1989 S.C. Op. Atty. Gen. 25 (S.C.A.G.), 1989 S.C. Op. Atty. Gen. No. 89-7, 1989 WL 406097

Office of the Attorney General

State of South Carolina
Opinion No. 89-7
January 27, 1989

*1 The Honorable Patrick B. Harris
Member
House of Representatives
519–B Blatt Building
Columbia, South Carolina 29211

Dear Representative Harris:
You have inquired about an individual's medical or clinical competency to make decisions regarding treatment when that individual has been involuntarily committed to a psychiatric facility. You have referenced Section 44–17–580 of the Code of Laws of South Carolina (1976, as revised) and have asked whether the language therein implies a finding by the probate court that the individual lacks the ability to engage in rational decision-making regarding the acceptance of psychiatric treatment and thus a finding of a lack of medical or clinical competency to make treatment decisions for oneself.

Section 44–17–580 of the Code provides in relevant part that:
If, upon completion of the hearing and consideration of the record, the court finds upon clear and convincing evidence that the person is mentally ill, needs treatment and because of his condition:

(1) lacks sufficient insight or capacity to make responsible decisions with respect to his treatment; or

(2) there is a likelihood of serious harm to himself or others, it shall order in-patient or out-patient treatment at a mental health facility, public or private, designated or licensed by the Department of Mental Health....

The probate court may find that an individual needs treatment for either or both of the conditions specified in Section 44–17–580 of the Code. If the first condition is found to exist, such finding would not necessarily be considered binding except as to that point in time; it may not bind the Department of Mental Health or the patient later in time, as in those instances in which the patient's condition has changed for the better.

It should also be noted at the outset that patients' rights are detailed by statute. See Sections 44–23–1010, –1020, –1030, and –1040 for examples. In particular, Section 44–23–1010 provides in relevant part:
All treatment and medication shall be authorized by the attending physician. The attending physician's authorization and the medical reasons for it shall be entered into the patient's clinical record. Such authorization shall not be valid for more than ninety days. The patient shall have the right to refuse any treatment not recognized as standard psychiatric treatment....

Upon review of statutes, current judicial decisions, and directives of the South Carolina Department of Mental Health, it is apparent that Section 44–17–580 does not automatically preclude an involuntarily committed individual from participating in decisions regarding his treatment.

It is our understanding that the Department of Mental Health seeks consent of its patients before administering medical treatment. In this regard, two directives of the Department of Mental Health are significant. Directive No. 703–87 concerns "Consent Forms for Neuroleptic Medications" and was adopted "to insure that all facilities and centers obtain informed consent and accomplish adequate documentation in all cases when prescribing neuroleptic medications." The policy states that "[a]n informed consent, as prompt and as valid as possible, will be obtained in all treatment cases." The directive further notes that "[f]or patients who refuse to consent to medication then Directive No. 537–80 entitled, 'Refusal of Medication by Patients in Mental Health Facilities' dated April 30, 1980 applies."

*2 The second directive, No. 537–80 as just described, provides the mechanism whereby voluntary and involuntary patients may be given medication over their objections. The involuntary patient's attending physician must determine why the patient is refusing medication, advise the patient of the reasonably anticipated medical consequences of not taking the medication, review all other viable treatment alternatives, and attempt to find an alternative acceptable to the patient. If the physician cannot identify an alternate treatment, or if the patient also refuses the alternate treatment, then the attending physician is directed to "have the chief medical officer of the facility or his designee and at least one other staff physician, chosen by the facility, to personally examine the patient and review the suggested treatment and alternatives."

The directive continues: "When this review confirms the need for the medication prescribed by the attending physician or when the reviewing physicians and attending physician are in agreement as to the medication indicated, such medication can be administered over the patient's objections." The directive notes that the instruction applies only to "involuntary patients who are dangerous to others, dangerous to themselves, or substantially unable to care for themselves." Other considerations, such as religious objections, are also specified in the directive.

Policies such as that adopted by the Department of Mental Health have been approved by courts in other jurisdictions; apparently the courts of this State have not yet been faced with the issue of whether such a policy adequately protects the right of a patient to decline such medical treatment. See Rennie v. Klein, 720 F.2d 266 (3d Cir.1983). In Rennie, it was held that
antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others. Once that determination is made, professional judgment must also be exercised in the resulting decision to administer medication.

Id., 720 F.2d at 269–70. A footnote notes that "[t]he standard adopted here would preclude the forcible administration of such drugs unless the predicate determination was made that the patient was a danger either to himself or others." Id. at 270. The resulting decision to administer medications will be presumed to be valid unless it is shown to be a "substantial departure from accepted professional judgment, practice or standards." Id. at 269, quoting from Romeo v. Youngberg, 457 U.S. 307 (1982).

A similar involuntary medication policy was upheld by the Minnesota Court of Appeals in Jarvis v. Levine, 403 N.W.2d 298 (Minn.App.1987). In determining that there was no right to judicial review of a decision by state hospital officials to administer involuntary neuroleptic medications in non-emergency situations, the court discussed the policy and noted that procedural safeguards adequately protected the patients' constitutional rights. When a professional review system has been established which requires the attending physician to seek approval from a treatment team if the patient withholds consent, so that the policy provides an opportunity for the exercise of professional judgment, such policy will be deemed in compliance with due process of the patients' rights.

*3 An involuntary medication policy in Texas passed constitutional muster in R.A.J. v. Miller, 590 F.Supp. 1319 (N.D.Tex.1984). The court noted that factors which must be considered in the exercise of professional judgment are outlined (i.e., beneficial effects of medication, probable consequences to patient if medication is not taken, existence of

alternatives, side effects of medication); in addition, a medical review process is provided for, to ensure the exercise of professional judgment. The policy under consideration in Texas provided for further review of the treatment decision by an independent psychiatrist, as well.

The court in R.A.J. v. Miller reiterated that applicable case law does not establish an absolute right of a competent, involuntarily committed patient to refuse neuroleptic medications:
Involuntary confinement represents a transfer from the patient to the State of the authority to make certain decisions affecting the patient's welfare.... The State is not restricted to helping the patient only if he wishes to be helped. That limitation was overcome when the patient was confined.

The State may therefore make decisions about different treatments that offer some hope of improving the patient's condition and returning him to his community.

Id., 590 F.Supp. at 1322–23, quoting from Rennie v. Klein, supra.

To reiterate the foregoing, when an involuntarily committed patient withholds his consent to be administered neuroleptic medication, such a right is not absolute. If a review of the attending physician's recommendations by the chief medical officer (or his designee) of the medical facility and at least one other staff physician confirms the necessity of the proposed treatment and all considerations outlined in Directive No. 537–80 have been taken into account, an involuntarily committed patient may have administered neuroleptic medications without his consent. The patient's reasons for refusal of medication and his participation in the process to determine viable treatment alternatives are not to be ignored in the exercise of professional judgment. Policies such as Directives No. 537–80 and 703–87 have passed constitutional muster in other states, as protecting the patients' rights while permitting the exercise of professional judgment. It cannot be said that merely because a patient has been involuntarily committed to a mental facility, he is not capable of participating in determining his course of treatment.

With kindest regards, I am
Sincerely,

Patricia D. Petway
Assistant Attorney General

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