 138 P.3d at 250.

47. *Id.* "The doctors who are attempting to treat as well as maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication . . . . Economic considerations may also create conflicts." *Id.* (quoting Rogers v. Comm'r of the Dep't of Mental Health, 458 N.E.2d 308, 317-18 (Mass. 1983)); *see also* WINICK, *supra* note 24, at 67-68 (providing background on frequency of use and revenue derived from psychotropic medication).

In *Washington v. Harper*, Justice Stevens' dissent discusses two conflicts of interest that should disqualify doctors as decision makers when a patient refuses psychotropic medication. 494 U.S. 210, 251 (1990) (Stevens, J., dissenting). First, the system of review employed by these institutions calls for review of treatment decisions by panels consisting only of colleagues within the institution. *Id.* Hence, a doctor may be reviewed by the same doctors whose decisions he or she may subsequently have to approve, creating a conflict of interest. *Id.* Second, the reviewing panel, because it consists only of hospital staff, is concerned not only with each patient's medical interests, but also with "most convenient means of controlling the mentally disturbed inmate." *Id.* at 253.

48. WINICK, *supra* note 24, at 76. "Some have even suggested the use of long-acting tranquilizers implanted beneath the skin of prisoners – a means of 'chemical incapacitation' urged as an alternative to prison." *Id.* at 77.

patients for convenience rather than as a means of furthering the patient interest in receiving appropriate treatment that is in the patient's best interest.[49] Furthermore, because institutions often administer antipsychotic medication either during or immediately thereafter the commitment process, such medication can mask important symptoms that would aid clinicians in reaching accurate diagnoses that might lead to more effective treatment.[50]

Such use, or arguably abuse, of antipsychotic medication in mental health facilities may reflect a societal trend of over-medication in general,[51] or it may merely reflect the unique environment of the state mental facility—one that is fraught with divergent doctor, patient and state interests. In either case, the *Myers* court's preservation of a judicial role in the treatment of

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49. *See Washington v. Harper*, 494 U.S. at 244, 250 (Stevens, J., dissenting) (admonishing the use of psychotropic drugs to "ease the institutional and administrative burdens of maintaining prison security . . . and managing an unruly prison population and preventing property damage," a practice that "eviscerates" prisoners' liberty interests for mere institutional convenience); *see also* Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979); Davis v. Hubbard, 506 F. Supp. 915, 926-27 (N.D. Ohio 1980); Rone v. Fireman, 473 F. Supp. 92 (N.D. Ohio 1979); Halderman v. Pennhurst State Sch. & Hosp., 446 F. Supp. 1295, 1307 (E.D. Pa. 1978); Clites v. State, 322 N.W.2d 917, 921 (Iowa Ct. App. 1982); WINICK, *supra* note 24, at 78-79 (noting that these putative and supervisory measures are often employed without the supervision of a physician); Litman, *supra* note 21, at 1721, 1724 (describing "evidence of an alarming degree of institutional abuse" of psychotropic medication).

In *Rennie v. Klein*, the court noted the over and inappropriate use of antipsychotic medication, but it also found that twenty-five to fifty percent of medication decisions were left to nurses and attendants. *Rennie*, 476 F. Supp. at 1301. Hence, API's contention in *Myers* that doctors are the appropriate decision makers in these cases becomes susceptible to the counterargument that doctors are not, in fact, making many of these decisions. Rather, staff members without medical degrees become responsible for determining questions which implicate both complicated medical issues as well as issues concerning fundamental constitutional protections. Similarly, in *Davis v. Hubbard*, the United States District Court found that both licensed and unlicensed physicians prescribed psychotropic drugs for seventy-three percent of patients, a number that the court believed could not be justified solely by medical necessity. *Davis*, 506 F. Supp. at 926. Rather, the court explained, staff convenience and patient punishment were the likely reasons for such widespread use of psychotropic medications. *Id.*

50. WINICK, *supra* note 24, at 82-83.

51. *See* JAY S. COHEN, OVER DOSE: THE CASE AGAINST THE DRUG COMPANIES 213-14 (2001). Cohen, writing from personal experience as a practicing physician, notes that "many doctors over identify with their medications," a situation he feels is responsible for making the prescription of medication the most common action taken by doctors today. *Id.* Cohen also suggests that, to a large extent, physician behavior is largely influenced by drug companies. *Id.* at 22-23. The introduction of this third party, whose interests may also be in conflict with mentally-ill patients, further justifies the need for judicial supervision of forced medical treatment.

involuntarily-committed, mentally-ill patients appears justified by the widespread overuse and/or misuse of psychotropic medication.[52] Despite initial objections by medical professionals, judicial intervention seems to have struck a balance between medical and legal interests rather than affected an unwarranted encroachment upon the medical professional realm.[53] "[In] crafting [the] right to refuse," notes Kapp,

> [courts] have mainly accommodated competing interests and forged reasonable, workable, compromises. The unfolding of the right-to-refuse story over the past decade and a half has caused attorneys and clinicians to talk to each other and to join together to advocate for a better treatment system with better treatment alternatives, as advocates' emphasis has shifted from unbridled zeal for individual liberty at all costs to a concern about quality and benefits of care.[54]

V. CONCLUSION

Involuntarily-committed, mentally-ill patients' rights to refuse antipsychotic medications seems to have become a settled question.[55] Oddly, despite Alaska's tradition of individuality and heightened privacy protection, Alaska reached this conclusion relatively late, following on the heels of many other similar state constitutional law decisions. In fact, the prevalence of cases concerning involuntarily committed patients' rights to refuse antipsychotic medication in non-emergency situations, as well as the scholarly literature on related law, has diminished considerably since the early 1990s.[56]

More recently, similar issues have resurfaced in the context of cases dealing with defendants' rights to refuse forced administration of psychotropic drugs in order to be competent to stand trial for criminal

52. *See* WINICK, *supra* note 24, at 81 ("[T]here appears to be a tendency to overprescribe these drugs, to use them inappropriately, and to make medication decisions before a proper diagnosis has been made.").

53. Kapp, *supra* note 33, at 279. Kapp notes that "the goals of law and mental health care have not proven irreconcilable, perhaps because both disciplines are intended to promote human welfare." *Id.* Kapp argues that courts following the approach employed in *Myers* have reached a workable compromise that protects both mental health patients' "rights and needs." *Id.*

54. *Id.* at 289.

55. *See supra* note 15.

56. *See* Kapp, *supra* note 33, at 279.

charges.[57] In addition, both state and federal courts of late have been attempting to carve out the rights of the mentally-ill regarding forcible antipsychotic medication in order to be made competent for execution.[58] Though the context in which the rights of incompetent, mentally-ill citizens are addressed has changed, these cases implicate the same liberty and privacy interests at issue in *Myers*. Again, states will likely look to the greater protections found in state constitutions in order to resolve these difficult questions.

57. For a discussion of criminal defendants' rights to refuse psychotropic medication in order to be made competent to stand trial, see Aimee Feinberg, *Forcible Medication of Mentally Ill Criminal Defendants*: *The Case of Russell Eugene Weston, Jr.,* 54 STAN. L. REV. 769 (2002); *see also* Megan Quinlan, *Forcible Medication and Personal Autonomy*: *The Case of Charles Thomas Sell*, 84 B.U. L. REV. 275 (2004).

58. For a discussion of forcible medication prior to execution, see Brent W. Stricker, *Seeking an Answer*: *Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die*, 32 MCGEORGE L. REV. 317 (2000); *see also* FRIESEN, *supra* note 12, at § 2-6.